

## Chapter 1

1. The nurse is caring for four clients on a medical–surgical unit. Which client should the nurse see initially?

1. A client admitted with hepatitis A who has had severe diarrhea for the last 24 hours
2. A client admitted with pneumonia who is has small amounts of yellow productive sputum
3. A client admitted with fever of unknown origin (FUO) who has been without fever for the last 48 hours
4. A client admitted with a wound infection whose WBC is 8,500 mm<sup>3</sup>

Answer: 1

Rationale: The nurse must decide which client should be seen on the initial rounds of the day. The nurse must remember that the first client to be seen should be the client who needs the attention of the nurse initially. A client with hepatitis A does experience diarrhea, but diarrhea for the last 24 hours could cause the client to have a problem with dehydration and experience a state of fluid volume deficit.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

2. The nurse is preparing to administer influenza vaccines to a mass drive-through clinic. Which statement by a client would indicate further questioning prior to giving the client the influenza vaccine?

1. “I am allergic to horse hair.”
2. “I try to get my vaccine every year.”
3. “I am not allergic to anything except eggs.”
4. “My husband had a severe allergic reaction after he received his influenza vaccine.”

Answer: 3

Rationale: Influenza vaccines are recommended for person at high risk for serious sequelae of influenza. The nurse should be aware that client with a sensitivity to eggs should not receive the vaccine. Vaccines prepared from chicken or duck embryos are contraindicated in clients who are allergic to eggs.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

3. The nurse is caring for four clients on a medical–surgical unit. The secretary gives the nurse the morning labs. Which of the following labs would require that the nurse call the physician and inform the healthcare provider about the client’s abnormalities?

1. WBC 14,600 mm<sup>3</sup>
2. Serum protein 6.9 g/dL
3. I & D (incision and drainage) showing no growth for the last 24 hours
4. Albumin 4.2 g/dL

Answer: 1

Rationale: When the nurse is caring for several clients, all of the labs should be checked frequently throughout the shift to assess for any abnormalities. The WBC in option 1 is abnormal. (Normal WBC 4,000–10,000 mm<sup>3</sup>.) All of the other lab results are within acceptable range; therefore, the results should not be called in to the physician.

Cognitive Level: Application

Client Needs: Physiologic Integrity

Nursing Process: Assessment

4. The nurse is orienting a new graduate. The nurse is reinforcing the importance of standard precautions. Which of the following observations by the nurse would require further education regarding standard precautions?

1. The graduate nurse understands to wash hands when entering and exiting the client’s room.
2. The graduate nurse wears gloves when serving breakfast trays to various clients.
3. The graduate nurse wears a gown, gloves, and goggles when suctioning a client.
4. The graduate nurse leaves all supplies in the room of a client who is in contact isolation.

Answer: 2

Rationale: The nurse must have an understanding of standard precautions. Prevention is the most important measure to prevent nosocomial infections. Standard precautions were published in 1996 that provide guidelines for the handling of blood and other body fluids. These guidelines are used with all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who have direct contact with clients or with their body

fluids. It is not necessary for the nurse to wear gloves while delivering food trays to the client, because there is not contact with the client.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Evaluation

5. The admitting department alerts the nurse on a medical–surgical unit that a client with active tuberculosis (TB) is being admitted to the unit. Which type of isolation is appropriate based on the client’s diagnosis?

1. Standard precautions
2. Airborne precautions
3. Droplet precautions
4. Contact precautions

Answer: 2

In addition to handwashing and standard precautions, the nature and spread of some infectious diseases require that special techniques be used to protect uninfected clients and workers. The client with pulmonary tuberculosis will be placed in airborne precautions. The client should be placed in a private room with special ventilation that does not allow air to circulate to general hospital ventilation; a mask or special filter respirators will be used for everyone entering the room.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

6. A client is receiving IV vancomycin for the treatment of Clostridium difficile. The nurse understands that the client who develops flushing, tachycardia, and hypotension during the infusion of vancomycin indicates:

1. Ototoxicity effect.
2. Superinfection.
3. Red man syndrome.
4. Hives.

Answer: 3

Rationale: Vancomycin inhibits cell wall synthesis, and is used for serious infections. It is only effective against gram-positive bacteria, especially *Staphylococcus aureus* and *Staphylococcus epidermidis*. The nurse should infuse this medication slowly over 60 minutes or more to avoid “red man” syndrome. The syndrome is characterized by

erythematous rash, flushing, tachycardia, and hypotension. Clients can become dizzy and agitated.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Evaluation

7. The physician has ordered for the client to receive a trough blood level to evaluate the therapeutic effect of an antibiotic. The nurse understands that the trough should be ordered:

1. A few minutes before the next scheduled dose of medication.
2. 1–2 hours after the oral administration of the medication.
3. 30 minutes after the IV administration.
4. During the infusion of the antibiotic.

Answer: 1

Rationale: Antibiotic peak and trough levels monitor therapeutic blood levels of the prescribed medication. The therapeutic range—the minimum and maximum blood levels at which the drug is effective—is known for a given drug. By measuring blood levels at the predicted peak (1–2 hours after oral administration, 1 hour after intramuscular administration, and 30 minutes after IV administration) and trough (usually a few minutes before the next scheduled dose), it is also possible to determine whether the drug is reaching a toxic or harmful level during therapy, increasing the likelihood of adverse effects.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

8. The nurse needs to change a dressing on the client's abdomen. Which of the following techniques should be implemented?

1. Contact precautions
2. Standard precautions
3. Droplet precautions
4. Airborne precautions

Answer: 2

Rationale: Standard precautions are used on all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who

have direct contact with clients or with their body fluids. Since the client has an abdominal dressing, the nurse will use standard precautions.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

9. The physician has ordered for the nurse to obtain a sputum specimen. The nurse understands that the sputum specimen should be collected:

1. Immediately after the first dose of antibiotic is administered.
2. 30 minutes after the first dose of antibiotics is administered.
3. During the first dose of antibiotics.
4. Before the first dose of antibiotics is administered.

Answer: 4

Rationale: When the physician orders a specimen to be collected, the nurse should collect the specimen before the first dose of antibiotics is administered, to ensure adequate organisms for culture.

Cognitive Level: Comprehension

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

10. Which of the following manifestations indicates a systemic reaction associated with an inflammatory response?

1. Erythema
2. Pain
3. Tachypnea (RR 26)
4. Edema

Answer: 3

Rationale: If the nurse observes a systemic reaction, the client will exhibit manifestations including temperature, increased pulse, tachypnea, and leukocytosis. Erythema, warmth, pain, edema, and functional impairment indicate a local reaction.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

11. A client develops hyperthermia related to a diagnosis of Pneumonia. Which of the following nursing interventions would be effective in the treatment of hyperthermia? Select all that apply.

1. Increase the temperature of the room environment to prevent shivering.
2. Use ice packs and a tepid bath as needed.
3. Administer antipyretic medications per physician's orders.
4. Promote frequent rest periods to increase energy reserve.
5. Restrict fluids during periods of hyperthermia because of the risk of electrolyte imbalance.

Answer: 2; 3; 4

Rationale: Hyperthermia is an expected consequence of the infectious disease process.

Fever can produce mild, short-term effects or, when prolonged, can cause life-threatening effects. The nurse should administer antipyretic medications as indicated for elevated temperatures. The nurse should use ice packs, cool/tepid baths, or hypothermia blanket with caution. The nurse should enforce frequent rest periods because rest increases energy reserve, which is depleted by an increased metabolic, heart, and respiratory rate. The nurse should encourage fluids rather than restrict fluids because of the risk of electrolyte imbalance.

Cognitive Level: Assessment

Client Needs: Physiological Integrity

Nursing Process: Implementation

12. The nurse is assessing a client's wound for signs and symptoms of inflammation. Which of the following would alert the nurse that the client is exhibiting signs of inflammation? Select all that apply.

1. Leg edema
2. Leg cool to touch
3. Severe pain from swelling
4. Decreased peripheral pulses
5. Severe erythema of leg

Answer: 1; 3; 5

Rationale: Regardless of the cause, location, or extent of the injury, the acute inflammatory response follows the sequence of vascular response, cellular and phagocytic response, and healing. Many manifestations of inflammation are produced by inflammatory mediators such as histamines and prostaglandins released when tissue is damaged. The cardinal signs of inflammation include erythema, local heat caused by the

increased blood flow to the injured area (hyperemia), swelling due to accumulated fluid at site, pain from tissue swelling and chemical irritation of nerve endings, and loss of function caused by the swelling and pain.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

Alternate item format – Select all that apply

Which of the following manifestations would the nurse expect to see with a client who has had previous knee surgery who suffered a surgical infection with signs of systemic manifestations? Select all that apply.

1. Erythema
2. WBC 14,200 mm<sup>3</sup>
3. Pain at the surgical site
4. 10% Bands
5. Respiratory rate of 16
6. Pulse 114

Answer: 2; 3; 6

Rationale: The client is post-surgical repair of the knee. The nurse should be able to distinguish between local reactions and system reactions. An elevated WBC and 10% bands are indicative of an infection. Vital sign changes typically associated with an infection include an elevation in temperature and tachycardia. Local manifestations include erythema, warmth, pain, edema, and functional impairment, whereas systemic manifestations include elevated temperature above 100.4°F, pulse greater than 90/min., respiratory rate greater than 20, and WBC greater than 12,000 mm<sup>3</sup> or > 10% bands.

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Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

## Chapter 2

1. When collecting data at the immunization clinic, which of the following disclosures by the client would cause the nurse to hold administration of the varicella vaccine?

- a. History of an allergic reaction to yeast bread
- b. Itching and swelling on the face and hands after ingesting eggs
- c. A low grade temperature within the past two days
- d. A blood transfusion after undergoing surgery three months ago

Answer: d

Rationale: Contradictions for the varicella vaccine include pregnancy, suppressed immunity, and a recent history of a blood transfusion. Recent hyperthermia and allergies to yeast or eggs do not indicate a potential difficulty with the administration of the varicella vaccine.

Nursing Process Step: Assessment

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

2. The nurse is planning an in-service to discuss primary levels of disease prevention. Which of the following topics should be included in this presentation?
- a. A discussion concerning the use of available community rehabilitation facilities
  - b. Available locations for diabetes screening
  - c. The need for annual colonoscopy examinations
  - d. The elimination of smoking and alcohol use

Answer: d

Rationale: Primary prevention involves activities geared toward the prevention of illness and disease. Screening activities such as glucose testing and colonoscopy examinations are a form of secondary prevention. Rehabilitation activities are considered a tertiary level of prevention.

Nursing Process Step: Planning

Client Needs Category: Health Promotion and Maintenance

Client Needs Category: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

3. A 45-year-old client voices concerns about gaining 12 pounds over the past two years. The client reports no change in dietary habits. Which response by the nurse is most appropriate?
- a. "Age-related changes in metabolism can result in weight gain despite consistent dietary intake."
  - b. "Are you exercising?"
  - c. "You might be eating more than you think."
  - d. "You are getting older."

Answer: a

Rationale: A reduction in metabolic rate often accompanies aging. This will cause weight gain despite not eating more calories. Asking the client about exercise fails to provide the

needed information to the client. It also assumes the client is sedentary. Implying the client is overeating is judgmental, and will do little to establish a therapeutic rapport. The client is aware of aging. Pointing this out does little to meet the client's obvious interest in more information.

Nursing Process Step: Diagnosis

Client Needs Category: Physiological Integrity

Client Needs Category: Physiological Adaptation

Cognitive Level: Application

4. The nurse is assisting an 18-year-old female client to plan a healthy diet to support recent weight loss. Which of the following should be included in the dietary plan?

Select all that apply.

- a. 200 mg folic acid are recommended in the daily diet.
- b. Eat at least six servings of grains.
- c. To avoid constipation, keep daily iron intake below 21 mg.
- d. Fat intake should be limited to less than 30% of the daily caloric intake.

Answer: b; d

Rationale: Grain intake should include at least six servings daily. To maintain a healthy weight and reduce incidence of cardiovascular disease, fat intake should not exceed 30% of the daily intake. Folic acid intake should be at 400 mg daily. Iron is a vital ingredient in the daily diet. 18 mg daily is reflective of the desired amount. Constipation should be managed by an adequate fluid and fiber intake.

Nursing Process Step: Planning

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Prevention and/or Detection of Early Health Problems

Cognitive Level: Application

5. During a routine physical examination for a 52-year-old Caucasian male, the client declines to have his prostate gland examined. He states he does not have a family history and does not feel he is at risk. What initial response by the nurse is most appropriate?

- a. "You may refuse any screening test you wish."
- b. "I will need to tell the physician about your refusal."
- c. "Your risk factors increase with aging."
- d. "You are right, Caucasian men have less incidence of prostate cancer."

Answer: c

Rationale: The need for prostate screening begins at age 50. Individuals with risk factors should begin screening at age 45. The client's age places him at an increased risk, so he should begin the screening process. While the client may refuse any testing, this does not allow the client to engage in secondary levels of prevention. The client's refusal should be recorded in the medical record but not used as a means to coerce the client.

Nursing Process Step: Implementation

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Growth and Development through the Lifespan

Cognitive Level: Analysis

6. The nurse is preparing to teach a class for a group of new parents. The nurse is attempting to determine what topic would be of the greatest interest to the audience. What selection would be most appropriate?

- a. Safety
- b. Chronic illness prevention
- c. Problem-solving skills
- d. Interventions to manage depression

Answer: a

Rationale: The parents of small children are interested in information geared toward keeping them safe. Household safety is a priority for children of all ages. The families attending the session likely will have limited interest in preventing illness, as they typically represent a healthy segment of the population. Depression is a greater concern for older adults.

Nursing Process Step: Assessment

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Growth and Development through the Lifespan

Cognitive Level: Analysis

7. An African-American male is discussing his dietary intake with the nurse. The nurse encourages the client to keep sodium intake below 1,500 mg per day. The client reports he does not have any known risk for the development of hypertension and feels this is too restrictive. How should the nurse respond?

- a. "African-Americans typically have higher sodium levels than their Caucasian counterparts."
- b. "This is the amount of sodium intake recommended for everyone."
- c. "This is what will be best for you."
- d. "Do you eat a great deal of salt?"

Answer: a

Rationale: After generations of conditioning, African-Americans frequently have higher sodium levels. The recommended sodium intake for African-Americans is slightly lower than are the levels for their Caucasian peers. Simply telling the client the recommendation is "best" does not provide an adequate level of information. The amount of salt ingested by the client should be recorded, but this is not the best response.

Nursing Process Step: Implementation

Client Needs Category: Physiological Integrity

Client Needs Subcategory: Physiological Adaptation

Cognitive Level: Analysis

8. A 45-year-old woman presents to the ambulatory clinic for a gynecological examination. The health history reveals no significant personal or family medical history. What information concerning health-promotion behaviors should be presented to the client?

- a. It is time to begin having mammograms every other year.
- b. If the client is in a monogamous relationship, Pap smears will not be needed.
- c. Bone density examinations are indicated every year.
- d. Recommended calcium intake is at least 1,200 mg per day.

Answer: d

Rationale: The recommended calcium intake is at least 1,200 mg per day. This will be beneficial in the prevention of osteoporosis. Women should begin having annual mammograms by age 40. Pap smears are continued for women in monogamous relationships. For women with no significant risk for the development of osteoporosis, bone density examinations should be done every other year.

Nursing Process Step: Implementation

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

9. A 75-year-old client seeks care at an ambulatory clinic. The client reports having experienced extreme drowsiness after recently taking dosages of an over-the-counter cold medication. When collecting data, the nurse notes the client reports taking only the prescribed amount of the preparation. What inferences can be made by the nurse concerning the events?

- a. The client likely has taken more of the preparation than stated.
- b. The client likely has experienced a reaction between the cold medication and other routine medications.
- c. The client's age has influenced his response to the medication.
- d. The client is allergic to the cold medication.

Answer: c

Rationale: Older clients often experience altered responses to medications. These changes are in response to age-related developments in the kidneys and liver. There is no evidence the client has taken too much medication. There is no information provided to indicate the client is taking other medications. Allergic reactions typically manifest with integumentary- or respiratory-related symptoms.

Nursing Process Step: Evaluation

Client Needs Category: Physiological Integrity

Client Needs Subcategory: Pharmacological and Parental Therapies

Cognitive Level: Analysis

## **Chapter 3**

1. A nursing student is reading about the concept of parish nursing. Which of the following statements indicates understanding of the key concepts of parish nursing?

1. "You must practice a certain faith to be involved in parish nursing."
2. "Parish nurses are independent practitioners providing care to members of a selected church."
3. "Parish nursing is reserved for nurse practitioners."
4. "Parish nurses may be employed by a hospital."

Answer: 4

Rationale: Parish nursing seeks to provide health care to traditionally underserved populations. Involvement in parish nursing is not limited to select faiths. The parish nurse may work directly for the church involved or be contracted by the church to provide nursing services and perform referrals. Parish nursing is not limited to nurse practitioners.

Nursing Process Step: Evaluation

Client Needs Category: Health Promotion and Maintenance

Client Needs Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

2. The mother of a severely handicapped child states she is exhausted and voices the need to "take a break" to the nurse. What type of referral would best benefit the client?
  1. A respite care provider
  2. Hospice care agency
  3. Home care
  4. Ambulatory clinic

Answer: 1

Rationale: Individuals who are faced with caring for ill or handicapped family members might need to have a "break." The best option would be for a respite care provider. Respite care offers short in-home services in which the care provider would be freed from her duties for a short time. Hospice care is designed to assist the dying client and family members. Home health care is best for clients who are unable to leave their home for care services. Ambulatory clinics are used for clients who are in need of limited point-of-care medical services.

Nursing Process Step: Implementation

Clients Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Application

3. The client who lives alone indicates concerns about their ability to perform the necessary dressing changes after discharge. Which action by the nurse is indicated at this time?
  1. Explain to the client that she will need to seek the assistance of a friend or neighbor to help as needed.
  2. Make a referral to the home healthcare agency preferred by the client.

3. Contact the hospital social worker.
4. Discuss the client's anticipated needs with the physician.

Answer: 4

Rationale: The client will likely need home health care. Home care requires a physician's order. The nurse will need to initiate the referral process. In some facilities, a discharge planner might be involved. The services of the hospital social worker are not indicated by the information provided. The client has already indicated the absence of assistance. If the client lacks the social resources for it, it will be up to the healthcare team to locate community-based resources.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

4. The nurse is evaluating a group of clients for referral to a home health agency. Each of the clients is on the Medicare program. Which client is most likely to qualify for home health services?
  1. The postoperative client needing reevaluated by the physician six weeks postoperatively
  2. The client having a moderate-sized stage III pressure ulcer requiring daily dressing changes
  3. The bedridden client who's physician has prescribed oral antibiotic therapy for two weeks
  4. The client having large stage I pressure ulcer

Answer: 2

Rationale: Home care is indicated for clients for whom travel to the healthcare provider would be impossible or quite difficult. A large stage III pressure ulcer would be painful for the client during travel. Daily dressing changes would not be a typical function of the physician's office, and would ideally be completed in the home. The client requiring a postoperative assessment in six weeks does not appear to have any limitations presented. Oral antibiotic therapy does not present challenges to the client that signal the need for home care. The stage I pressure ulcer does not have skin breakdown or require professional healthcare services.

Nursing Process Step: Planning

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Analysis

5. During a home care visit, the nurse notices the client's dressing supplies are not being kept in a readily assessable environment. The nurse has discussed this with the client and family in previous visits. What action by the nurse is indicated?
1. Document the activities relating to the situation.
  2. Continue to discuss the issues each visit.
  3. Notify the physician.
  4. Take the supplies and arrange to bring them back with each visit.

Answer: 1

Rationale: The nurse has attempted to address the concerns with the client and family.

The client's failures to make changes in routine indicate a lack of intent to change.

Continued discussion likely will prove futile. There is no need to notify the physician at this time. Taking custody of the supplies, carrying them around and bringing them back each time, is not feasible for the nurse. Goals of the nurse are not necessarily shared by the client.

Nursing Process Step: Planning

Client Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Application

6. While conducting a home health care visit, the nurse is asked to administer insulin to the client's ailing husband. What action by the nurse is indicated?

1. The nurse should refuse to administer the medication.
2. The nurse may agree to assist with the administration of the insulin this time only but should caution the client and family that this is not the purpose for their visit.
3. The nurse should contact the physician for the husband for an order for the medication.
4. The nurse should contact his supervisor to obtain permission to administer the medication.

Answer: 1

Rationale: The home healthcare nurse is there to care for the client. Providing nursing services for the other members of the household is not appropriate. Legal issues would preclude the nurse from providing care without an order. Making contact with the physician is not appropriate, as the client's husband is not a client of the home health agency.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Analysis

7. The home health nurse observes several small, round bruises on the back side of an elderly client's arms. What action by the nurse is indicated first?

1. Question the client about the cause of the bruises.
2. Discuss the bruises with the client's spouse.
3. Document the bruises, with plans to review them for changes on the next visit.
4. Contact the home health supervisor to report the findings.

Answer: 1

Rationale: The client should be asked about the cause of the bruises. Nurses suspecting abuse are legally required to report it. Pending the client's response, the supervisor will likely require notification. The client's spouse should not be the first contact concerning the bruises, as he might be the source of the injury. Documentation about the findings is indicated. Delaying action until the next visit does not meet the legal responsibilities of the nurse.

Nursing Process Step: Assessment

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Safety and Infection Control

Cognitive Level: Analysis

8. A home health nurse is preparing to begin a series of visits with a client. Based upon the client's condition, the client is expected to require home care visits weekly for the next two months. Which of the following tasks should take place first?

1. Set priorities.
2. Assess the home environment.
3. Establish trust and rapport.
4. Promote learning.

Answer: 3

Rationale: The basis for a successful long-term relationship between the nurse and the client is founded in trust. Once a rapport is established, it will be possible to begin to identify priorities that are of mutual interest. A review of the home environment will be needed to determine needs for all aspects of care and to promote and maintain safety. Learning is an ongoing process. The client will be more receptive to interventions by the nurse once a rapport is established.

Nursing Process Step: Planning

Client Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Application

9. A postoperative client is preparing for discharge. A home health nurse has been scheduled to call on the client in two days. The client tires easily and voices an inability

to concentrate on all of the information the nurse is attempting to review. Which of the subjects concerning the client's condition and home care may be deferred for the home health nurse?

1. The recommended diet after discharge
2. The activities that will take place during the four-week checkup with the physician
3. Potential adverse reactions of the prescribed medications
4. The actions of the prescribed medications

Answer: 2

Rationale: The client must be discharged with the needed information to safely manage until the home healthcare nurse has the first visit in two days. Information concerning prescribed medications and the recommended diet are of the greatest priority, as they will require action by the client prior to the health nurse's visit. A discussion involving activities planned four weeks in the future can wait until the client is better able to tolerate the information.

Nursing Process Step: Evaluation

Client Needs Category: Physiological Integrity

Client Needs Subcategory: Physiological Adaptation

Cognitive Level: Analysis

10. The home health nurse has identified a series of concerns while providing services to a client. During one of the visits, the nurse becomes concerned about criminal activity in the home. What initial action by the nurse is most appropriate?

1. Dial 911 to obtain assistance in removing the client from the home.
2. Contact the physician to discuss the situation.
3. Leave the home.
4. Advise the client to leave the home as soon as possible.

Answer: 3

Rationale: The nurse working in the client's home must always be aware of personal safety. Leaving the home in the presence of criminal activity would be the safest alternative. Removing the client from the home is beyond the scope of the nurse's responsibility. Contact with the physician might be indicated, but it does not have a higher priority than leaving the scene to ensure personal safety.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Analysis

11. The nurse is teaching the client about ways to increase personal safety in the home. During the interaction, the client advises the nurse that he has no plans to make the recommended changes. What response by the nurse is most appropriate?
1. "You might not get well if you do not follow my recommendations."
  2. "I will need to tell your physician the home is not safe enough."
  3. "If you need more information about what we have discussed, please let me know."
  4. "I might not be able to continue my visits if you do not conform."

Answer: 3

Rationale: When providing patient teaching, the nurse must be aware that not all recommendations considered important by the nurse will be held at the same priority by the client. A failure to have the same goals does not mean the interaction is without merit. Telling the client he might not recover might not be true. At no time should the client feel threatened by the nurse's responses. Implying that the visits will stop or that the physician will be called could be considered threatening.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Safety and Infection Control

Cognitive Level: Analysis

12. During a home health visit, the client indicates he feels he might need physical therapy to facilitate his recovery. What action by the nurse is indicated?
1. The nurse should contact the client's insurance carrier to determine benefit eligibility.
  2. The nurse should provide the client with the contact information for a local agency that offers physical therapy services.
  3. The nurse should contact the physician to discuss the client's concerns.
  4. The nurse should advise the client to contact the physician to discuss his concerns.

Answer: 3

Rationale: The home health nurse is responsible for making contact with needed agencies. Contact with the physician will be needed to initiate physical therapy.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

13. The nurse is assessing the client's perception of safety issues in the home. Which of the following questions and statements will best assist the nurse in obtaining the needed data?
1. "Do you feel safe at home?"
  2. "Can you see room for improving safety at home?"
  3. "Please tell me some safety concerns you have."
  4. "Have you ever fallen at home?"

Answer: 3

Rationale: Open-ended questions or statements will yield the most information. Encouraging the client to share safety concerns will allow the greatest exchange of information directly related to the identified topic. Asking the client about feeling safe at home is broad, and might not yield the desired information.

Nursing Process Step: Assessment

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Safety and Infection Control

Cognitive Level: Application

## CHAPTER 4

- When preparing a client for surgery, the nurse observes that the client has been crying. When the nurse asks the client to sign the surgery consent form, the client states “I guess

I should just go ahead and sign it, even though I'm not really sure about doing this." The best response by the nurse would be:

- a. "Most people are usually nervous before surgery."
- b. "The surgeon is waiting, so you should decide."
- c. "What concerns are you having?"
- d. "Should we just cancel your surgery?"

Correct answer: c

Rationale: The nurse has a responsibility to assess further what the client is upset/concerned about prior to surgery. If the nurse was present when the physician gave informed consent, he can reinforce any information. If he was not present, or there are still questions, the surgeon should be notified to make any other clarifications. The surgery should not just be cancelled. Telling the client that others are usually nervous does not address this client's individual needs. The client has a right to have all questions answered prior to signing a consent for surgery, and should not be pressured for any reason.

Application; Implementation; Safe, Effective Care Environment

2. Upon review of the medical history prior to surgery, the nurse notes that a client has a history of alcoholism. The nurse makes a point to bring this to the surgeon's attention when informed consent is being provided. The rationale for this action would be:

- a. The client could be at risk for depression postoperatively.
- b. The client will be at greater risk for respiratory complications postoperatively.
- c. The client could be dehydrated.
- d. The client might require more general anesthesia.

Correct answer: d

Rationale: Clients need to be assessed for surgical risk factors preoperatively for planning. There is no reason to anticipate depression, respiratory complications, or dehydration simply due to a history of alcoholism. Damage to the client's liver might have occurred, and this could affect how the client metabolizes medications.

Analysis; Planning; Safe, Effective Care Environment

3. The nurse is providing preoperative teaching to a client with diabetes. The client states "I know I won't need as much insulin after surgery, since I haven't had anything to eat or drink since midnight." Which response by the nurse would be most appropriate?

- a. "You are right, the insulin need will be less postoperatively."

- b. "Your insulin need will be adjusted and most likely will increase due to the stress of surgery on your body."
- c. "We will give you your usual dose of insulin just prior to surgery."
- d. "You will be given insulin during surgery to avoid complications postoperatively."

Correct answer: b

Rationale: The stress of surgery, not of being n.p.o. preoperatively, often increases rather than decreases blood sugar, and thus insulin needs. Insulin is not typically given just prior to or during surgery.

Analysis; Implementation; Physiological Integrity

4. A client has a history of malignant hyperthermia. A bowel resection with colostomy placement surgery is scheduled. The nurse anticipates which type of anesthesia will be used with this client?

- a. Regional anesthesia
- b. Inhaled anesthesia
- c. Conscious sedation
- d. Total intravenous anesthesia

Correct answer: d

Rationale: The client is having a major surgery. General anesthesia would be indicated. Inhaled and total intravenous anesthesia are general anesthesia options. The use of inhaled anesthesia in a client with a history of malignant hyperthermia would be avoided, as it can trigger malignant hyperthermia. Total intravenous anesthesia would be used in this situation.

Analysis; Planning; Physiological Integrity

5. A client reports a pain level of 6 on a 0–10 pain scale. The nurse offers to review the orders for additional pain medication. The client states "I really don't want to take any more pain medication, because I am afraid I will become addicted." The nurse's response should focus on which concept?

- a. Physical dependence on pain medication is uncommon during the short-term postoperative use.
- b. This client already might have an addiction problem.
- c. This client might benefit from a placebo dose.
- d. The physician should be notified to discuss pain management.

Correct answer: a

Rationale: Clients might fear "addiction" or physical dependence on pain medications, especially opioids, postoperatively. The duration of use is typically short-term, and this concern should be discussed, but is not anticipated to occur. The client who already has an addiction problem most likely would be requesting more medication, not refusing it.

The client is verbalizing pain, so administration of a placebo is unethical, against client rights for pain management, and should not be administered. It is within the scope of the nurse to review and make decisions with the client regarding safe use of pain medications that have been ordered by the physician. The physician does not need to be called at this time unless the nurse's interventions with the client are unsuccessful.

Analysis; Implementation; Physiological Integrity

6. The nurse has many teaching responsibilities preoperatively. From the following list, select all topics that would be within the nurse's scope to provide instructions about preoperatively:

- a. Diaphragmatic breathing
- b. Positioning/turning in bed
- c. Coughing exercises
- d. Potential risks of the surgery

Correct answers: a; b; c

Rationale: Measures to ensure respiratory, circulatory, and gastrointestinal functioning are important for the nurse to teach the client preoperatively. The physician would discuss the potential risks and benefits of the surgery during the informed consent process.

Application; Implementation; Physiological Integrity

7. Assessment findings that would alert the nurse that a client might be at greater risk for deep vein thrombosis include: (Select all that apply.)

- a. Client is 35 years old.
- b. Client has varicose veins.
- c. Client is obese.
- d. Client is on an anticoagulant medication.

Correct answers: b; c

Rationale: The development of a blood clot is an increased risk in the client with an impaired circulatory system; as evidenced by varicose veins, a client who is obese, and over the age of 40 years, has an infection or malignancy. Anticoagulant medications are given to dissolve clots, and do not increase the risk of development.

Analysis; Planning; Physiological Integrity

8. Following a coughing episode, a client who is 12 hours postoperative from abdominal surgery notifies the nurse of "a feeling of pressure in the surgical wound." The nurse observes that the surgical wound is open. The initial response by the nurse should be:

- a. Check the client's vital signs, then notify the physician.

- b. Cover the wound with a sterile dressing moistened with normal saline, then notify the physician.
- c. Notify the physician.
- d. Place the client in the Trendelenburg position.

Correct answer: b

Rationale: When the wound dehiscence occurs, the site must be covered immediately and be kept sterile. The physician should then be notified. The client will be returning to surgery. Vital signs can be taken after the wound is covered and the physician notified. Client positioning is not the priority.

Analysis; Implementation; Physiological Integrity

## Chapter 5

1. The hospice nurse is working with the family of a 30-year-old client who is dying. The client voices concerns about how her death will be perceived by her 7-year-old child. What advice from the nurse would be most beneficial?
  1. Advise the client that children that age emotionally distance themselves from the death.
  2. Explain to the client that children of this age recognize death is permanent.
  3. Encourage the client to begin to prepare the child by explaining that death is permanent, as the child fears separation, and might lack comprehension of permanent separation.
  4. Advise the client that children at this age fear death.

Answer: 2

Rationale: Age is a great determinant of beliefs about death. Children at this age understand the finality of death. At the age of 7, children do not have the emotional maturity to distance themselves from death. The ability to understand separation has been mastered by the age of 7. The fear of death is typically seen in children this young.

Nursing Process Step: Implementation

Client Needs Category: Psychological Integrity

Client Needs Subcategory:

Cognitive Level: Application

2. A client has reported to the physician's office with complaints of an inability to sleep at night. During the data collection, the client reports her estranged husband died a little over a year ago. She states "I am not sure why this is so difficult, I really couldn't stand him near the end." Which response by the nurse is most appropriate?
  1. "You seem angry."
  2. "You should contact a therapist."
  3. "Sometimes a rocky relationship with someone at the time of their death can impact your ability to grieve."
  4. "You are just entering the grief process, things will get better."

Answer: 3

Rationale: Unresolved conflict at the time of death can impact the ability of survivors to successfully grieve the deceased. The client's demeanor does not seem angry. It is inappropriate for the nurse to refer the client to a therapist. Referrals must be initiated by the physician. The death occurred more than a year ago. The client's continued inability to sleep indicates impaired grieving.

Nursing Process Step: Implementation

Client Needs Category: Psychological Integrity

Client Needs Subcategory:

Cognitive Level: Analysis

3. After suffering a massive cerebral hemorrhage, a client of American Indian descent is not expected to survive. The family arrives at the hospital. In conversation with the family, they report they observe most of their religious and cultural traditions. Which of the following interventions by the nursing staff would be most appropriate?
1. Offer the family a private room to sit together.
  2. Discourage the family from sitting with their loved one prior to death.
  3. Discuss the possibility of transferring the client home for the death.
  4. Encourage the family to assist in the care of the dying client.

Answer: 1

Rationale: Traditional American Indians prefer to mourn in private. They often will mourn away from the dying client. While the American Indian culture might not encourage the family to be with the dying individual, it is not appropriate for the nurse to discourage the family from having time with the client at this critical point. The severity of the client's condition does not allow for transfer at this time. Traditional American Indian rituals associated with death do not encompass assistance with the care.

Nursing Process Step: Planning

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

4. A competent elderly client has a living will. The living will expressed the desire to avoid resuscitation and heroic life support measures. The family members are not supportive of this directive. Which of the following actions by the nursing staff is most appropriate?

1. Contact the Social Services department.
2. Notify the hospital attorney.
3. Place the document on the chart.
4. Explain to the client that the conflict could invalidate the document.

Answer: 3

Rationale: The client is competent. The wishes of the client must take priority. The document should first be placed on the chart and the physician notified. If there are concerns about the authenticity of the document, the Social Services department or the unit supervisor will need to be contacted. A lack of support by the family does not invalidate the document.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

5. At the time of admission, the client is asked if he has a healthcare directive. The client reports that his daughter will be allowed to make health-related decisions if he becomes incapacitated. Based upon your knowledge, the client has a/n:

1. Living will.
2. Healthcare surrogate.
3. Durable power of attorney.
4. Advanced directive.

Answer: 2

Rational: The healthcare surrogate is an individual who will make medical decisions in the event the client becomes unable to do so. The living will provides written directions about life-prolonging decisions. The power of attorney delegates the decision maker concerning business matters.

Nursing Process Step: Evaluation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

6. While preparing for the discharge of an elderly, terminally ill client, the family asks for information concerning the most appropriate time to become involved with a hospice agency. What action by the nurse is most correct?

1. Assist the family with making contact with hospice at this time.
2. Determine the client's expected life expectancy to gauge when the contact should be made.
3. Encourage the family to "hold off" making the contact until death is very close.
4. Determine what expectations the family has of the hospice agency.

Answer: 1

Rationale: Hospice agencies provide vital services to clients who are facing death and to their families. Information concerning available services should be met with facts. This is an indication of willingness to embrace the supportive service. Referrals for elderly clients should be prompt. It is inappropriate to determine life expectancy. This is an inaccurate measurement of the degree of services needed. Waiting until the time of death nears does not leave much time for the hospice agency to assist the family.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

7. The client is diagnosed with Huntington's disease. While at a follow-up visit with the physician, the client breaks down and questions her ability to cope with the situation. What response by the nurse will be most beneficial to the client?

1. "You are certainly facing a difficult road ahead."
2. "Unfortunately, your prognosis is bleak."
3. "How have other members of your family coped with this diagnosis?"
4. "You should contact a support group."

Answer: 1

Rationale: The client is facing a terminal illness. The illness is characterized by a continual and increasing loss of function and control. The client needs to have validation of her feelings. The client realizes the prognosis is bleak, and will not benefit from the nurse's restating the obvious. Certainly, Huntington's disease is inherited, and the client might have family members who have faced the disease, but this line of questioning will not provide comfort for the client. A support group might be helpful, but suggestions about joining should follow supportive statements by the nurse.

Nursing Process Step: Implementation

Client Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Analysis

8. The client, age 20, dies after an unsuccessful resuscitation attempt. What nursing action is indicated first?

1. Notify the funeral home.
2. Document the time of death.
3. Contact the physician.
4. Contact the orderly for transport to the morgue.

Answer: 2

Rationale: After death, the time must be recorded in the client's record. After documentation is completed, the attending physician will require notification.

Notification of the funeral home must wait pending a decision about the need for an autopsy as well as a review of the family's wishes. Transportation of the body to the morgue can take place after the family members have been notified and allowed to see their loved one.

Nursing Process Step: Implementation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Application

9. The client has been diagnosed with chronic sorrow related to her husband's recent diagnosis of terminal cancer. Which action by the nurse would be most helpful to the client?

1. Question the client about her knowledge of cancer treatment options.
2. Question the client about her husband's prognosis.
3. Determine the means used by the client to cope with loss in the past.
4. Encourage the client to identify potential sources of emotional support.

Answer: 4

Rationale: Chronic sorrow is a recurring sense of overwhelming sadness in response to a loss. The best means to assist the client is to assist the client to discuss her feelings. The use of emotional supports will enable the client to manage these seemingly all-encompassing emotions. The client is attempting to discuss her own feelings. Turning the conversation's focus to the client's knowledge about her husband's illness would not meet the needs presented. Past coping does not influence the needs accompanying chronic sorrow.

Nursing Process Step: Implementation

Client Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Analysis

10. A client hospitalized for diagnostic testing reports an intense fear of being found to have a terminal condition. What response by the nurse will be most therapeutic?
1. "There is no indication you are going to die."
  2. "I am not sure why you feel that way."
  3. "What has your doctor told you about your condition?"
  4. "What types of symptoms lead you to feel this way?"

Answer: 3

Rationale: The client is demonstrating signs of death anxiety. This involves a fear of dying. The nurse's responsibility will be to determine what has caused this belief. Telling the client that the feelings are unfounded will do little to ease the client's anxiety. Further, this might not be entirely true. Expressing to the client a lack of understanding about his feelings will not gain much data or promote a rapport between the client and the nurse.

Nursing Process Step: Evaluation

Client Needs Category: Psychological Integrity

Client Needs Subcategory: Coping and Adaptation

Cognitive Level: Application

11. A group of students is attending an in-service about do-not-resuscitate orders. Which of the following statements by one of the students indicate the need for further teaching? Select all that apply.
1. "Do-not-resuscitate orders are a form of euthanasia."
  2. "My nursing license will not be in jeopardy if I follow do-not resuscitate orders."
  3. "If a client does not have completed do-not-resuscitate orders, I can just participate in a 'slow code'."

4. “Do-not-resuscitate orders may be rescinded if the client wishes.”

Answer: 1; 3

Rationale: Do-not-resuscitate orders outline the plans for a patient who stops breathing. Euthanasia refers to the process of initiating actions to cause or promote a death. The concepts are not the same. Participation in a “slow code” is malpractice. The nurse is legally bound to make every effort to revive any client who does not have valid do-not-resuscitate orders. Nurses who follow the policies of their facilities regarding the use of do-not-resuscitate orders will not face legal action. The client retains the right to change her perspective concerning their code status.

Nursing Process Step: Evaluation

Client Needs Category: Safe, Effective Care Environment

Client Needs Subcategory: Management of Care

Cognitive Level: Analysis

## Chapter 6

1. During a class for teens, a participant states she frequently “overindulges” in numerous activities, including eating. She questions her likelihood for becoming addicted to alcohol as a result of her “addictive personality.” What information should be provided to the client?
  - a. There are no data to support the existence of an addictive personality, although individuals who become addicted to substances frequently display an affinity for engaging in risky behaviors.
  - b. It is true the addictive personality does have a greater incidence of becoming addicted to a variety of substances.
  - c. There is no relationship between addiction and personalities who are prone to “overindulgence.”
  - d. The client is not at an advanced enough age to make this determination.

Answer: a

Rationale: Certain personality traits are associated with risk-taking behaviors and addiction. There is a relationship between personality type and addiction. Age does not play a factor in this scenario.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. After surgery, the nurse notes a client is unable to achieve pain relief from the analgesics prescribed. A review of the client’s medical records reveals a history of alcohol abuse. What inferences can the nurse make?

1. The client has an unreported addiction to the pain medication being prescribed.
2. The client has a history of using this medication at home.
3. The client is likely cross-tolerant to the prescribed analgesic.
4. The client has a dual diagnosis relating to alcohol and drug addiction.

Answer: 3

Rationale: Cross-tolerance results when tolerance to one substance also results in a tolerance to another drug. The client’s heavy use of alcohol likely has resulted in a tolerance to alcohol and, by association, to the prescribed analgesic. There are no data to support a suspicion that the client takes the medication at home or is addicted to the medication.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

3. A client is being treated for alcohol dependency. During the treatment, the client reports having been treated and undergone detoxification three times in the past. The client states that this time has been more difficult than the previous detoxification experiences. What information can be provided to the client?

1. Aging can impact the ability of the body to handle detoxification from alcohol and drugs.
2. Increased difficulty with alcohol detoxification is likely the result of an addiction to another substance at the same time.
3. The dependency might have been greater this time.
4. With each subsequent episode, detoxification becomes more difficult.

Answer: 4

Rationale: The body responds more harshly with each episode of detoxification. Aging does not play a role in the process. There is no evidence to support addiction to additional substances or an increased degree of dependence.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

4. During a routine physical, the nurse asks the client about alcohol use. The client denies alcohol use. The client reports having alcoholic parents, and wonders about the likelihood of becoming an alcoholic as well. What response by the nurse is most correct?

1. "You are right to avoid alcohol use."
2. "You will likely become an alcoholic."
3. "There are studies that support a genetic link for developing alcoholism."
4. "You should be fine to drink."

Answer: 3

Rationale: Studies have identified a link between biologic factors and the development of an addiction. Although the client does have an increased risk, advising the client he is right to avoid drinking, or that he will become an alcoholic, is inappropriate. Giving the client permission to drink does not address the question being posed by the client.

NURSING PROCESS: Implementation

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Application

5. A client involved in a minor accident reports having used "crank" an hour ago. The client denies having used the drug before. Based upon your knowledge, what manifestations can be anticipated?

1. The client might report feelings of increased strength and intelligence.
2. The client will display increased strength and cognition.
3. The client will be drowsy.

4. The client will exhibit hallucinations and paranoia.

Answer: 1

Rationale: Crank is a form of methamphetamine. It will promote the client to feel as if she has increased strength and intelligence. These are simply the client's impressions, and are not present in reality. Drowsiness is not anticipated for this client. Hallucinations and paranoia might be seen in an individual who has been using crank for a long period of time.

NURSING PROCESS: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

6. A teen client is brought to the Emergency Department by parents. The client's mother reports the client reported taking goofballs and hootch before refusing to communicate further. Based upon your knowledge, which of the following will be the greatest concern for this client?

1. The client will require close observation for seizure activity.
2. The client will require close observation for respiratory depression.
3. The client will require close observation for signs of withdrawal.
4. The client will require close observation for signs of hallucinations.

Answer: 2

Rationale: "Goofballs" are barbiturates. These are central nervous system depressants. "Hootch" is a street term for alcohol. Barbiturates and hootch are a lethal combination. The client who has ingested both items is at risk for varying degrees of sedation, up to coma and death. Seizure activity, signs of withdrawal, and hallucinations are not the greatest risks for this client.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Analysis

7. A client is admitted to the Emergency Department after taking PCP (phencyclidine piperidine). The physician has determined that the client overdosed on the drug. You are anticipating the care that will be provided to this client. What actions can be anticipated? Select all that apply.

1. Induce vomiting.
2. Obtain materials to assist with lavage.
3. Initiate seizure precautions.
4. Initiate an IV.
5. Administer Narcan as prescribed.

Answer: 3; 4

Rationale: The client has taken an overdose of phencyclidine piperidine (PCP), which can produce an adrenaline-like response, or “speed” reaction. PCP overdose is associated with possible hypertensive crisis, respiratory arrest, hyperthermia, and seizures. The client will require an IV line. The client will need to have seizure precautions such as padded side rails initiated. Vomiting is induced for overdoses of alcohol, barbiturates, and benzodiazepines. Narcan is a narcotic antagonist administered for opiate overdose.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

8. The nurse is collecting data from a client regarding past alcohol use history. What question will provide the greatest amount of information?

1. Are you a heavy drinker?
2. How often do you use alcohol?
3. Drinking doesn't cause any problems for you, does it?
4. Is alcohol use a concern for you?

Answer: 2

Rationale: Open-ended questions will elicit the greatest amount of information. Asking closed questions will limit the information obtained.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Application

9. A new nurse orienting to the unit is preparing to assist with obtaining data for a screening tool to review the likelihood that a client is addicted to methamphetamine. Based upon your knowledge, which of the following tools will be used?

1. B-DAST
2. The CAGE questionnaire
3. MAST
4. CIWA-ar

Answer: 1

Rationale: The B-DAST (Brief Drug Abuse Screening Test) is used to assess for addiction to substances other than alcohol. The CAGE questionnaire, MAST (Michigan Alcohol Screening Test), and CIWA-ar (Clinical Institute Withdrawal Assessment of Alcohol Revised) are all used to assess for alcohol-related problems.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Psychosocial Adaptation  
COGNITIVE LEVEL: Comprehension

10. The client with a history of alcohol abuse is being discharged. The physician has prescribed disulfiram (Antabuse). The client asks about the action of the medication. Which of the following statements by the nurse is most correct?
1. "The medication will help curb your craving for alcohol."
  2. "The medication will reduce the anxiety you might experience during this difficult time."
  3. "The medication will prevent seizures and other symptoms of withdrawal."
  4. "The medication will prevent your body from breaking down alcohol."

Answer: 4

Rationale: Disulfiram (Antabuse) is used in the management of clients with alcohol dependence. The medication will prevent the body from breaking down alcohol, and will cause illness if taken and alcohol is then ingested. The medication does not reduce the craving for alcohol, reduce onset of seizures, or lessen anxiety.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Comprehension

11. A nurse is concerned about potential substance abuse by a coworker. Which of the following behaviors warrants further investigation?
1. The nurse in question frequently requests the largest patient care assignment for the shift.
  2. The nurse in question prefers not to be the "medication nurse" on the shift.
  3. The nurse in question declines to take scheduled breaks.
  4. The nurse in question frequently wastes medications.

Answer: 4

Rationale: Excessive medication wasting could be a sign that a nurse is using or diverting drugs. The nurse might be wasting erroneous amounts of medications. The nurse who is unable or unwilling to manage a patient care assignment could be a substance abuser. Taking frequent or lengthy breaks might signal substance abuse.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Safety and Infection Control

COGNITIVE LEVEL: Analysis

12. A formerly homeless client has been treated for alcoholism. The client's physical examination reveals the client is underweight and malnourished. Which of the following

medications prescribed by the physician is intended to manage the client's nutritional status?

1. Folic acid
2. Magnesium sulfate
3. Methadone
4. Sertraline (Zoloft)

Answer: 1

Rationale: Folic acid may be prescribed to manage the alcoholic client's nutritional imbalances and correct the associated vitamin deficiencies. Magnesium sulfate is used to control seizures. Methadone is prescribed to manage heroin cravings. Sertraline (Zoloft) is used to reduce anxiety and stabilize the mood.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

13. The client reports to the Emergency Department with signs of drug use. The client reports having ingested "mellow yellows." Which of the following medications will be indicated to manage a potential overdose?

1. Narcan
2. Diazepam
3. Haldol
4. Vitamin B<sub>12</sub>

Answer: 2

Rationale: "Mellow yellows" are a type of hallucinogen. Diazepam can be prescribed to manage signs of an overdose. Narcan is used to treat an overdose of opiates. Haldol can be administered to manage an overdose of phenocyldine piperidine (PCP). Vitamin B<sub>12</sub> is used to manage the neurologic symptoms that might accompany a nitrate overdose.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiologic Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacologic and Parenteral Therapies

COGNITIVE LEVEL: Analysis

## Chapter 7

1. A nursing coordinator is being briefed on a situation that needs special attention. A school bus transporting a local university's basketball team has just crashed in the rain on the side of the road. The bus was transporting approximately 60 people. Which classification would most closely describe the situation?

Hint: Types of Disasters

Answer Choices:

1. A natural disaster
2. A multiple-casualty incident
3. A manmade disaster
4. A mass-casualty incident

Answer: 2

Rationale: Disasters are typically called multiple-casualty incidents if more than 2 but fewer than 100 people are injured. Mass casualties refer to incidents where more than 100 people are injured. Natural disasters are caused by acts of nature or emerging diseases. Manmade disasters are either accidental or intentional.

Nursing Process: Assessment

Client Need: Safe, Effective Care Environment

Cognitive Level: Application

Objective: Distinguish the difference between an emergency and a disaster.

Strategy: Look at each type of disaster or emergency listed. Determine which one best describes the situation outlined in the stem of the question.

2. An Emergency Department nurse is working when a dirty bomb detonates at a nearby shopping mall. Which types of injuries should the nurse expect to see in the victims?

Hint: Types of Disasters and Common Injuries

Answer Choices:

1. Fractured limbs and spinal injury
2. Radiation sickness
3. Thermal burns
4. Overexertion and exhaustion

Answer: 2

Rationale: Radiation sickness commonly occurs with a radiological dispersion bomb (dirty bomb) blast. Fractured limbs and spinal injury can occur with blunt trauma. Thermal burns occur with nuclear detonation. Overexertion and exhaustion occur in snowstorm-related injuries.

Nursing Process: Diagnosis

Client Need: Safe, Effective Care Environment

Cognitive Level: Analysis

Objective: Describe the types of injuries or symptoms that are associated with biological, chemical, or radiological terrorism.

Strategy: Examine each answer choice for the correct injuries that might be present in bomb victims. Since there are multiple injuries in each answer choice, eliminate the answer with at least one incorrect injury. All injuries must be correlated to this type of attack.

3. A new-to-practice nurse is caring for a client who suffered a blast injury to the eye. Which nursing intervention, performed by this new-to-practice nurse, would require follow-up by the preceptor?

Hint: Disaster-Related Eye Injuries

Answer Choices:

1. The nurse encourages the client to rub the eye to get out specks of dust.
2. The nurse uses eyewash to flush the client's eye.
3. The nurse stabilizes the eye with a rigid shield.
4. The nurse tapes a plastic bag full of crushed ice to the client's forehead.

Answer: 1

Rationale: Clients should be cautioned not to rub the eye that has specks of dust or debris in it. They should instead use eyewash, flushing the eye with copious amounts of water. The eye should be stabilized with a rigid shield without pressure. A plastic bag full of crushed ice can be taped to the forehead to rest gently on the injured eye.

Nursing Process: Planning

Client Need: Safe, Effective Care Environment

Cognitive Level: Analysis

Objective: Evaluate nursing interventions related to the treatment of injuries related to biological, chemical, or radiological terrorism.

Strategy: Consider each nursing action. Eliminate any correct actions. Choose an incorrect action for an eye injury as the correct answer.

4. An Emergency Department nurse is working when two school buses carrying 75 children each collide in route to an out-of-state field trip. The Emergency Department nurse knows that reverse triage will need to be instituted. Which principles come under reverse triage? Select all that apply.

Hint: Casualty Management

Answer Choices:

1. When there is a mass casualty event with greater than 100 victims, reverse triage may be instituted.
2. A very basic reverse triage system is to categorize or label victims needing the most support and emergency care as red, so they can be treated first.
3. Victims most likely to survive are color-coded black, and are treated first.
4. Reverse triage works on the principle of the greatest good for the greatest number.
5. Reverse triage works on the principle of the greatest good for the most critically ill.

Answer: 1; 4

Rationale: During a disaster, nurses may be expected to perform triage. Triage means sorting. A mass casualty is an event with more than 100 victims, thus necessitating reverse triage. Victims least likely to survive or who are already dead are color-coded black. Reverse triage works on the principle of the greatest good for the greatest number.

Nursing Process: Planning

Client Need: Safe, Effective Care Environment

Cognitive Level: Application

Objective: Explain the rationale for reverse triage in disasters versus conventional triage in emergencies.

Strategy: Read each answer choice to decide which statement correctly depicts the concepts of reverse triage. Multiple answers will be correct.

5. An Emergency Department nurse is informed of a nearby bombing at the World Trade Center. This nurse needs to be aware of the principles of triage and decontamination. In which zone does decontamination usually occur?

Hint: Casualty Management

Answer Choices:

1. In the hot zone
2. In the warm zone
3. In the cold zone
4. In the artic zone

Answer: 2

Rationale: The site of the disaster where a weapon was released or where the contamination occurred is called the hot zone. It is considered contaminated, and only those persons in the appropriate personal protective equipment may enter this zone. The warm zone is adjacent to the hot zone. Another name for this area is the control zone. This area is where the decontamination of victims or triage and emergency treatment takes place. The cold zone is considered to be the safe zone.

Nursing Process: Planning

Client Need: Safe, Effective Care Environment

Cognitive Level: Application

Objective: Discuss situations requiring the need for client isolation or client decontamination.

Strategy: Determine in which zone it is safe to decontaminate clients who were exposed to either a weapon release or contamination.

6. A nurse is working during a routine, scheduled disaster drill. The nurse is reviewing the stages and phases of a disaster with a new-to-practice nurse. Which answer choice, if provided by this new-to-practice nurse, correctly lists the order of the stages of a disaster?

Hint: Disaster Planning, Response, and Mitigation

Answer Choices:

1. The nondisaster stage, the predisaster stage, the impact stage, the emergency stage, and the reconstruction stage
2. The predisaster stage, the nondisaster stage, the impact stage, the emergency stage, and the reconstruction stage
3. The emergency stage, the predisaster stage, the nondisaster stage, the emergency stage, and the reconstruction stage
4. The impact stage, the nondisaster stage, the predisaster stage, the emergency stage, and the reconstruction stage

Answer: 1

Rationale: The five stages of disaster preparedness are the nondisaster or interdisaster stage, the predisaster stage, the impact stage, the emergency stage, and the reconstruction or rehabilitation stage.

Nursing Process: Planning

Client Need: Safe, Effective Care Environment

Cognitive Level: Application

Objective: Discuss the role of the nurse in disaster planning, response, and mitigation.

Strategy: Determine the correct sequence of the stages and phases of a disaster.

7. A nurse is teaching a seminar on disaster preparedness to a group of senior citizens at an assisted living facility. Which statement, if made by a client, demonstrates the need for further teaching?

Hint: Special Considerations, Older Adults

Answer Choices:

1. "I need to keep a list of names and phone numbers of significant persons or relatives to be notified in a secure place in case of an emergency."
2. "I need to keep a 24-hour supply of medications and the style and serial numbers of medical devices in a secure place in case of an emergency."
3. "I need to keep a list of allergies, blood type, checkbook, credit cards, and dietary needs in a secure place in case of an emergency."
4. "I need to keep a blanket, sturdy shoes, warm clothes, hearing aids, and hearing aid batteries in a secure place in case of an emergency."

Answer: 2

Rationale: Teaching about disaster preparedness is important in all communities. A current list of medications, doses, and times of administration should be kept in an easily accessible, secure place. The names and phone numbers of significant persons, relatives, those with power of attorney, healthcare providers, or any others to be notified in case of an emergency should also be kept in an easily accessible place. Additionally, the following materials should be considered essential in keeping with the person should evacuation to a shelter be necessary: eyeglasses and eyeglass prescriptions; style and serial numbers of medical devices, such as pacemakers; healthcare policies and numbers; identification; list of allergies; blood type; checkbook; credit cards; insurance agent's name and number; driver's license; 72-hour supply of medications; dentures; list of special dietary needs; sturdy shoes; warm clothing; blankets; incontinence briefs; prostheses; hearing aids; hearing aid batteries; extra wheelchair batteries; oxygen; and other assistive devices.

Nursing Process: Planning

Client Need: Safe and Effective Care Environment

Cognitive Level: Analysis:

Objective: Identify ways that nurses are able to provide care to clients with special considerations.

Strategy: Determine if each statement is correct with regard to planning disaster preparedness for the older adult client. Choose the incorrect statement as the answer choice.

## Chapter 8

### Question #1

The nurse is educating a group of nursing students regarding parents who are carriers of certain genetic conditions. The nurse understands that carriers are:

1. Results of an altered gene on the X chromosome.
2. A problem on the Y chromosome.
3. Parents who have a single gene alteration on one chromosome or a pair of chromosomes.
4. Diseases that occur in spite of the fact that there exists one unaltered gene.

Answer: 3

Rationale: The definition of a carrier is “an individual with a recessive condition who has inherited one altered gene from his mother and one from his father.” In most cases, neither parent is affected; therefore, each of the parents must have a single gene alteration on one chromosome of a pair.

Cognitive Level: Application

Client Need: Health Promotion and Maintenance

Nursing Process: Assessment

### Question #2

The nurse is educating a group of parents about the cause of Turner's syndrome. The nurse explains to the parents that Turner's syndrome is due to a variation in chromosomal number called:

1. Monosomy.
2. Trisomy.
3. Euploidy.
4. Polyploidy.

Answer: 1

Rationale: Turner's syndrome results from the loss of a single chromosome from a pair known as monosomy. Trisomy is the gain of a single chromosome, making a total of three copies of a certain chromosome. This can result in trisomy 21, or Down syndrome. Euploidy is the presence of the normal number of 46 chromosomes, and polyploidy is the condition where more than two pairs of all of the chromosomes are present.

Cognitive Level: Comprehension

Client Need: Health Promotion and Maintenance

Nursing Process: Assessment

### #3

The nurse is developing a teaching plan for a group of parents who need genetic counseling. Which statement by a parent would indicate the need for further education?

1. "We understand that half of the sets of chromosomes come from the mother and the other half come from the father."
2. "We understand that the 23<sup>rd</sup> pair of chromosomes will determine if our child will be male or female."
3. "We understand that a chromosome called a karyotype is a chromosomal profile."
4. "We understand that all the chromosomes are the same size in males and females alike."

Answer: 4

Rationale: A basic understanding of the cell, DNA, cell division, and chromosomes is important for young families receiving genetic counseling. The cell nucleus contains about 6 feet of DNA that are tightly wound and packaged into 23 pairs of chromosomes, making a complete set of 46 chromosomes. The structure and number of chromosomes can be shown by karyotype, or picture of an individual's chromosomes. There are two copies of each chromosome. One copy, or half of the complete set of these 46

chromosomes, is inherited from the mother, and the other copy is inherited from the father. For example, an individual will have two #1 chromosomes, one inherited from her mother and one inherited from her father. These two copies or pairs of inherited chromosomes are called homologous pairs. Chromosomes are numbered according to size, with chromosome #1 being the largest and chromosome 22 being the smallest. The first 22 pairs of chromosomes, known as autosomes, are alike in males and females. The 23<sup>rd</sup> pair, the sex chromosomes, determines an individual's gender. A female has two copies of the X chromosomes (one copy inherited from each parent) and a male has one X chromosome (inherited from his mother) and a Y chromosome (inherited from his father). These X and Y chromosomes are known as sex chromosomes. The remaining 22 pairs of non-sex chromosomes are alike in both males and females, and are called autosomes.

Cognitive Level: Analysis

Client Need: Health Promotion and Maintenance

Nursing Process: Assessment

## CHAPTER 9

1. Discharge teaching is being done by the nurse for a client who had a myocardial infarction. The client asks why the pain he experienced prior to the event was felt primarily in his left arm. The nurse's best response would be:

- a. "Cardiac pain is generally unexplainable."
- b. "Were you doing some physical activity with your arm just prior to the event?"
- c. "What you are describing relates to psychogenic pain."
- d. "Pain in the arm related to cardiac tissue damage is a type of referred pain."

Correct answer: d

Rationale: Pain in a spinal nerve can be felt over the skin in any body area where neurons share the same spinal nerve route. This is known as a dermatome. Cardiac pain is explainable as referred pain. Pain in the arm did not trigger the cardiac event.

Psychogenic pain occurs in the absence of a diagnosed physiological cause or event.

Application, Implementation, Physiological Integrity

2. A nursing student is teaching her peers about pain. Which teaching point supports the idea that each person's pain response should be assessed individually in each situation?

- a. "Everyone has the same pain threshold."
- b. "Everyone has a unique tolerance to pain."
- c. "Everyone perceives painful stimuli at the same intensity."
- d. "Most people have the same pain response to surgery."

Correct answer: b

Rationale: Each person's pain tolerance is different, and will need to be assessed on an individual basis. Everyone has the same pain threshold and perceives pain at the same intensity. Even though the same surgery is performed on different people, each individual might have a different pain response.

Application, Implementation, Physiological Integrity

3. Which response by the nurse would be most appropriate to the client comment "I know I won't feel as much pain with this knee surgery as I did with the other one when I was 20 years younger"?

- a. "You are most likely correct."
- b. "It should not be quite as bad with the newer technology."
- c. "You need to consider that you are getting older, and might experience more pain."
- d. "Your pain response might be the same, since one's pain sensitivity does not decrease with age."

Correct answer: d

Rationale: There is no evidence that normal aging decreases sensitivity to pain. This is a common misconception. The client did not anticipate feeling as much pain compared with a prior surgery, but the nurse needs to explain this concept.

Application, Implementation, Physiological Integrity

4. Each client's response to pain may be influenced by multiple factors. Select all that apply:

- a. Age
- b. Past experience with pain
- c. Cultural influences
- d. Knowledge

Correct Answers: a; b; c; d

Rationale: All factors listed can influence a client's response to pain.

Application, Implementation, Physiological Integrity

5. A client has returned to the unit following surgery. The nurse knows that which intervention will provide the most pain relief for the client?

- a. Offer pain relief before the client complains of pain.
- b. Wait until the client can describe the pain specifically.
- c. Assess the pain level every four hours around the clock.
- d. Allow the client to “sleep off” the anesthesia, and then offer pain medication.

Correct answer: a

Rationale: Anticipating a client’s pain will ensure a more manageable pain experience than will waiting until the client complains of pain. Pain management need to be implemented prior to the client describing specific postoperative pain, or “sleeping off” anesthesia. If the client is asleep, she should not be awakened simply to assess the pain every four hours unless there are other significant nonverbal signs during sleep that indicate the client is in pain. These can include grimacing, moaning, thrashing, or guarding of a surgical site.

Analysis, Planning, Physiological Integrity

6. During the discharge teaching process, the nurse explains the physician’s order for the client to take Motrin (ibuprofen) at home for any further discomfort. Since this is an NSAID (nonsteroidal anti-inflammatory drug), what other teaching will be done with this client who also has diabetes?

- a. NSAIDs can increase the effect of hypoglycemic medications.
- b. NSAIDs can decrease the effect of anticoagulant medications.
- c. NSAIDs cause minimal gastrointestinal side effects.
- d. NSAIDs have no effect on fever.

Correct answer: a

Rationale: The diabetic client needs to be taught that NSAIDs can cause an increased response to hypoglycemic medications. The client’s hypoglycemic medications might need to be altered to adjust for this. NSAIDs can increase the effect of anticoagulant medications, not decrease them. NSAIDs could cause gastrointestinal bleeding, and should be taken with meals, milk, or a full glass of water to decrease gastric irritation. NSAIDs have anti-inflammatory, analgesic, and antipyretic (fever-lowering) effects.

Analysis, Implementation, Physiological Integrity

7. A client is receiving a narcotic for severe acute pain. Which of the following should the nurse encourage the client to consume on a greater level due to the pain medication?

- a. Vitamin D
- b. Fiber
- c. Protein
- d. Carbohydrates

Correct answer: b

Rationale: Clients who are administered narcotics are at risk for constipation. Increasing fiber in the diet will help to decrease this effect. Increasing vitamin D, protein, and carbohydrates is not needed specifically related to the effect of a narcotic medication.

Analysis, Implementation, Physiological Integrity

8. An extensive spinal surgery was performed on a client five days ago. The client continues to have pain despite around-the-clock dosing of a narcotic. When assessing the client's pain, the nurse discovers that the client's pain level is not decreasing significantly between doses. This is an example of which of the following?

- a. Pseudoaddiction
- b. Psychologic drug dependence
- c. Drug tolerance
- d. Addiction

Correct answer: c

Rationale: Over a period of time, a person's body might require a progressively greater amount of a drug to achieve the same results. Pseudoaddiction involves drug-seeking behavior as a result of inadequate pain relief. Psychologic drug dependency is seen with psychologic drug withdrawal symptoms. Addiction is a compulsive use of a drug despite negative consequences.

Application, Evaluation, Physiological Integrity

9. An elderly woman is complaining of lower leg pain. Which information found in her medical history would be the most likely indicator of this pain?

- a. History of cardiovascular disease
- b. History of shingles
- c. History of smoking for 20 years
- d. History of alcoholism

Correct answer: b

Rationale: Post-herpetic neuralgia (following shingles) is an example of a chronic neuralgia type of pain. There has been damage to a peripheral nerve, which has resulted in the current pain. Cardiovascular disease, a history of smoking, and alcoholism are not the likely direct causes of this pain.

Application, Assessment, Physiological Integrity

10. Pain in the elderly is subject to many misconceptions. Which of the following are common misconceptions related to aging? Select all that apply.

- a. Opioids will cause excessive respiratory depression.
- b. Aging decreases a person's sensitivity to pain.
- c. Older adults are likely to become addicted to narcotics if used.
- d. Pain is an expected part of the aging process.

Correct answers: a; b; c; d

Rationale: All are common misconceptions that the nurse must be aware of when caring for older adults. There are basic truths to each misconception that must be explored and discussed.

Application, Implementation, Health Promotion and Maintenance

11. Pain can be managed by classes of medications. Which class is also used to treat migraine headaches?

- a. Antidepressants
- b. Local anesthetics
- c. Anticonvulsants
- d. Narcotics

Correct answer: c

Rationale: Some seizure medications are effective with peripheral pain, such as with migraine headaches. This is a type of neuropathic pain, and can be treated with an anticonvulsant.

Analysis, Assessment, Physiological Integrity

12. The nurse is planning to administer a pain medication to a client who is two hours postoperative following bowel resection surgery. The client has four standing orders for pain medication. The nurse should administer which medication based on this situation?

- a. Select the one that will be given intramuscularly (IM) to work quickly.
- b. Select the one that is ordered on a "p.r.n." basis.
- c. Select the one to be administered intravenously by patient demand and under patient control.
- d. Select the one to be administered orally.

Correct answer: c

Rationale: Patient-controlled analgesia allows self-management of pain, and is a common postoperative method of administering pain medication. The advantages to this method are dose precision, timeliness, and convenience. Selecting an oral medication or a "p.r.n."

medication two hours after a major surgery would not be the most effective. The medication that is administered IM is not typically recommended for moderate-to-severe pain that will require more than one dose.

Analysis, Implementation, Physiological Integrity

13. A client is receiving intraspinal analgesia. Nursing care will focus on:

- a. Decrease in heart rate.
- b. Increase in heart rate.
- c. Increase in urine output.
- d. Decrease in urine output.

Correct answer: c

Rationale: Intraspinal narcotics can block the micturition reflex, causing urinary retention. A Foley catheter might need to be inserted. The respiratory rate, not the heart rate, would be another focus directly related to intraspinal anesthesia.

Analysis, Assessment, Physiological Integrity

## CHAPTER 10

1. What is a primary concern regarding fluid and electrolytes when caring for the older adult who is intermittently confused?

- a. Risk of kidney damage
- b. Risk of stroke
- c. Risk of bleeding
- d. Risk of dehydration

Correct answer: d

Rationale: As an adult ages, the thirst mechanism declines. This, in a client with an altered level of consciousness, can increase the risk of dehydration and high serum osmolality. The risks for kidney damage, stroke, and bleeding are not specifically related to aging or fluid and electrolyte issues.

Application, Planning, Health Promotion and Maintenance

2. A client is experiencing a multisystem fluid volume deficit. Symptoms present include tachycardia; pale, cool skin; and decreased urine output. These signs are most likely a direct result of:

- a. The body's natural compensatory mechanisms.
- b. Pharmacological effects of a diuretic.

- c. Effects of rapidly infused intravenous fluids.
- d. Cardiac failure.

Correct answer: a

Rationale: The internal vasoconstrictive compensatory reactions within the body are responsible for the symptoms exhibited. The body naturally attempts to conserve fluid internally specifically for the brain and heart. A diuretic would cause further fluid loss, and is contraindicated. Rapidly infused intravenous fluids would not cause a decrease in urine output. The manifestations reported are not indicative of cardiac failure in this client.

Analysis, Evaluation, Physiological Integrity

3. Clients experiencing a fluid volume deficit would most likely exhibit which of the following lab results? Select all that apply.

- a. Increased serum potassium
- b. Decreased serum sodium
- c. Increased hemoglobin
- d. Increased hematocrit

Correct answers: c; d

Rationale: Increased hemoglobin and hematocrit are common due to loss of intravascular volume and hemoconcentration. A decreased, not increased, potassium level is common in fluid volume deficits. Serum sodium levels can be within normal limits with an isotonic fluid deficit, or increased when the loss is water only.

Analysis, Assessment, Physiological Integrity

4. Which of the following tests would be indicated when a client who has a history of cardiovascular disease is receiving intravenous fluids?

- a. Cardiac catheterization
- b. Echocardiogram
- c. Fluid challenge
- d. Central venous pressure monitoring

Correct answer: c

Rationale: A fluid challenge may be performed to evaluate the cardiovascular and renal function related to fluid volume capabilities. This can prevent fluid volume overload. Cardiac catheterization and echocardiogram are directly related to evaluating cardiovascular disease. Central venous pressure monitoring is a method of evaluating fluid volume status.

Analysis, Planning, Physiological Integrity

5. A postoperative client has an indwelling urinary catheter in place. Which 24-hour urine output total volume would necessitate a primary healthcare provider to be notified?

- a. 1,000 milliliters
- b. 750 milliliters
- c. 1,200 milliliters
- d. 600 milliliters

Correct answer: d

Rationale: A urine output of less than 30 milliliters per hour must be reported to the primary healthcare provider. This indicates inadequate renal perfusion, placing the client at increased risk for acute renal failure and inadequate tissue perfusion. A minimum of 720 milliliters over a 24-hour period is desired. (30 milliliters multiplied by 24 hours equals 720 milliliters per 24 hours).

Application, Assessment, Physiological Integrity

6. A client is receiving intravenous fluids postoperatively following cardiac surgery. Nursing assessments should focus on which postoperative complication?

- a. Fluid volume deficit
- b. Fluid volume excess
- c. Liver failure
- d. Seizure activity

Correct answer: b

Rationale: Antidiuretic hormone (ADH) and aldosterone levels are commonly increased following the stress response before, during, and immediately after surgery. This increase leads to sodium and water retention. Adding more fluids intravenously can cause a fluid volume excess and stress upon the heart and circulatory system. Liver failure is not anticipated related to postoperative intravenous fluid administration. Seizure activity would more commonly be associated with electrolyte imbalances.

Application, Assessment, Physiological Integrity

7. Clients with severe hyponatremia will need which specific intervention once the diagnosis is made?

- a. Infection precautions
- b. Seizure precautions
- c. High-risk fall precautions
- d. Neutropenic precautions

Correct answer: b

Rationale: Severe hyponatremia can lead to seizures. Seizure precautions such as a quiet environment, raised side rails, and having an oral airway at the bedside would be included. Infection or neutropenic precautions and high-risk fall precautions are not specifically indicated.

Application, Implementation, Physiological Integrity

8. A client is admitted with hypokalemia. Which medication that the client has been prescribed might have contributed to this problem?

- a. Thiazide diuretic
- b. Narcotic
- c. Corticosteroid
- d. Muscle relaxer

Correct answer: C

Rationale: Excess potassium loss through the kidneys is often caused by such medications as corticosteroids, potassium-wasting (loop) diuretics, amphotericin B, and large doses of some antibiotics.

Analysis, Assessment, Physiological Integrity

## Chapter 11

1. A client is admitted to the ICU (intensive care unit) after sustaining multiple injuries. The physician has ordered for the client to receive a colloid solution. Which one of the following solutions would be appropriate for the nurse to infuse, based on the physician's orders?

- 1. 9% saline
- 2. D5 ½ NS
- 3. 5% dextrose in water (D<sub>5</sub>W)
- 4. 25% albumin

Answer: 4

Rationale: Colloid solutions contain substances that should not diffuse through capillary walls. Colloids tend to remain in the vascular system and increase the osmotic pressure of the serum, causing fluid to move into the vascular compartment from the interstitial space. As a result, plasma volume expands. Colloid solutions used to treat shock include 5% albumin, 25% albumin, hetastarch, plasma protein fraction, and dextran. Crystalloid solutions contain dextrose or electrolytes dissolved in water; they are either isotonic or hypotonic. All crystalloid solutions increase fluid volume in the intravascular and the interstitial space.

Cognitive Level: Comprehension

Client Needs: Physiological Integrity

Nursing Process: Implementation

2. A client is admitted to the medical intensive unit after being involved in a motor vehicle collision. During the nurse's initial assessment, the client develops hypotension, and severe jugular distension with a tracheal deviation. What does the nurse suspect has occurred?

1. Hemorrhage
2. Tension pneumothorax
3. Compensatory shock
4. Hypovolemic shock

Answer: 2

Rationale: A tension pneumothorax is a special type of pneumothorax that is life-threatening and requires immediate intervention. On inspiration, air enters the pleural space, does not escape on expiration, and increases the intrapleural pressure. This pressure collapses the injured lung and shifts the mediastinal contents, compressing the heart, great vessels, trachea, and eventually the uninjured lung.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Diagnosis

3. When assessing a client with a traumatic brain injury, the nurse assesses the client for which of the following signs and symptoms that would be consistent with brain death? Select all that apply.

1. Absence of gag or corneal reflex
2. Toxic metabolic disorders
3. Response to deep stimuli
4. Absence of oculovestibular reflex
5. Apnea with  $\text{PaCO}_2$  of 66 mm Hg

Answer: 1; 4; 5

The clinical signs of brain death criteria include apnea with a  $\text{PaCO}_2$  greater than 60 mmHg, no response to deep stimuli, no spontaneous movement, no gag or corneal reflex, no oculocephalic or oculovestibular reflex, and absence of toxic or metabolic disorders.

The diagnostic tests used to confirm brain death include electroencephalogram and cerebral blood flow studies.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

4. A client is admitted with a diagnosis of blunt trauma to the abdomen after a motor vehicle collision. What should be the initial action by the nurse when the client arrives in the Emergency Department (ED)?

1. Assess the client's abdomen for any abnormalities.
2. Assess the client's cervical spine for tenderness.
3. Assess the client for signs of neurological deficits.
4. Assess the client's airway for patency.

Answer: 4

Rationale: Assessment of the airway is the highest priority in the trauma client.

Assessment includes determining airway patency. If the client is unresponsive, manual opening of the airway using a jaw thrust or chin lift maneuver is necessary. Once the airway is opened, the practitioner must identify any potential obstruction from the tongue, loose teeth, foreign bodies, bleeding, secretions, vomitus, or edema. If the client is responsive and can vocalize, that is a good indication that the airway is clear. All of the other responses are important, but certainly the nurse should address airway initially. The nurse should assess the cervical spine area after initial ABC assessment. The nurse is always concerned about the neurological assessment of a client, but this client has a blunt trauma injury from a motor vehicle, therefore this would not be the initial assessment for the client.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Analysis

5. Which of the following interventions would be essential for the nurse to assess first for a client admitted with severe facial injuries?

1. Assess the client's level of consciousness.
2. Assess for signs of stridor, cough, or respiratory distress.
3. Assess the need for suctioning.
4. Assess the mouth for loose teeth or obvious problems with the mouth.

Answer: 2

Rationale: The client with multiple injuries is at great risk for developing airway obstruction and apnea. All of the choices are very important; however, the most important intervention for the nurse to assess is always to make sure the airway is patent and maintainable. The nurse should assess for manifestations of airway obstruction including stridor, tachypnea, bradypnea, cough, cyanosis, dyspnea, decreased or absent breath sounds, changes in oxygen levels, and changes in level of consciousness.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

6. A client presents to the ED (Emergency Department) after sustaining a penetrating wound to the neck. The client is dyspneic and cyanotic, and has evidence of subcutaneous emphysema. What does the nurse expect the physician to do initially?

1. Intubate the client because of the severe wound.
2. Notify the next of kin regarding the client's condition.
3. Order x-rays of the lumbar area to assess for fractures.
4. Administer a beta blocker to alleviate the sympathetic response.

Answer: 1

Rationale: Penetrating trauma to the neck is associated with a high degree of morbidity and mortality. Airway involvement includes dyspnea, cyanosis, subcutaneous emphysema, hoarseness, or air bubbling from the wound. The key is early identification of the need for intubation before the client has no airway at all. The physician will do all of the options in the question; however, the most important is to maintain the airway.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

7. A client is admitted with a traumatic injury to the spinal cord. He develops marked bradycardia, with a bounding pulse. The client becomes extremely restless, and the nurse notes that the client has developed oliguria as well. The nurse would suspect:

1. Anaphylactic shock.
2. Septic shock.
3. Hypovolemic shock.

4. Neurogenic shock.

Answer: 4

Rationale: Neurogenic shock is the result of an imbalance between parasympathetic and sympathetic stimulation of vascular smooth muscle. If parasympathetic overstimulation or sympathetic understimulation persists, sustained vasodilation occurs, and blood pools in the venous and capillary beds. The manifestations of hypovolemic shock result directly from the decrease in circulating blood volume and the initiation of compensatory mechanisms. Clients at risk for developing infections leading to septic shock include those who are hospitalized, have debilitating chronic illnesses, or have poor nutritional status. Septic shock does not usually present with a client who presents with a traumatic injury. Anaphylactic shock is the result of a widespread hypersensitivity reaction from medications, blood administration, latex, foods, snake venom, and insect stings.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Diagnosis

8. A client presents to the trauma center after sustaining multiple injuries. The client experienced severe blood loss prior to arriving at the trauma center. The physician has ordered for the client to receive blood immediately. The nurse understands that since there is not sufficient time for type and crossmatch, the client will therefore receive:

1. O group blood.
2. A group blood.
3. B group blood.
4. AB group blood.

Answer: 1

Rationale: Type O blood is the universal donor. ABO antibodies develop in the serum of people whose RBCs lack the corresponding antigen; these antibodies are called anti-A and anti-B. The person with blood type B has A antibodies, the person with type A has B antibodies, the person with type O has both types of antibodies, and the person with AB has no antibodies; therefore, this client is known as the universal recipient.

Cognitive Level: Application

Client Needs: Safe and Effective Care

Nursing Process: Assessment

9. A client who was a victim of rape six months ago presents to an outpatient clinic for the treatment of post-traumatic stress disorder (PTSD). Which data collected during the client's assessment would indicate a manifestation associated with PTSD?

1. The client denied anger or shock.
2. The client discussed severe nightmares related to the traumatic event.
3. The client denied the need for drug or alcohol counseling.
4. The client stated that her family is very supportive.

Answer: 2

Rationale: Post-trauma syndrome is an intense, sustained emotional response to a disastrous event. It is characterized by emotions that range from anger to fear, and by flashbacks or psychic numbing. In the initial stage, the client can be calm or might express feelings of anger, disbelief, terror, and shock. In the long-term phase, which begins anywhere from a few days to several months after the event, the client often experiences flashbacks and nightmares of the traumatic event. The client also might call on ineffective coping mechanisms, such as alcohol or drugs, and withdraw from relationships.

Cognitive Level: Application

Client Needs: Psychosocial Integrity

Nursing Process: Assessment

10. The nurse is caring for a client in the ICU who sustained a traumatic injury several days ago. During the assessment, the nurse notes that the client is hypotensive, oliguric, and has cool pale skin and acidosis. The nurse understands that these manifestations are indicative of:

1. Hypovolemic shock.
2. Cardiogenic shock.
3. Septic shock.
4. Anaphylactic shock.

Answer: 1

Rationale: Hypovolemic shock is caused by a decrease in intravascular volume. In hypovolemic shock, the venous blood returning to the heart decreases, and ventricular fills drops. As a result, stroke volume, cardiac output, and blood pressure decrease. Hypovolemic shock affects all body systems. Clients at risk for developing infections leading to septic shock include those who are hospitalized, have debilitating chronic

illnesses, or have poor nutritional status. Septic shock does not usually present with a client who presents with a traumatic injury. Anaphylactic shock is the result of a widespread hypersensitivity reaction from medications, blood administration, latex, foods, snake venom, and insect stings.

Cognitive Level: Application

Client Needs: Physiologic Integrity

Nursing Process: Assessment

11. A 25-year-old male presents to the trauma center after a motor vehicle collision. The nurse is assessing the client and notes the abdomen to be distended with bruising around the umbilicus. Which of the following diagnostics would the nurse anticipate the physician ordering for the client? Select all that apply.

1. CBC (complete blood count)
2. Blood type and crossmatch
3. Urine drug screen
4. Thyroid profile
5. RA factor

Answer: 1; 2; 3

Rationale: The diagnostic tests ordered once the client reaches the hospital depend on the type of injury the client has sustained. Tests that might be ordered will include blood type and crossmatching for the client's serum and donor red blood cells. Blood alcohol level and urine drug screen might be ordered to assess alcohol or drugs. Thyroid studies should always be considered, but based on the client's presenting symptoms, it is not a critical diagnostic at this time.

Cognitive Level: Application

Client Needs: Health Promotion and Maintenance

Nursing Process: Assessment

12. A client presents to a major trauma center for evaluation after being struck by a car while riding a bicycle. Identify the sequence of interventions for a rapid assessment that should be completed on the client.

1. Assessment of level of consciousness (LOC) and pupillary function
2. Assessment of obvious injuries
3. Assessment of the airway, using the jaw thrust or chin lift maneuver
4. Assessment of family support for client

5. Assessment of circulation, including pulses, skin color, and the temperature of the skin

Answer: 3, 5, 1, 2, 4

Rationale: Many different methods help healthcare providers determine the seriousness of the client's injuries and the potential for survival. A rapid but comprehensive trauma assessment, completed on the scene, includes airway and breathing assessment first; circulation assessment to palpate peripheral and central pulses; assessment of capillary refill, skin color, and temperature, and identification of any external sources of bleeding. Level of consciousness and papillary function should be assessed as well. Once the nurse determines that the ABCs have been assessed, then the nurse can continue to assess for any obvious injuries.

Cognitive Level: Application

Client Needs: Health Promotion and Maintenance

Nursing Process: Assessment

#### Question #13 – Alternate Question

You are the nurse caring for four clients on a medical–surgical unit. Evaluate the order of assessing these clients.

1. A male who was in an MVC four days ago who is preparing for discharge
2. A female restrained passenger in an MVC three days ago, who is receiving treatment for burns on 20% of her right leg
3. A male client admitted yesterday from an MVC who complains of severe pain in the chest when he takes a deep breath
4. A client admitted 24 hours ago for observation after a neck injury who complains to the nurse about numbness in the left arm

Answer: 4, 3, 2, 1

Rationale: The nurse should always assess the client's based on the ABCs (airway, breathing, and circulation). The nurse should always assess the client with possible airway problems. The client with a neck injury with numbness in the left arm could be a severe problem because this could represent a circulation problem. All of these clients will require the nurse to carry out a rapid assessment. The client being discharged will require extensive education; therefore, the nurse should assess clients in distress prior to seeing a client preparing for discharge.

Cognitive Level: Analysis

Client Needs: Physiologic Integrity

Nursing Process: Planning

## Chapter 12

### Question #1

The nurse is caring for four clients on a medical–surgical unit. Which client should the nurse see initially?

1. A client admitted with hepatitis A who has had severe diarrhea for the last 24 hours
2. A client admitted with pneumonia who is has small amounts of yellow productive sputum
3. A client admitted with fever of unknown origin (FUO) who has been without fever for the last 48 hours
4. A client admitted with a wound infection whose WBC is 8,500 mm<sup>3</sup>

Answer: 1

Rationale: The nurse must decide which client should be seen on the initial rounds of the day. The nurse must remember that the first client to be seen should be the client who needs the attention of the nurse initially. A client with hepatitis A does experience diarrhea, but diarrhea for the last 24 hours could cause the client to have a problem with dehydration and experience a state of fluid volume deficit.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

#### Question #2

The nurse is preparing to administer influenza vaccines to a mass drive-through clinic. Which statement by a client would indicate further questioning prior to giving the client the influenza vaccine?

1. "I am allergic to horse hair."
2. "I try to get my vaccine every year."
3. "I am not allergic to anything except eggs."
4. "My husband had a severe allergic reaction after he received his influenza vaccine."

Answer: 3

Rationale: Influenza vaccines are recommended for person at high risk for serious sequelae of influenza. The nurse should be aware that clients with a sensitivity to eggs should not receive the vaccine. Vaccines prepared from chicken or duck embryos are contraindicated in clients who are allergic to eggs.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

#### Question #3

The nurse is caring for four clients on a medical–surgical unit. The secretary gives the nurse the morning labs. Which of the following labs would require that the nurse call the physician and inform the healthcare provider regarding the client's abnormalities?

1. WBC 14,600 mm<sup>3</sup>

2. Serum protein 6.9 g/dL
3. I & D (incision and drainage) showing no growth for the last 24 hours
4. Albumin 4.2 g/dL

Answer: 1

Rationale: When the nurse is caring for several clients, all of the labs should be checked frequently throughout the shift to assess for any abnormalities. The WBC in option 1 is abnormal. (Normal WBC 4,000–10,000 mm<sup>3</sup>.) All of the other lab results are within acceptable range; therefore, the results should not be called to the physician.

Cognitive Level: Application

Client Needs: Physiologic Integrity

Nursing Process: Assessment

#### Question #4

The nurse is orienting a new graduate. The nurse is reinforcing the importance of standard precautions. Which of the following observations made by the nurse would require further education regarding standard precautions?

1. The graduate nurse understands to wash hands when entering and exiting the client's room.
2. The graduate nurse wears gloves when serving breakfast trays to various clients.
3. The graduate nurse wears a gown, gloves, and goggles when suctioning a client.
4. The graduate nurse leaves all supplies in the room of a client who is in contact isolation.

Answer: 2

Rationale: The nurse must have an understanding of standard precautions. Prevention is the most important measure to prevent nosocomial infections. Standard precautions were published in 1996, providing guidelines for the handling of blood and other body fluids. These guidelines are used with all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who have direct contact with clients or their body fluids. It is not necessary for the nurse to wear gloves while delivering food trays to the client because there is no contact with the client.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Evaluation

Questions #5

The admitting department alerts the nurse on a medical–surgical unit that a client with active tuberculosis (TB) is being admitted to the unit. Which type of isolation should be informed based on the client’s diagnosis?

1. Standard precautions
2. Airborne precautions
3. Droplet precautions
4. Contact precautions

Answer: 2

In addition to handwashing and standard precautions, the nature and spread of some infectious diseases require that special techniques be used to protect uninfected clients and workers. The client with pulmonary tuberculosis will be placed in airborne precautions. The client should be placed in a private room with special ventilation that does not allow air to circulate to general hospital ventilation; mask or special filter respirators will be used for everyone entering the room.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

Question #6

A client is receiving IV vancomycin for the treatment of *Clostridium difficile*. The nurse understands that the client who develops flushing, tachycardia, and hypotension during the infusion of vancomycin indicates:

1. Ototoxicity effect.
2. Superinfection.
3. Red man syndrome.
4. Hives.

Answer: 3

Rationale: Vancomycin inhibits cell wall synthesis, and is used for serious infections. It is only effective against gram-positive bacteria, especially *Staphylococcus aureus* and *Staphylococcus epidermidis*. The nurse should infuse this medication slowly over 60 minutes or more to avoid “red man” syndrome. The syndrome is characterized by erythematous rash, flushing, tachycardia, and hypotension. Clients can become dizzy and agitated.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Evaluation

Question #7

The physician has ordered for the client to receive a trough blood level to evaluate the therapeutic effect of an antibiotic. The nurse understands that the trough should be ordered:

1. A few minutes before the next scheduled dose of medication.
2. 1–2 hours after the oral administration of the medication.
3. 30 minutes after the IV administration.
4. During the infusion of the antibiotic.

Answer: 1

Rationale: Antibiotic peak and trough levels monitor therapeutic blood levels of the prescribed medication. The therapeutic range—that is, the minimum and maximum blood levels at which the drug is effective—is known for a given drug. By measuring blood levels at the predicted peak (1–2 hours after oral administration, 1 hour after intramuscular administration, and 30 minutes after IV administration) and trough usually a few minutes before the next scheduled dose, it is also possible to determine whether the drug is reaching a toxic or harmful level during therapy, increasing the likelihood of adverse effects.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

Question #8

The nurse needs to change a dressing on the client's abdomen. Which of the following techniques should be implemented?

1. Contact precautions
2. Standard precautions
3. Droplet precautions
4. Airborne precautions

Answer: 2

Rationale: Standard precautions are used on all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who have direct contact with clients or with their body fluids. Since the client has an abdominal dressing, the nurse will use standard precautions.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

#### Question #9

The physician has ordered for the nurse to obtain a sputum specimen. The nurse understands that the sputum specimen should be collected:

1. Immediately after the first dose of antibiotic is administered.
2. 30 minutes after the first dose of antibiotics is administered.
3. During the first dose of antibiotics.
4. Before the first dose of antibiotics is administered.

Answer: 4

Rationale: When the physician orders a specimen to be collected, the nurse should collect the specimen before the first dose of antibiotics is administered to ensure adequate organisms for culture.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

Question # 10

Which of the following manifestations indicate a systemic reaction associated with an inflammatory response?

1. Erythema
2. Pain
3. Tachypnea (RR 26)
4. Edema

Answer: 3

Rationale: If the nurse observes a systemic reaction, the client will exhibit manifestations including temperature, increased pulse, tachypnea, and leukocytosis. Erythema, warmth, pain, edema, and functional impairment indicate a local reaction.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

Question #11 – Alternate Question

A client develops hyperthermia related to a diagnosis of pneumonia. Which of the following nursing interventions would be effective in the treatment of hyperthermia? Select all that apply.

1. Increase the temperature of the room environment to prevent shivering.
2. Use ice packs and a tepid bath as needed.
3. Administer antipyretic medications per physician's orders.
4. Promote frequent rest periods to increase energy reserve.
5. Restrict fluids during periods of hyperthermia because of the risk of electrolyte imbalance.

Answer: 2; 3; 4

Rationale: Hyperthermia is an expected consequence of the infectious disease process. Fever can produce mild, short-term effects, and when prolonged can cause life-

threatening effects. The nurse should administer antipyretic medications as indicated for elevated temperatures. The nurse should use ice packs, cool/tepid baths, or a hypothermia blanket with caution. The nurse should enforce frequent rest periods because rest increases energy reserve that is depleted by increased metabolic, heart, and respiratory rates. The nurse should encourage fluids rather than restrict fluids because of the risk of electrolyte imbalance.

Cognitive Level: Assessment

Client Needs: Physiological Integrity

Nursing Process: Implementation

#### Question #12 – Alternate Question

The nurse is assessing a client's wound for signs and symptoms of inflammation. Which of the following would alert the nurse that the client is exhibiting signs of inflammation? Select all that apply.

1. Leg edema
2. Leg cool to touch
3. Severe pain from swelling
4. Decreased peripheral pulses
5. Severe erythema of leg

Answer: 1; 3; 5

Rationale: Regardless of the cause, location, or extent of the injury, the acute inflammatory response follows the sequence of vascular response; cellular and phagocytic response; and healing. Many manifestations of inflammation are produced by inflammatory mediators such as histamines and prostaglandins released when tissue is damaged. The cardinal signs of inflammation include erythema, local heat caused by the increased blood flow to the injured area (hyperemia), swelling due to accumulated fluid at site, pain from tissue swelling and chemical irritation of nerve endings, loss of function caused by the swelling, and pain.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

Alternate item format – Select all that apply

Which of the following manifestations would the nurse expect to see with a client who has had knee surgery and who suffered a surgical infection with signs of systemic manifestations? Select all that apply.

1. Erythema
2. WBC 14,200 mm<sup>3</sup>
3. Pain at the surgical site
4. 10% bands
5. Respiratory rate of 16
6. Pulse 114

Answer: 2; 4; 6

Rationale: The client is post-surgical repair of the knee. The nurse should be able to distinguish between local reactions and system reactions. An elevated WBC and 10% bands are indicative of an infection. Vital sign changes typically associated with an infection include an elevation in temperature and tachycardia. Local manifestations include erythema, warmth, pain, edema, and functional impairment, whereas systemic manifestations include elevated temperature above 100.4°F, pulse greater than 90/min., respiratory rate greater than 20, and WBC greater than 12,000 mm<sup>3</sup> or > 10% bands.

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Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

## Chapter 13

1. A client with a history of latex allergies develops audible wheezing, pruritus, urticaria, and signs of angioedema. Which of the following would the nurse perform initially?

1. Administer epinephrine 1:100,000 IV per MD orders.
2. Collect a detailed history from the client regarding the history of latex allergies.
3. Teach the client regarding using a kit that contains treatment for allergic reactions.
4. Administer diphenhydramine (Benadryl) by mouth every four hours per physician's orders.

Answer: 1

Rationale: For mild reactions with wheezing, pruritus, urticaria, and angioedema, a subcutaneous injection of 0.3–0.5 mL of 1:1,000 epinephrine is generally sufficient. The nurse should give the epinephrine first due to the symptoms. Intravenous epinephrine

using a 1:100,000 concentrations may be used in the client with a more severe anaphylactic reaction. The nurse does not have time to collect a detailed history, because of the severity of the client's signs and symptoms. Clients who have experienced an anaphylactic reaction to insect venom or another potentially unavoidable allergen should carry a bee sting kit.

Cognitive Level: Analysis

Client Needs: Physiological Integrity

Integrated Process: Assessment

2. A client who is a bone marrow transplant recipient develops a maculopapular rash on the palms of both hands and the soles of the feet. The client complains of severe abdominal pain with bloody diarrhea. The nurse would suspect that the client is experiencing:

1. Chronic tissue rejection.
2. Graft-versus-host disease.
3. Acute tissue rejection.
4. Hyperacute tissue rejection.

Answer: 2

If a transplant client develops a maculopapular pruritic rash beginning on the palms of the hands and soles of the feet, it indicates GVH (Graft-versus-host disease). The rash can spread to involve the entire body and lead to desquamation. Gastrointestinal manifestations include abdominal pain, nausea, and bloody diarrhea. GVH that lasts longer than 100 days is said to be chronic. Chronic tissue rejection occurs from 4 months to years after transplant of new tissue. Acute tissue rejection is the most common type of rejection, and occurs between 4 days and 3 months after the transplant. Acute rejection is mediated primarily by the cellular immune response, resulting in transplant cell destruction. The client experiencing rejection demonstrates manifestations of the inflammatory process, with fever, redness, swelling, elevated BUN, creatinine, lower enzymes, and elevated bilirubin and cardiac enzymes.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

3. A client with AIDS is taking an antiretroviral medication. The client complains of nausea, fever, severe diarrhea, and anorexia. Which of the following medications would be the most effective to relieve the anorexia, as well as to stimulate the client's appetite?

1. Megestrol (Megace)
2. Ciprofloxacin (Cipro)
3. Zidovudine (Retrovir, AZT)
4. Abacavir (Ziagen)

Answer: 1

Rationale: Megestrol (Megace) and dronabinol (Marinol) are often ordered to increase the client's appetite and promote weight gain. Ciprofloxacin (Cipro) is an anti-infective medication and zidovudine (Retrovir, AZT) is an antiretroviral agent. Abacavir (Ziagen) is a potent inhibitor of reverse transcriptase.

Cognitive Level: Application

Client Needs: Physiological Integrity (Pharmacology and Parenteral Therapy)

Nursing Process: Implementation

#### Question #4

4. Which statement made by the client taking an immunosuppressive agent would require further teaching?

1. "I know to call the physician if I start experiencing a lot of bruising."
2. "I should drink plenty of water to keep me from getting dehydrated."
3. "I should drink a lot of fruit juices, such as grapefruit juice."
4. "If I experience any joint pain, I should take ibuprofen for the pain as needed every four hours."

Answer: 3

Rationale: Immunosuppressive agents inhibit T cell development and activation. They are given concurrently with a glucocorticoids and in combination with other immunosuppressants, and inhibit immune system activity and organ rejection. Nursing responsibilities include monitoring BUN and creatinine for evidence of nephrotoxicity.

The client should avoid grapefruit juice, which can raise cyclosporine levels by 50–200% and increase the risk of toxicity. Fluids should be increased to maintain good hydration and urinary output. Ibuprofen is acceptable for immunosuppressive medications, but should not be taken with cytotoxic agents.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Implementation

5. A client is suspected of having a reaction. Which lab test would alert the nurse regarding the possibility of a hypersensitivity reaction?

1. Eosinophils of 2% of the total WBC
2. Indirect Coombs' showing no agglutination
3. Patch test with a one-inch area of erythema
4. Rh antigen with negative results

Answer: 3

Rationale: A patch test assesses a one-inch area impregnated with the allergen, which is applied for 48 hours. Absence of a response indicates a negative result. Positive responses are graded from mild (erythema in the exposed area) to severe (papules, vesicles, or ulcerations). Direct Coombs' test detects antibodies in the client's RBC that damage and destroy the cells. This is used following a suspected transfusion reaction to detect antibodies coating the transfused RBCs. This is also part of the crossmatch of a blood type and crossmatch. Indirect Coombs' test detects the presence of circulating antibodies against RBCs. The eosinophil count is 1–4%, which is within normal range.

Cognitive Level: Comprehension

Client Needs: Physiological Integrity

Nursing Process: Assessment

6. A client has a diagnosis of AIDS. The nurse is teaching the client regarding a diet with increased kilocalories. Which of the following diets would indicate that the client has an understanding of the appropriate diet?

1. Spaghetti and meat sauce, raisin salad, whole grain roll with butter, vanilla milkshake (with Ensure), and a piece of pecan pie

2. Baked chicken (thigh), cabbage, small green salad, slice of white bread, dried prunes, and a soda
3. Red beans and rice, slaw, tomato, crackers, chocolate pudding, and iced tea
4. Vegetable soup, small piece of cornbread, banana pudding, and water

Answer: 1

Rationale: Provide a diet high in protein and kilocalories. A high-protein, high-kilocalorie diet provides the necessary nutrients to meet metabolic and tissue healing needs. The diet with the most kilocalories is the spaghetti and meat sauce with the vanilla milkshake made with Ensure and pecan pie.

Cognitive Level: Application

Client Needs: Health Promotion and Maintenance

Nursing Process: Implementation

7. Which of the following statements by the client who has HIV would require further teaching by the healthcare professional?

1. “I know I have to practice safe sex with my partner.”
2. “I will not share my toothbrush or razor with my partner.”
3. “I know I can’t donate blood anymore since I have HIV.”
4. “I know to use an oil-based lubricant to prevent spread of the disease to my partner.”

Answer: 4

Rationale: The nurse should educate the client regarding the prevention of the spread of HIV. The client will need further education when he states that he will use an oil-based lubricant. The client should be educated to use latex condoms for oral, vaginal, or anal intercourse; avoid natural or animal skin condoms, which allow passage of HIV. The client should use only water-based lubricants—not oil-based, such as petroleum jelly, which can result in condom damage. The client is correct in stating that it is not an acceptable practice to share toothbrushes or razors. The client is also correct in stating that blood donation is prohibited.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Implementation

8. The home health nurse is planning the day. Which of the following clients should the nurse see first?

1. A client with wasting syndrome who has end-stage AIDS who needs modifications and education regarding dietary changes
2. A client with a long history of AIDS who is receiving IV antibiotics daily for toxoplasmosis
3. A client with PCP (Pneumocystis carinii pneumonia) who called the office to report a new onset of fever, cough, and SOB this AM
4. A client with AIDS who is receiving Epivir (lamivudine) because of a diagnosis of a low CD4 cell count.

Answer: 3

Rationale: The home health nurse should see the client with Pneumocystis carinii pneumonia because of the complaint of shortness of breath with the new onset of fever. All of the clients need to be seen by the nurse, but based on the ABCs (airway, breathing, and circulation), the nurse should visit this client first and obtain vital signs and perform a respiratory assessment initially.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

9. A nurse is performing an admission assessment on a client with AIDS. Which of the following questions would be inappropriate for the nurse to ask the client in the interview process?

1. “Have you ever experimented with recreational drugs?”
2. “How long have you had AIDS?”
3. “Does your partner have AIDS?”
4. “Have you had any fever, diarrhea, or chills over the last 48 hours?”

Answer: 3

Rationale: During the interview process, the nurse should ask questions specific to the client’s history, including current medications, diet, and signs and symptoms that the client has experienced. The nurse cannot ask about the client’s partner.

Cognitive Level: Application

Client Needs: Psychosocial Integrity

Nursing Process: Assessment

10. A client with HIV states “I don’t think I am going to live much longer. I feel so bad.” The nurse determines that which of the following would be the best response?

1. “You will be fine; you just need to let the medication have a chance to work.”
2. “It must be very difficult for you right now dealing with your diagnosis.”
3. “You need to be more positive about your diagnosis because it will improve your chances of surviving this disease.”
4. “Try not to be negative. You need to give yourself some time to feel better about your diagnosis.”

Answer: 2

Rationale: The nurse should be realistic with the client. The nurse cannot give false reassurance or false hope about a terminal illness. It is important for the nurse to express empathy for the client.

Cognitive Level: Application

Client Needs: Psychosocial Integrity

Nursing Process: Evaluation

11. A nurse is monitoring a client who is receiving a unit of packed red blood cells. The client suddenly develops chest pains, hives, chills, and hypotension. Number the action that the nurse would take in order of priority.

- \_\_\_\_\_ 1. Start normal saline at KVO (keep vein open).
- \_\_\_\_\_ 2. Stop the transfusion.
- \_\_\_\_\_ 3. Notify the physician and blood bank.
- \_\_\_\_\_ 4. Remove the blood bag and the tubing with the blood in it.
- \_\_\_\_\_ 5. Obtain a urine specimen and send to the lab.

Answer: 2, 4, 1, 3, 5

Rationale: The client is experiencing an adverse reaction to the blood transfusion. The blood should be stopped immediately if a reaction occurs, no matter how mild. The nurse should remove the blood bag and the tubing with blood in it. Flush new intravenous tubing with normal saline, keeping the IV line open. Notify the physician and the blood bank. If a reaction is suspected, send the blood and administration set to the laboratory with a freshly drawn blood sample and urine specimen from the client. These will be used to identify the reaction as well as its effect on the client.

Cognitive Level: Application

Client Needs: Physiological Integrity

### Nursing Process: Implementation

12. The nurse has admitted a client who has a diagnosis of Cryptosporidium. Which care activity would be appropriate to delegate to the UAP (unlicensed assistive personnel)? Select all that apply.

1. Obtain a detailed history regarding the client's history.
2. Obtain the client's admitting height and weight.
3. Review the client's home medications, and complete the medication reconciliation sheet.
4. Obtain the client's admitting vital signs.
5. Educate the client regarding the diet that the physician has ordered.

Answer: 2; 4

Rationale: The nurse can never delegate assessment or education. The nurse can appropriately delegate to the UAP the task of obtaining weight, height, and vital signs. The nurse practice act assists the nurse with the tasks that can be delegated. Anytime the nurse delegates activities to other professionals, that nurse is accountable for the overall nursing care of the client.

Cognitive Level: Analysis

Client Needs: Safe, Effective Care

Nursing Process: Implementation

13. The nurse would report to the physician which of the following laboratory values for a client newly diagnosed with AIDS? Select all that apply.

1. CD4 cell count 344/mm<sup>3</sup>
2. T<sub>4</sub> cell count 150
3. WBC 6,500
4. CD4 lymphocytes 12%
5. Viral load 11,500 copies/mL

Answers: 1; 2; 4; 5

Rationale: The risk of opportunistic infection is the most common manifestation of AIDS. The risk of opportunistic infection is predictable by the T4 and CD4 cell count. The normal CD4 call count is greater than 1,000/mm<sup>3</sup>. All of the labs are abnormal except for the WBC, which was within normal range (4,500–10,000).

Cognitive Level: Analysis

Client Needs: Physiological Integrity

Nursing Process: Implementation

## **Chapter 14**

1. A client is attending a health fair at work today. The client shows the nurse a new sore on the forearm that has been increasing in size and will not heal. The nurse caring for this client knows that which of the following signs could also point to a diagnosis of a malignant neoplasm?

Hint: Types of Neoplasms

Answer Choices:

1. Rapid growth, well-defined borders, and cohesiveness
2. Invasive, local, and does not stop at tissue border
3. Noncohesive, invasive, and invades and destroys surrounding tissues
4. Slow growth, well-defined borders, and encapsulated

Answer: 3

Rationale: Benign neoplasms are local, cohesive, with well-defined borders. They push other tissues out of the way, are characterized by slow growth, are encapsulated, are easily removed, and do not recur. Malignant neoplasms are invasive, are noncohesive, do not stop at the tissue border, invade and destroy surrounding tissues, are characterized by rapid growth, metastasize to distant sites, are not always easy to remove, and can recur.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

Objective: Define cancer, and differentiate benign from malignant neoplasms.

Strategy: Look at every sign provided in each answer choice. The correct answer has to have all correct components to be correct. If any component is incorrect, then the answer is incorrect.

2. A nursing student is learning about the theories of carcinogenesis. Which statement by the nursing student indicates the need for further teaching?

Hint: Theories of Carcinogenesis

Answer Choices:

1. “Oncogenes are genes that promote cell proliferation and are capable of triggering cancerous characteristics.”
2. “Inherited cancers can become inactive by deletion or mutation.”
3. “The theory of cellular mutation suggests that carcinogens cause mutations in cellular RNA.”
4. “Known carcinogens include viruses, drugs, hormones, and chemical and physical agents.”

Answer: 3

Rationale: Oncogenes are genes that promote cell proliferation and are capable of triggering cancerous characteristics. Inherited cancers can become inactive by deletion or mutation. The theory of cellular mutation suggests that carcinogens cause mutations in cellular DNA, not RNA. Known carcinogens include viruses, drugs, hormones, and chemical and physical agents.

Nursing Process: Evaluation

Client Need: Physiological Integrity

Client Need Subcategory: Physiological Adaptation

Cognitive Level: Analysis

Objective: Describe the theories of carcinogenesis.

Strategy: Read each statement. Choose the incorrect statement as the correct answer, since the stem of the questions asks for an indication that further teaching is needed.

3. A college student is studying for final examinations. The student falls ill and presents to the student health center. The student is diagnosed with Epstein-Barr virus. The student has a history of smoking and recreational cocaine use, and works for a floor refinishing company part-time. Which risk factors are present in this student for developing cancer? Select all that apply.

Hint: Known Carcinogens

Answer Choices:

1. Drug use
2. Occupation
3. Age
4. Smoking
5. Viral infection

Answers: 1; 2; 4; 5

Rationale: Several viruses have been associated with the development of cancer. Some of these viruses include herpes simplex viruses I and II, the human cytomegalovirus, Epstein-Barr virus, the human herpesvirus-6, the hepatitis B virus, the papillomavirus, and the human T-lymphotropic viruses. Viruses play a significant role in weakening immunologic defenses against neoplasms. Some recreational drugs are also implicated as carcinogens. Immunosuppressant promoters include heroin and cocaine. Examples of industrial and environmental carcinogens include polycyclic hydrocarbons, found in soot; benzopyrene, found in cigarette smoke; and arsenic, found in pesticides. Other industrial and environmental chemicals are considered promotional agents. These include wood and leather dust, polymer esters used in plastics and paints, carbon tetrachloride, asbestos, and phenol.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Explain and discuss known carcinogens, and identify risk factors for cancer.

Strategy: Consider each risk factor in the development of cancer in this client. Multiple answers will be correct.

4. A student nurse extern is working for the summer on an oncology unit. The extern's preceptor has been explaining the characteristics of malignant cells. Which statement by the student nurse extern demonstrates a good understanding of the information?

Hint: Characteristics of Malignant Cells

Answer Choices:

1. "Malignant cells continue to perform cellular functions."
2. "The transformation into a malignant cell is reversible if treated promptly."
3. "Malignant cells rarely break away from the primary tissue site and travel to other locations."
4. "The work of malignant cells is simpler than that of normal cells."

Answer: 4

Rationale: A characteristic of malignant cells is loss of specialization and differentiation. Malignant cells do not perform typical cellular functions. Another characteristic of malignant cells is irreversibility. The transformation into a malignant cell is irreversible. Rarely does a malignant neoplasm revert to a benign state. Transplantability is another characteristic of malignant cells. Malignant cells often break away from the primary tissue site and travel to other locations in the body. Simplified metabolic activities are another characteristic of malignant cells. The work of malignant cells is simpler than that of normal cells.

Nursing Process: Evaluation

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Compare the mechanisms and characteristics of normal cells with those of malignant cells.

Strategy: Read each statement. Eliminate incorrect statements. Choose as the answer the statement that is correct and therefore demonstrates a good understanding on the part of the student nurse extern.

5. A client newly diagnosed with cancer is speaking to the nurse in the physician's office. The nurse knows that because of this new diagnosis, the client might experience different physiologic and psychologic symptoms. Which effects would the nurse consider possible physiologic or psychologic effects of cancer?

Hint: Physiologic and Psychologic Effects of Cancer

Answer Choices:

1. Hyperglycemia, nephrotic syndrome, and body image concerns
2. Altered taste and smell, deep vein thrombosis, and increased leukocytes
3. Hypoglycemia, grief, and anorexia–cachexia syndrome
4. Decreased intracranial pressure, isolation, and acute pain

Answer: 1

Rationale: Box 14-5 lists the physiologic and psychosocial effects of cancer. Some effects include hyperglycemia, nephrotic syndrome, body image concerns, altered taste and smell, deep vein thrombosis, decreased leukocytes, grief, anorexia–cachexia syndrome, increased intracranial pressure, isolation, and acute or chronic pain.

Nursing Process: Diagnosis

Client Need: Physiological Integrity

Client Need Integrity: Physiological Adaptation

Cognitive Level: Analysis

Objective: Describe physical and psychologic effects of cancer.

Strategy: Each answer has three components. Consider each component. Eliminate any answer choice with at least one incorrect component.

6. A client presents to her gynecologist's office as follow-up to a tumor found in her left breast. Today the client will be undergoing a procedure to remove part of the large tumor by cutting through the skin. Which procedure will this client be having done today?

Hint: Table 14-9 Surgical Diagnostic Procedures

Answer Choices:

1. A fine-needle biopsy
2. A needle core biopsy
3. An incisional biopsy
4. An excisional biopsy

Answer: 3

Rationale: A fine-needle biopsy uses a very thin needle to aspirate a small amount of tissue from the tumors. A needle core biopsy uses a slightly larger needle than that used for a fine-needle biopsy to extract a small amount of tissue from tumors that cannot be aspirated by fine-needle aspiration. An incisional biopsy is the removal of part of a larger tumor by cutting through the skin. An excisional biopsy is the removal of an entire tumor through operation.

Nursing Process: Planning

Client Need: Physiological Integrity

Client Need Subcategory: Reduction of Risk Potential

Cognitive Level: Application

Objective: Describe and compare laboratory and diagnostic tests for cancer.

Strategy: Consider each procedure. Choose the procedure that is best described in the stem of the question.

7. A nursing student is studying for a pharmacology examination on chemotherapeutic agents. Which statement by the nursing student indicates the need for further teaching?

Hint: Classes of Chemotherapy Drugs

Answer Choices:

1. “The main hormones used in cancer therapy are the corticosteroids, which are phase-specific.”
2. “Mitotic inhibitors are drugs that act to prevent cell division during the M phase.”
3. “Antitumor antibiotics disrupt RNA replication and DNA transcription.”
4. “Alkylating agents basically act on preformed nucleic acids by creating defects in tumor DNA.”

Answer: 3

Rationale: Hormones and hormone antagonists are one class of chemotherapeutic agents. The main hormones used in cancer therapy are the corticosteroids, which are phase-specific. Mitotic inhibitors are drugs that act to prevent cell division during the M phase. Antitumor antibiotics disrupt DNA replication and RNA transcription, not the other way around. Alkylating agents basically act on preformed nucleic acids by creating defects in tumor DNA.

Nursing Process: Evaluation

Client Need: Physiological Integrity

Client Need Subcategory: Pharmacological and Parenteral Therapies

Cognitive Level: Analysis

Objective: Discuss the role of chemotherapy in cancer treatment, and classify chemotherapeutic agents.

Strategy: Look for an incorrect statement that indicates the need for further teaching.

8. A nurse is caring for a client undergoing brachytherapy. Which precaution should the nurse take when caring for this client?

Hint: Box 14-6 Safety Principles for Radiation

Answer Choices:

1. Care for this client regardless of pregnancy status.
2. Maintain the least possible distance from the client.
3. Avoid indirect exposure with radioisotopes containers.
4. Wear a monitoring device to measure whole-body exposure.

Answer: 4

Rationale: Many safety principles apply when caring for a client receiving radiation. Refer to box 14-6 for a complete list. In brachytherapy, the radioactive material is placed directly into or adjacent to the tumor. If pregnant, avoid contact with radiation sources. Maintain the greatest possible distance from the source of radiation. Avoid direct, not indirect, exposure with radioisotopes containers; for example, do not touch the container. Wear a monitoring device to measure whole-body exposure.

Nursing Process: Planning

Client Need: Physiological Integrity

Client Need Subcategory: Reduction of Risk Potential

Cognitive Level: Application

Objective: Discuss the role of surgery, radiation therapy, and biotherapy in the treatment of cancer.

Strategy: Look for a correct action when caring for a client with internal radiation.

9. A client is admitted to the hospital with a history of squamous-cell lung cancer. Upon admission, the client exhibits signs of arm and periorbital edema. Within the hour, the client exhibits dyspnea, cyanosis, tachypnea, and an altered level of consciousness. Which action should the nurse take FIRST?

Hint: Nursing Interventions for Oncologic Emergencies

Answer Choices:

1. Call the physician.
2. Administer oxygen.
3. Monitor vital signs.

4. Initiate seizure precautions.

Answer: 2

Rationale: The superior vena cava can be compressed by mediastinal tumors or adjacent thoracic tumors. The most common cause is small-cell or squamous-cell lung cancers. Signs and symptoms can develop slowly, and include facial, periorbital, and arm edema as early signs. As the problem progresses, respiratory distress, dyspnea, cyanosis, tachypnea, and altered consciousness and neurologic deficits can occur. Emergency measures include the following: Provide respiratory support with oxygen, and prepare for a tracheostomy; monitor vital signs; administer corticosteroids to reduce edema; if the disorder is due to a clot, administer antifibrinolytic or anticoagulant drugs; provide a safe environment, including seizure precautions.

Nursing Process: Implementation

Client Need: Physiological Integrity

Client Need Subcategory: Basic Care and Comfort

Cognitive Level: Analysis

Objective: Identify causes and discuss the nursing interventions for common oncologic emergencies.

Strategy: Consider whether the client needs further assessment or an action implemented due to the severity of the situation. Prioritize actions based on airway, breathing, and circulation.

10. A client with renal cancer is preparing for discharge. The nurse is teaching both the client and the family about when to call for help after discharge. Which statement by the client indicates that teaching has been successful?

Hint: Box 14-13 When to Call for Help

Answer Choices:

1. "I should call my physician if I experience new bleeding from any site."
2. "I should call my physician if I have an oral temperature higher than 100.5°F."
3. "I should call my physician if I have an episode of diarrhea."
4. "I should call my physician if I experience an occasional headache."

Answer: 1

Rationale: Instruct the client or family member to call the nurse or physician if any of the following signs or symptoms occur: oral temperature higher than 101.5°F; severe headache; significant increase in pain at usual site, especially if the pain is not relieved by the medication regimen, or severe pain at a new site; difficulty breathing; new bleeding

from any site; confusion, irritability, or restlessness; verbalizations of deep sadness or a desire to end life; changes in eating patterns; changes in body functioning, such as severe diarrhea or constipation; withdrawal; frequent crying; greatly decreased activity level; and the appearance of edema in the extremities or significant increase in edema already present.

Nursing Process: Evaluation

Client Need: Physiological Integrity

Client Need Subcategory: Reduction of Risk Potential

Cognitive Level: Analysis

Objective: Design an appropriate care plan for clients with cancer and their families regarding cancer diagnosis, treatment, and coping strategies.

Strategy: Look for a correct statement, indicating that client teaching has been successful.

11. A 34-year-old client, who is at her annual gynecologic examination, is being taught about early screening for breast cancer. The client has a sister and mother with a history of breast cancer. Which action by the client demonstrates good screening techniques for someone with her family history?

Hint: Box 14-10 American Cancer Society Guidelines for Cancer Screening

Answer Choices:

1. Routine breast exams to begin after age 35
2. Reporting of any changes in breast tissue to the health provider at the next routine visit
3. Annual screening mammography starting at age 40
4. Clinical breast examination every three years

Answer: 4

Rationale: American Cancer Society guidelines for cancer screening include routine breast self-examination starting at age 20; prompt reporting of any change in breast tissue to healthcare provider; clinical breast examination every three years from ages 20 to 39, and yearly thereafter; annual screening mammography starting at age 40, except in women at increased risk, who may have more frequent mammography or other tests such as breast ultrasound exams.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Design an appropriate care plan for clients with cancer and their families regarding cancer diagnosis, treatment, and coping strategies.

Strategy: Consider screening techniques for a woman with a family history of breast cancer.

12. A student nurse is studying risk factors in developing cancer. Which client should this student nurse determine to have the highest risk of developing cancer?

Hint: Incidence and Mortality

Answer Choices:

1. An African-American man
2. A Native American woman
3. A Hispanic man
4. A Hispanic woman

Answer: 1

Rationale: African-Americans are more likely to develop cancer than is any other ethnic or racial group in the United States. Cancer incidence and mortality are lower in Native American men and women than in any other ethnic or racial group. The incidence and mortality rates for all types of cancer are 35–39 percent lower in Hispanics.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Cognitive Level: Analysis

Objective: Explain and discuss known carcinogens, and identify risk factors for cancer.

Strategy: Weigh the risk factors for developing cancer based on the client's sex and ethnic background.

13. A client with breast cancer is receiving 5-Fluorouracil (5-FU). Based on knowledge of this medication, and anticipated adverse effects or side effects, which nursing action should the nurse perform?

Hint: Table 14-10 Classifications of Chemotherapeutic Drugs

Answer Choices:

1. Monitor ECG.

2. Assess lung sounds.
3. Test stool for occult blood.
4. Encourage daily fluid intake of 2–3 liters.

Answer: 3

Rationale: The possible adverse effects or side effects associated with 5-FU are stomatitis, alopecia, nausea and vomiting, gastritis, enteritis, diarrhea, anemia, leucopenia, and thrombocytopenia. Assessing for bleeding by checking stool for occult blood is recommended in this client. Monitoring the ECG is recommended in clients receiving antitumor antibiotics. Assessing lung sounds is recommended in clients receiving alkylating agents, due to the potential for developing pulmonary fibrosis. Encouraging a daily fluid intake of 2–3 liters is recommended also for clients receiving alkylating agents because they could potentially develop renal failure.

Nursing Process: Implementation

Client Need: Physiological Integrity

Client Need Subcategory: Pharmacological and Parenteral Therapies

Cognitive Level: Analysis

Objective: Discuss the role of chemotherapy in cancer treatment, and classify chemotherapeutic agents.

Strategy: Consider each nursing action. Determine which action is needed based on potential complications of the chemotherapeutic agent 5-FU.

## Chapter 15

1. A nursing student is studying the functions of the skin. Which statement by the nursing student indicates the need for further teaching?

Hint: Table 15-1 Functions of the Skin and Its Appendages

Answer Choices:

1. “The epidermis protects tissues from physical, chemical, and biologic damage.”
2. “The dermis regulates body temperature by dilating and constricting capillaries.”
3. “The eccrine sweat glands regulate body heat by excretion of perspiration.”
4. “The apocrine sweat glands cushion the scalp and provide insulation in cold weather.”

Answer: 4

Rationale: The epidermis protects tissues from physical, chemical, and biologic damage. The dermis regulates body temperature by dilating and constricting capillaries. The

eccrine sweat glands regulate body heat by excretion of perspiration. The apocrine sweat glands are a remnant of the sexual scent gland. Hair cushions the scalp and provides insulation in cold weather.

Nursing Process: Assessment

Client Need: Physiological Integrity

Client Needs Subcategory: Physiological Adaptation

Cognitive Level: Analysis

Objective: Describe the anatomy, physiology, and functions of the skin, hair, and nails.

Strategy: Evaluate each statement to determine if it is correct. Eliminate correct statements. Identify the incorrect statement, since the question stem references the need for further teaching.

2. The nurse is caring for an African-American client who has a serum bilirubin of 6 mg/100 mL. What is the best way of assessing for changes in skin color in this client?

Hint: Table 15-2 Skin Color Assessment Variations in People with Light and Dark Skin

Answer Choices:

1. Assess the sclera.
2. Assess the palms of the hands.
3. Assess the fingernails.
4. Assess the mucous membranes.

Answer: 2

Rationale: Jaundice is the yellowish discoloration of the skin, mucous membranes, and sclera of the eyes, caused by increased amounts of bilirubin or other pigments in the blood. An increased serum bilirubin is when the value is greater than 2–3 mg/100 mL. In clients with dark skin, yellowing is best assessed at the junction of the hard palate and the soft palate, or on the palms of the hands.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

Objective: Discuss factors that influence skin color.

Strategy: Consider the physical assessment techniques needed in an African-American client with jaundice.

3. The nurse is caring for a client with oculocutaneous albinism. Which statement by the nurse demonstrates a good understanding of this disorder?

Hint: Genetic Considerations: Integumentary System

Answer Choices:

1. “Oculocutaneous albinism causes hypopigmentation of the skin, hair, and eyes as a result of an inability to synthesize melanin.”
2. “Oculocutaneous albinism is characterized by elevated scars, has a familial tendency, and is most commonly found in African-Americans.”
3. “Oculocutaneous albinism is the sudden appearance of white patches on the skin, and has a familial tendency.”
4. “Oculocutaneous albinism is an autosomal-dominant inheritance disorder that causes hyperpigmentation of the skin, hair, and eyes.”

Answer: 1

Rationale: Oculocutaneous albinism is an autosomal-recessive, not -dominant, inheritance disorder. Oculocutaneous albinism causes hypopigmentation, not hyperpigmentation, of the skin, hair, and eyes as a result of an inability to synthesize melanin. Vitiligo, not oculocutaneous albinism, is the sudden appearance of white patches on the skin, and has a familial tendency. Keloids, not oculocutaneous albinism, are elevated scars, have a familial tendency and are more commonly found in African-Americans.

Nursing Process: Evaluation

Client Need: Physiological Integrity

Client Need Subcategory: Physiological Adaptation

Cognitive Level: Analysis

Objective: Discuss factors that influence skin color.

Strategy:

4. A nursing student is performing a functional health pattern interview of a client. If the student needs to assess the health perception and health management of the client, which question by the nursing student is best?

Hint: Functional Health Pattern Interview

Answer Choices:

1. “Do you bruise easily?”
2. “How well do your cuts and scratches heal?”
3. “Do you have any allergies to foods, plants, or pets?”
4. “Have you noticed swelling around your eyes or ankles?”

Answer: 3

Rationale: “Do you bruise easily?” is a question used to assess activity and exercise. “How well do your cuts and scratches heal?” is a question used to assess nutritional/metabolic. “Do you have any allergies to foods, plants, or pets?” is a question used to assess health perception and health management. “Have you noticed swelling around your eyes or ankles?” is a question used to assess elimination.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Identify specific topics for a health history interview of the client with problems involving the skin, hair, and nails.

Strategy: Look for a question that would satisfy the health perception/health management question of a client interview. Eliminate questions that would not fall into this category.

5. A client presents to the physician’s office with a superficial lesion. The nurse understands that the client’s physician will need to perform a test to differentiate between an infectious and inflammatory lesion. Which test would best determine this?

Hint: Diagnostic Tests of the Integumentary System

Answer Choices:

1. Shave skin biopsy
2. Incisional skin biopsy
3. Punch skin biopsy
4. Excisional skin biopsy

Answer: 1

Rationale: A shave skin biopsy is done to shave off superficial lesions and to differentiate infectious from inflammatory lesions. An incisional skin biopsy is done to differentiate benign lesions from skin cancers. A punch skin biopsy is done to differentiate benign

lesions from skin cancer. An excisional skin biopsy also is done to differentiate benign lesions from skin cancers.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

Objective: Compare and contrast normal and abnormal findings when conducting an assessment of the integumentary system.

Strategy: Consider each test, and which benefits it has with regard to diagnosis.

6. A client has an area of rough, thickened, hardened epidermis. Which disorder could be the reason for this skin lesion?

Hint: Secondary Skin Lesions

Answer Choices:

1. Chronic dermatitis
2. Athlete's foot
3. Earring piercing
4. Psoriasis

Answer: 1

Rationale: Lichenification is a rough, thickened, hardened area of epidermis resulting from chronic irritation such as scratching or rubbing. An example of lichenification is chronic dermatitis. A fissure is a linear crack with sharp edges, extending into the dermis. Examples of a fissure include cracks at the corners of the mouth or in the hands, or those seen with athlete's foot. A keloid is an elevated, irregular, darkened area of excess scar tissue caused by excessive collagen formation during healing. It extends beyond the site of the original injury. An example of a keloid is scar tissue from ear piercing. Scales are shedding flakes of greasy, keratinized skin tissue. Examples of scales include dry skin, dandruff, psoriasis, and eczema.

Nursing Process: Diagnosis

Client Need: Physiological Integrity

Client Need Subcategory: Physiological Adaptation

Cognitive Level: Application

Objective: Identify abnormal findings that might indicate impairment of the integumentary system.

Strategy: Consider each type of skin disorder, and see which one most closely fits the description in the stem.

7. A client is being treated for an elevated, darkened area of excess scar tissue. A nurse is explaining the reason for this skin lesion to a nursing student. Which statement by the nursing student indicates that teaching has been effective?

Hint: Secondary Skin Lesions

Answer Choices:

1. "This scar was caused by the wearing away of the superficial epidermis, causing a moist, shallow depression."
2. "This scar was caused by excessive collagen formation during healing."
3. "This scar was caused by skin loss extending into the dermis or subcutaneous tissue."
4. "This scar was caused by wasting of the skin due to loss of collagen."

Answer: 2

Rationale: Erosion is the wearing away of the superficial epidermis, causing a moist, shallow depression. Because erosions do not extend into the dermis, they heal without scarring. A keloid is an elevated, irregular area of excess scar tissue caused by excessive collagen formation during healing. It extends beyond the site of the original injury. An ulcer is a deep, irregularly shaped area of skin loss extending into the dermis or subcutaneous tissue. Atrophy is a translucent, dry paper-like, sometimes wrinkled skin surface resulting from thinning or wasting of the skin due to loss of collagen and elastin.

Nursing Process: Evaluation

Client Need: Physiological Integrity

Client Need Subcategory: Physiological Adaptation

Cognitive Level: Analysis

Objective: Explain techniques for assessing the skin, hair, and nails.

Strategy: Consider each statement. Consider which statement is true of the formation of keloids.

8. The nurse is assessing a geriatric client. Which age-related changes should the nurse

expect to see in this client? Select all that apply.

Hint: Table 15-3 Age-Related Skin Changes

Answer Choices:

1. Dry skin
2. Perspiration
3. Double chin
4. Skin tears
5. Purpura

Answer: 1; 3; 4; 5

Rationale: Dry skin is common due to a decrease in eccrine and apocrine activity. This also causes perspiration to be absent. A double chin forms from the redistribution of adipose tissue in the subcutaneous skin layer. Skin tears can be caused by a decrease in thickness of the elderly client's epidermis. Skin tears and purpura can occur due to the flattening of the dermal–epidermal junction.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Growth and Development Throughout the Life Span

Cognitive Level: Application

Objective: Describe normal variations in assessment findings for the older client.

Strategy: Consider the age-related skin changes in an elderly client. Eliminate any incorrect answers. Multiple answers will be correct.

9. A nursing student is performing integumentary assessments on older adult clients. Which skin lesion would best name the client's brown benign macule with a defined border?

Hint: Box 15-1 Common Skin Lesions of Older Adults

Answer Choices:

1. Keratoses
2. Angiomas
3. Lentigines
4. Telangiectases

Answer: 3

Rationale: Keratoses are the horny growth of keratinocytes. Angiomas are benign

vascular tumors with dilated blood vessels, found in the middle to upper dermis. Lentigines, or liver spots, are brown or black benign macules with a defined border. Telangiectases are single dilated blood vessels, capillaries, or terminal arteries.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Growth and Development Through the Life Span

Cognitive Level: Knowledge

Objective: Describe normal variations in assessment findings for the older client.

Strategy: Consider each skin lesion in the older adult. Choose the skin lesion that best matches the description in the stem.

10. The nurse is caring for a client with thinning of the nails. Which test result would most likely be the reason for this nail disorder?

Hint: Integumentary Assessments

Answer Choices:

1. A low pulse ox
2. A low hemoglobin
3. A low serum albumin
4. A low white blood cell count

Answer: 3

Rationale: Thinning of the nails is seen in nutritional deficiencies. Trauma to the nails usually causes thickening. Other causes of thick nails include psoriasis, fungal infections, and decreased peripheral vascular blood supply.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

Objective: Identify abnormal findings that might indicate impairment of the integumentary system.

Strategy: Consider which lab value, if decreased, could result in thinning of the nails.

11. The nurse is assessing a client admitted with heart failure exacerbation. The client has 3+ lower extremity edema. Which description most accurately describes this client's edema?

Hint: Integumentary Assessments

Answer Choices:

1. Slight pitting, no obvious distortion
2. Deeper pit, no obvious distortion
3. Pit is obvious, extremities are swollen.
4. Pit remains with obvious distortion.

Answer: 3

Rationale: Edema is the accumulation of fluid in the body's tissues. Edema can be assessed by depressing the client's skin. 1+ edema is slight pitting with no obvious distortion. 2+ edema is a deeper pit, but there is no obvious distortion. In 3+ edema, the pit is obvious, and the extremities are swollen. In 4+ edema, the pit remains, with obvious distortion.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Identify abnormal findings that might indicate impairment of the integumentary system.

Strategy: Consider the different stages of edema, and which characterization is consistent with 3+ edema.

12. A nursing student is learning about integumentary changes in the elderly. Which change is expected in an older adult?

Hint: Table 15-3 Age-Related Skin Changes

Answer Choices:

1. A decrease in abdominal fat
2. An increase in perfusion
3. A decrease in vitamin D production
4. An increase in vasomotor response

Answer: 3

Rationale: In the elderly, there will be an increase in abdominal fat due to the redistribution of adipose tissue. There will be a decrease in perfusion of the dermis. There will be a decrease in vitamin D production of the epidermis. There will be a decrease in the vasomotor response of the dermis.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Growth and Development Through the Life Span

Cognitive Level: Comprehension

Objective: Describe normal variations in assessment findings for the older client.

Strategy: Consider each change listed, and determine if it is a change that might be seen in an elderly client. Eliminate any incorrect answers. Only one answer will remain.

13. A client is being seen for a problem with the eccrine sweat glands. Because of this structural problem, the nurse knows that which function will be impacted in this client?

Hint: Table 15-1 Functions of the Skin and Its Appendages

Answer Choices:

1. Body temperature regulation
2. Regulation of body heat by excretion of perspiration
3. Sebum secretion
4. Sexual scent gland

Answer: 2

Rationale: The dermis regulates body temperature by dilating and constricting capillaries. The eccrine sweat glands regulate body heat by excretion of perspiration. Sebaceous (oil) glands secrete sebum, which lubricates skin and hair, and plays a role in killing bacteria. The apocrine sweat glands function as a remnant of the sexual scent gland.

Nursing Process: Planning

Client Need: Physiological Integrity

Client Need Subcategory: Physiological Adaptation

Cognitive Level: Analysis

Objective: Describe the anatomy, physiology, and functions of the skin, hair, and nails.

Strategy: Consider the function of each structure of the skin.

14. A nurse is performing an assessment of the client's nails. Which assessment should be included in this examination? Select all that apply.

Hint: Integumentary Assessment

Answer Choices:

1. Inspect nail thickness.
2. Inspect nail color.
3. Inspect nail curvature.
4. Inspect for pitting.
5. Inspect for grooves.

Answer: 1; 2; 3; 4; 5

Rationale: Nails should be inspected for color and thickness. Also, the surface of the nail should be inspected for nail folds, grooves, pitting, curvature, and inflammation.

Nursing Process: Assessment

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Application

Objective: Explain techniques for assessing the skin, hair, and nails.

Strategy: Determine which assessments listed should be included in the nail assessment of a client. Multiple answers will be correct.

15. A nurse is assessing a client whose lab values this morning include a sodium of 144 mEq/L, a potassium of 3.8 mEq/L, a hemoglobin of 8.4 g/dL, and a glucose of 105 mg/dL. Which assessment might correlate with these findings?

Hint: Integumentary Assessments

Answer Choices:

1. The nail plate is separate from the nailbed.
2. The nail folds are inflamed and swollen.
3. The nail is spoon-shaped.
4. The nail has a transverse groove.

Answer: 3

Rationale: A normal hemoglobin in men is 13.5–16.5 g/dL. A normal hemoglobin in women is 12.0–15.0 g/dL. A normal sodium is 135–147 mEq/L. A normal potassium is 3.5–5.2 mEq/L. A normal glucose is 60–110 mg/dL. In this question stem, the client has a normal sodium, potassium, and glucose. The hemoglobin is low. Thin, spoon-shaped nails might be seen in anemia.

Nursing Process: Diagnosis

Client Need: Health Promotion and Maintenance

Client Need Subcategory: Prevention and/or Early Detection of Health Problems

Cognitive Level: Analysis

Objective: Identify abnormal findings that might indicate impairment of the integumentary system.

Strategy: Consider each lab value. Determine which lab values, if any, are abnormal. Relate the abnormal lab value to the corresponding integumentary assessment.

## CHAPTER 16

1. A client reports intense itching of the scalp and face. Pediculosis is identified in the hair and eyebrows. Which of the following should be included in the information provided to the client?

1. “You should start washing your hair more often to avoid this condition.”
2. “A single treatment will manage the infestation.”
3. “Infestations in the eyebrows will be treated by applying a thin layer of permethrin 1% cream (NIX) to the brows.”
4. “Apply the medication for at least 30 minutes before washing it off.”

Answer: 4

Rationale: The treatment should be applied for at least 30 minutes and up to a period of 8 hours. The cleanliness of the hair has little to do with the presence of pediculosis. At least two treatments will be needed to treat the condition successfully. Permethrin 1% (NIX) should never be used around the eyes. Lice in the lashes or brows should be treated with petroleum jelly.

Implementation; Physiological Integrity: Pharmacological and Parenteral Therapies; Analysis

2. A client diagnosed with scabies asks the nurse how he “caught” the disorder. What information should be provided to the client?

1. The disorder is transmitted by the feces of infected animals.
2. The disorder is transmitted by contact with infected persons or their possessions.
3. Scabies is a bacterial infection transmitted by direct contact with infected persons.
4. Scabies is a fungal infection transmitted by contact with infected respiratory secretions.

Answer: 2

Rationale: Scabies is the result of infestation of the itch mite. It is transmitted via contact with infected people or their contaminated articles. Scabies is a parasitic disorder. It is not bacterial, viral, or fungal.

Implementation; Health Promotion and Maintenance: Prevention and or Early Detection of Health Problems; Application

3. When planning care for the client newly diagnosed with herpes zoster, which of the following nursing diagnoses has the highest priority?

1. Health Maintenance, Ineffective
2. Anxiety
3. Deficient Knowledge
4. Pain, Acute

Answer: 4

Rationale: All of the nursing diagnoses presented are applicable to the client diagnosed with herpes zoster. In the initial period of the disorder, pain is a primary concern. Until the pain is successfully managed, teaching, anxiety, and health maintenance behaviors cannot be altered.

Diagnosis; Physiological Integrity: Physiological Adaptation; Analysis

4. The client with herpes zoster reports difficulty resting at night. The nurse assists the client to manage this concern. Which of the following interventions will best aid the client?

1. Massage the irritated skin areas with lotion.
2. Apply powder to the lesions.
3. Encourage the client to take prescribed antipruritic agents approximately one hour before bedtime.
4. Use heavy bed linens to avoid chilling at night.

Answer: 3

Rationale: The client with herpes zoster might express difficulty sleeping. The inability to rest is often related to pruritus. The use of antipruritic agents prior to bedtime will facilitate rest. Lotions and powders can irritate the skin lesions. Heat will increase the occurrence of itching.

Planning; Physiological Integrity: Physiological Adaptation; Application

5. The mother of a teenaged female experiencing a severe case of acne voices concern about her daughter's hygiene habits. Which of the following responses by the nurse is best?

1. "Your daughter needs to improve her facial hygiene to help in reducing the severity of the acne outbreaks."
2. "The greatest culprit for the acne is dietary habits, not inadequate hygiene."
3. "Are you embarrassed by her appearance?"
4. "What are your concerns about her hygiene practices?"

Answer: 4

Rationale: Soliciting the concerns about her daughter's hygiene practices is primary. Once the concerns are identified, it will allow the nurse to begin to address the disorder and any related concerns. Dietary intake and hygiene are not the primary causes of acne. Acne is caused by excess sebum production. It is premature of the nurse to address the potential for the mother to be embarrassed about her daughter's condition.

Implementation; Physiological Integrity: Basic Care and Comfort; Application

6. The physician has prescribed isotretinoin (Accutane) to a female client. Which of the following should be included in the instructions to the client? Select all that apply.

1. Take pills on an empty stomach to avoid nausea and vomiting.
2. Avoid prolonged exposure to sunlight.
3. Use a reliable form of contraception one month prior to and during use of the medication..
4. Avoid the use of vitamin A supplements.
5. Use caution when driving at night.

Answers: 2; 4; 5

Rationale: The medication could cause hypersensitivity to sun. Vitamin A supplements are to be avoided, as they might increase the effects of the medication. The medication could reduce night vision, so caution is recommended. The medication should be taken with meals. The use of two reliable methods of contraception is needed the month prior to, during, and one month after use of the medication.

Planning; Physiological Integrity: Pharmacological and Parenteral Therapies; Application

7. A client at risk for the development of skin cancer is discussing sun exposure prevention with the nurse. What information should be included in the discussion?

1. Sunscreen is not needed on cloudy days.
2. The higher the sunscreen rating, the less the protection provided.
3. When swimming, sunscreen should be reapplied every four hours.
4. A higher-rated sunscreen is needed between 10 a.m. and 3 p.m.

Answer: 4

Rationale: Sun exposure is greatest between 10 a.m. and 3 p.m. Sun exposure is possible on both cloudy and sunny days. The higher the level of the sunscreen's rating, the greater the protection. When swimming, sunscreen should be reapplied hourly.

Implementation; Health Promotion and Maintenance: Prevention and/or Early Detection of Health Problems; Application

8. When planning care for a client at risk for the development of pressure ulcers, which of the following should be included in the care?

1. Turn the client q.4h.
2. Massage pressure areas with lotion q.4h.
3. Use inflatable donut rings to reduce pressure on the sacrum.
4. Initiate a frequent toileting schedule.

Answer: 4

Rationale: Urine and feces are destructive to skin. A frequent toileting schedule will reduce periods of incontinence and potential for skin breakdown. The client should be turned at least every two hours. Massage of pressure areas can cause friction and damage to problem skin areas. Inflatable donut rings are contraindicated, as they increase pressure and reduce perfusion to affected areas.

Implementation; Health Promotion and Maintenance: Prevention and/or Early Detection of Health Problems

9. A client with a history of tinea pedis reports concerns about developing the disorder again. Which of the following interventions suggested by the nurse will reduce the likelihood of a reoccurrence?

1. Begin to wear cotton undergarments
2. Wear sandal style footwear
3. Soak affected extremities in salted water nightly
4. Apply lotions to moisturize potential areas of outbreak daily

Answer: 2

Rationale: Tinea pedis is a fungal infection of the soles of the feet, toes, and toenails. The condition is chronic, and can be seen more when the feet are hot and perspire. Wearing of open-style shoes such as sandals would allow the feet to be open to air. Cotton

undergarments would not impact tinea pedis. They could assist in the management of tinea corporis. Salt water is not associated with the management of tinea pedis. Lotions would increase moisture to the areas and potentially cause additional problems.

Implementation: Health Promotion and Maintenance: Prevention and/or Early Detection of Health Problems; Application

10. The charge nurse is preparing assignments for the shift. Two of the clients have been diagnosed with herpes zoster. When planning care assignments, which of the following nurses should be assigned to care for these clients?

1. The nurse who is pregnant at 24 weeks' gestation
2. The nurse who had chickenpox just one year ago
3. The nurse who has never had chickenpox
4. The nurse who is in her first trimester of pregnancy

Answer: 2

Rationale: The client who has had chickenpox is the safest choice to provide care. The lesions should be avoided by all pregnant women regardless of gestation. The client who has never had chickenpox could be infected by the disorder.

Planning; Safe, Effective Care Environment: Safety and Infection Control; Analysis

## Chapter 17

1. A client is being evaluated in the Emergency Department after suffering severe burns to his torso and upper extremities. The nurse notes edema at the burned areas. Which of the following best describes the underlying cause for this manifestation?

- a. Reduced vascular permeability at the site of the burned area
- b. Decreased osmotic pressure in the burned tissue
- c. Increased fluids in the extracellular compartment
- d. Inability of the damaged capillaries to maintain fluids in the cell walls

Answer: d

Rationale: Burn shock occurs during the first 24–36 hours after the injury. During this period, there is an increase in microvascular permeability at the burn site. The osmotic pressure is increased, causing fluid accumulation. There is a reduction of fluids in the extracellular body compartments.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

2. The client having severe burns over more than half of his body has an indwelling catheter. When evaluating the client's intake and output, which of the following should be taken into consideration?

- a. The amount of urine output will be greatest in the first 24 hours after the burn injury.
- b. The amount of urine will be reduced during the first 8 hours of the burn injury and will then increase as the diuresis begins.
- c. The amount of urine will be reduced in the first 24–48 hours, and will then increase.
- d. The amount of urine will be elevated due to the amount of intravenous fluids administered during the initial phases of treatment.

Answer: c

Rationale: The client will have an initial reduction in urinary output. Fluid is reduced in the initial phases as the body manages the insult caused by the injury and fluids are drawn into the interstitial spaces. After the shock period passes, the client will enter a period of diuresis. The diuresis begins between 24 and 36 hours after the burn injury.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

3. The nurse is reviewing the laboratory results of the renal system for a client who experienced a major burn event on 45% of the body 24 hours ago. Which of the following results would the nurse expect to see? Select all that apply.

- a. Creatinine clearance reduced

- b. BUN reduced
- c. Uric acid decreased
- d. GFR reduced
- e. Specific gravity elevated

Answer: d; e

Rationale: During the initial phases of a burn injury, blood flow to the renal system is reduced, resulting in reduction in filtration rate and an increase in specific gravity. During this period, BUN levels and uric acid are increased.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

4. While working in the Emergency Department, the nurse is planning care for the client who has been admitted with a burn injury. Which of the following areas will be included in the plan of care?

- a. Fluid management
- b. Nutrition
- c. Psychosocial support
- d. Fluid resuscitation

Answer: d

Rationale: The nurse caring for the client during the emergent stage of burn injuries will be expected to administer intravenous fluids to meet the body's needs. Fluid management will take place in the burn unit or intensive care unit. Nutrition management will begin in the burn unit and continue throughout the client's care. Psychosocial support will be needed once the client has stabilized.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

5. The physician has ordered the cleansing of a burn injury to a client's ear. After cleaning the wound, which of the following steps should be completed next?

- a. Cover the ear with a sterile dressing.
- b. Provide a soft pillow to cushion the area.
- c. Use a foam doughnut to reduce pressure to the area.
- d. Place cotton gauze between the head and the ear to reduce the incidence of adhesions.

Answer: c

Rationale: To reduce pressure to the area, doughnut rings are recommended. Burns to the ears are not covered with dressings. A soft pillow will increase pressure to the area. Placement of cotton gauze will provide a source of irritation to the area, and should be avoided.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

6. A client who has experienced a burn injury has been brought to the Emergency Department by family members. Which of the following interventions by the nurse is of the highest priority at this time?

- a. Determination of the type of burn injury
- b. Determination of the types of home remedies attempted prior to the client's coming to the hospital
- c. Assessment of past medical history
- d. Determination of body weight

Answer: a

Rationale: Determination of the type of burn is the first step. The type of injury will dictate the interventions performed. Determining the use of home remedies, past medical history, and body weight must be completed, but are not of the highest priority.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

7. A client is scheduled to undergo grafting to a burn injury to the arm. Which of the following statements by the nurse should be included in the teaching prior to the procedure?

- a. "You will need to report any itching, as it might signal infection."
- b. "Performing the procedure near the end of the hospitalization will reduce the incidence of infection and improve success of the procedure."
- c. "The procedure will be performed in your room."
- d. "You will begin to perform exercises to promote flexibility and reduce contractures after five days."

Answer: d

Rationale: The client will begin to perform range-of-motion exercises after five days. Itching is not a symptom of infection but an anticipated occurrence that signals cellular growth. The ideal time to perform the procedure is early in the treatment of the burn injury. The procedure is performed in a surgical suite.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

8. The client who has suffered a major burn injury is complaining of pain. Which of the following medications will be most therapeutic to the client?

- a. Morphine 10 mg IM q.3–4h.
- b. Morphine 4 mg IV q.5m.
- c. Meperidine 75 mg IM q.3–4h.
- d. Meperidine 50 mg PO q.3–4h.

Answer: b

Rationale: Morphine is preferred over meperidine for the burn-injured client. The intravenous route is preferred over oral and intramuscular routes.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

9. When evaluating the laboratory values of the burn-injured client, which of the following can be anticipated?

- a. Elevated hemoglobin and elevated hematocrit levels
- b. Elevated hemoglobin and decreased hematocrit levels
- c. Decreased hemoglobin and decreased hematocrit levels
- d. Decreased hemoglobin and elevated hematocrit levels

Answer: d

Rationale: Hemoglobin levels are reduced in response to the hemolysis of red blood cells. Hematocrit levels are elevated secondary to hemoconcentration and fluid shifts from the intravascular compartment.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

10. The burn-injured client has been prescribed silver nitrate. Which of the following nursing interventions should be included for the client?

- a. Monitor daily weight.
- b. Prepare to change the dressings every two hours.
- c. Report black skin discolorations.

- d. Push fluid intake.

Answer: a

Rationale: Taking silver nitrate can result in hypotonicity. Manifestations of hypotonicity include weight gain and edema, which can be monitored by the determination of daily weights. Changing the dressing q.2h. is too frequent for the client. Black discolorations in the skin are anticipated for clients using silver nitrate, and do not highlight a complication of therapy. Silver sulfadiazine, not silver nitrate, administration can result in the development of sulfa crystals in the urine.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

11. The nurse is evaluating the adequacy of the burn-injured client's nutritional intake. Which of the following laboratory values is the best indicator of nutritional status?

- a. Creatine phosphokinase (CPK)
- b. BUN levels
- c. Glycosuria
- d. Hemoglobin

Answer: c

Rationale: Glucose in the urine is seen after a major burn injury. It signals the need to re-evaluate the client's nutritional plan. Creatine phosphokinase is used to identify the presence of muscle injuries. BUN levels are used to evaluate kidney function. Hemoglobin levels will fluctuate with the stages of the burn injury dependent upon the fluid status.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

12. When monitoring the vital signs of the client who has experienced a major burn injury, the nurse notes a heart rate of 112 and a temperature of 99.9°F. Which of the following best describes the findings?

- a. The client is demonstrating manifestations consistent with the onset of an infection.
- b. The client is demonstrating manifestations consistent with an electrolyte imbalance.
- c. These values are normal for the client's post-burn injury condition.
- d. The client is demonstrating manifestations consistent with renal failure.

**Hint:** Risk for Infection

**Strategy:** Utilize knowledge of the pathophysiology of burn injuries and the process of elimination to select the correct answer.

**Objective:** Discuss the systemic pathophysiologic effects of a major burn and the stages of burn wound healing.

**Answer:** c

**Rationale:** The burn-injured client is not considered tachycardic until the heart rate reaches 120 beats per minute. In the absence of other symptoms, the temperature does not signal the presence of an infection. It could be a response to a hypermetabolic response.

**NURSING PROCESS STEP:** Assessment

**CLIENT NEEDS CATEGORY:** Physiological Integrity

**CLIENT NEEDS SUBCATEGORY:** Physiologic Adaptation

**COGNITIVE LEVEL:** Analysis

13. After the skin graft procedure to the leg, the client is returned to the burn care unit. When positioning the client, which of the following positions will be most therapeutic for the client?

- a. Elevate the HOB 30 degrees.
- b. Elevate the affected extremity.
- c. Maintain the HOB flat.
- d. Place the client flat with the affected extremity abducted.

**Answer:** b

**Rationale:** Elevating the affected extremity will reduce edema and promote perfusion. Elevating the HOB, leaving the HOB flat, and abducting the extremity will not increase healing or improve the client's long-range prognosis.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

14. A client has presented with a burn injury. The injury site is pale and waxy with large flat blisters. The client asks questions about the severity of the injury and how long it will take for this injury to heal. Based upon your knowledge, what information should be provided to the client?

- a. The wound is a partial-thickness burn, and could take up to two weeks to heal.
- b. The wound is a superficial burn, and will take up to three weeks to heal.
- c. The wound is a deep partial-thickness burn, and will take more than three weeks to heal.
- d. Wound healing is individualized.

Answer: c

Rationale: The wound describes is a deep partial-thickness burn. Deep partial thickness wounds will take more than three weeks to heal. A superficial burn is bright red and moist, and might appear glistening with blister formation. The healing time for this type of wound is within 21 days.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiologic Adaptation

COGNITIVE LEVEL: Application

## Chapter 18

1. The nurse is assessing the client for an endocrine problem. During the health assessment interview, it is essential that the nurse obtain which data about the skin when the client is experiencing hypothyroidism?

1. Is the skin rough and dry?
2. Is the skin smooth?
3. Is the skin clammy?
4. Does the client have brown shiny patches on the lower extremities?

Answer: 1

The client experiencing hypothyroidism has rough, dry skin. Smooth skin is associated with hyperthyroidism. Cool, clammy skin is found in clients with low blood sugar. Brown shiny patches on the lower extremities are associated with poor circulation

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

2. The nurse is performing an assessment on client experiencing hypoparathyroidism. While taking a blood pressure on this client, the nurse notes spasms of the hands. The nurse should document this clinical manifestation as:

1. Chvostek's sign.
2. Troussseau's sign.
3. Turner's sign.
4. Cullen's sign.

Answer: 2

Troussseau's sign is elicited when placing a blood pressure cuff on the arm; when the cuff is inflated, the client experiences carpal spasms. Chvostek's sign is elicited by tapping on the face in front of the ear and observing for contractions of the muscle. Turner's sign indicates retroperitoneal bleeding. Cullen's sign is associated with retroperitoneal bleeding.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Communication and Documentation

3. A nurse assesses a client with hypoparathyroidism who has a positive Troussseau's sign. The nurse should develop a plan of care based on which of these nursing diagnoses?

1. Fluid Volume, Excess
2. Breathing Pattern, Ineffective
3. Comfort, Readiness for Enhanced
4. Tissue Perfusion, Ineffective

Answer: 3

A positive Trousseau's sign causes painful carpal spasms due to decreased calcium. A diagnosis for which a plan of care should be developed is Alteration in comfort. Fluid volume excess is not associated with hypoparathyroidism, and might be the result of pituitary problems. The parathyroid gland does not influence respirations. The parathyroid gland is responsible for phosphorous and calcium regulation.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Diagnosis

4. When performing an endocrine assessment on a client, the nurse asks the client if she has experienced weight changes. Evaluating weight changes might provide the nurse with data about which endocrine systems? Select all that apply.

1. Adrenal gland
2. Thyroid gland
3. Parathyroid gland
4. Pituitary gland
5. Gonads

Answer: 1; 2; 4

In adrenal, thyroid, and pituitary disease, the client's weight changes might provide information as to the endocrine disorder the client is experiencing. The client might gain weight with an adrenal disorder such as Cushing's disease, or thyroid disease such as hypothyroidism or hyperthyroidism. The pituitary gland controls ADH, which influences the renal tubules to absorb water. The parathyroid gland regulates calcium and phosphorous, whereas the gonads influence estrogen and androgens.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Evaluation

5. When assessing a client who presents with a pituitary disorder, for which of these clinical manifestations should the nurse evaluate the client?

1. Enlargement of the hands and feet
2. Smooth, silky hair
3. Facial hair growth
4. Purple striae over the trunk

Answer: 1

In the client experiencing a pituitary disorder such as acromegaly, there might be enlargement of the hands and feet. Smooth silky hair and hirsutism are associated

with hyperthyroidism. Purple striae are associated with an adrenal disease such as Cushing's disease.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

6. A client who has a clinical manifestation of exophthalmus is in the clinic. Based on this finding, the nurse would also assess the client for:

1. Dry, thick nails.
2. Dry skin.
3. Decreased reflexes.
4. An enlarged thyroid gland.

Answer: 4

Exophthalmus is a clinical manifestation associated with hyperthyroidism.

Dry, thick nails; dry skin; and decreased reflexes are associated with hypothyroidism.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

7. Which of these factors in the client's history is most likely related to the development of a pituitary disorder?

1. Carpal spasms
2. Dwarfism
3. An enlarged thyroid nodule
4. Hyperpigmentation of the skin

Answer: 2

Dwarfism results from insufficient growth hormone produced by the pituitary gland. Carpal spasms can indicate a parathyroid gland disorder. An enlarged thyroid nodule could be associated with a thyroid malignancy. Hyperpigmentation of the skin might be associated with an adrenal disorder such as Addison's disease or Cushing's syndrome.

Cognitive Level: Analysis

Test Plan: Health Promotion

Integrated Process: Nursing Process: Assessment

8. Which of these laboratory results would be most important for the nurse to assess in the client who has Graves' disease?

1. Thyroxine

2. Urine-specific gravity
3. Cortisol level
4. Calcium level

Answer: 1

Thyroxine (T4) is the hormone secreted by the thyroid gland. Thyroxine (T4) is converted to triiodothyronine (T3), and both are secreted in response to thyroid-stimulating hormone (TSH). Urine-specific gravity would be measured to provide information about the posterior pituitary. The adrenal gland produces cortisol. The parathyroid gland regulates calcium and phosphorous.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

9. Which of these approaches would be most appropriate for the nurse to take when assessing the thyroid gland of an adult client?

1. Stand in front of the client and palpate the thyroid.
2. Place the client supine and palpate one side of the neck at a time.
3. Stand behind the client and palpate the thyroid.
4. Have the client flex the neck forward and palpate the thyroid.

Answer: 3

The thyroid is palpated by standing behind the client and placing the fingers on each side of the trachea below the thyroid, and asking the client to swallow to palpate the right lobe. Repeat the procedure, tilting the neck to the left. The nurse has better access to the thyroid from a posterior approach than from the anterior aspect. Placing the client supine would not permit the nurse to have full access to the neck. Flexing the neck forward if there were a mass could occlude the airway.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Implementation

10. In order to perform a physical assessment of the client experiencing an endocrine disorder, the nurse should include: (Select all that apply.)

1. Measurement of height and weight.
2. Assessment of skin, hair, and nails.
3. Evaluation of deep tendon reflexes.
4. Evaluation of the respiratory system.
5. Assessment of the musculoskeletal system.

Answer: 1; 2; 3; 5

The nurse performing an assessment of the endocrine system should inspect the skin, nails, hair, affect, reflexes, musculoskeletal system, height, and weight. The respiratory system does not influence the endocrine system.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Implementation

11. A client scheduled for an assessment of the endocrine system asks the nurse "Is this going to hurt?" The nurse's best response is:
1. "The assessment will consist of a health assessment interview."
  2. "A complete head-to-toe assessment will not be necessary."
  3. "The assessment will involve anesthesia and multiple laboratory studies."
  4. "The assessment will not be painful. What concerns or questions do you have? I will explain the procedure as I go along."

Answer: 4

The client should be provided with an opportunity to ask questions or voice concerns, and should be informed that the nurse will explain the procedure as it is performed. The assessment is not painful; it consists of interview, a physical assessment, and laboratory studies. The client should have a head-to-toe physical examination. No anesthesia is needed for an endocrine assessment.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Caring

12. A client has been given instruction about an endocrine assessment. Which statement made by the client would indicate to the nurse that further instruction is necessary?

1. "I will need to stay in the hospital for several days."
2. "The nurse will begin with a health assessment interview."
3. "The nurse will inspect my skin, nails, and hair."
4. "The nurse will need to palpate my thyroid gland."

Answer: 1

The assessment of the endocrine system can be accomplished in an examination room as an outpatient visit; no hospitalization is required. The nurse usually begins with a health assessment interview to put the client at ease and to develop a trusting relationship. The endocrine assessment includes inspection of the skin, nails, and hair, as well as palpation of the thyroid.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Evaluation

13. During the health assessment interview for the assessment of the endocrine system, the nurse should ask the client to provide information about: (Select all that apply.)

1. Occupation.
2. Use of alcohol, drugs, and tobacco.
3. Lifestyle.
4. Alterations in bowel habits.
5. Exercise and sleep patterns.

Answer: 1; 2; 3; 5

During assessment of the endocrine system, the nurse should ascertain data about occupation, substance use, lifestyle, personal relationships, exercise, and sleep patterns. The nurse should also gather information about weight changes, thirst, appetite, urinary or visual changes, changes in menstruation if female, changes in memory or the ability to concentrate, and medication history. Bowel habits are not influenced by the endocrine system.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

14. Which of these questions seek the data that would be most important for a nurse to obtain when assessing the endocrine system of a female client?

1. Do you have children?
2. Are you able to provide for your children?
3. Is your menstrual cycle regular?
4. How old were you when your menses first began?

Answer: 3

The client who has a change in her menstrual cycle might be experiencing an endocrine disorder such as increased androgen production or decreased estrogen levels. Having children is not a function of the endocrine system. Asking how the client is able to provide for her children provides psychosocial information.

Asking when menses first began might provide information about cancer risk but not about endocrine function.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

15. During an endocrine assessment of the client in the clinic, the nurse discovers severe hypertension in the client. The nurse would conclude that this finding might indicate a disorder of the:

1. Thyroid gland.
2. Parathyroid gland.
3. Gonads.
4. Adrenal gland.

Answer: 4

The client with hypertension could be experiencing an adrenal disorder, as the adrenals regulate epinephrine and norepinephrine, both of which can influence the blood pressure of the client. The adrenal gland also regulates blood pressure by secreting mineralocorticoids and aldosterone. The thyroid regulates metabolism. The parathyroid gland regulates calcium. The gonads secrete the hormones of sexuality.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

## Chapter 20

1. The client with diabetes mellitus reports having difficulty cutting his toenails. The nurse assesses the toenails and notes the nails are thick and ingrown. Which of the following recommendations should be provided to the client?

- a. Cut the nails straight across with a clipper after the bath.
- b. Make an appointment with a nail shop for a pedicure.
- c. Make an appointment with a podiatrist.
- d. Offer to file the tops of the nails to reduce thickness after cutting.

Hint: Foot Care Teaching Session

Strategy: Employ knowledge of the complications associated with diabetes mellitus and the process of elimination to make the correct selection.

Objective: Provide accurate information to clients with diabetes mellitus to facilitate self-management of medications, diet planning, exercise, and self-assessment, including foot care.

Answer: c

Rationale: The toenails of the client with diabetes require close care. If the nails are thick or ingrown, they require the attention of a podiatrist. Cutting the nails across after the bath is correct for toenails that do not demonstrate the complications listed. The client with diabetes is at an increased risk for infection, and should avoid situations in which this risk is increased, such as the nail shop pedicure. The nurse should not cut the nails of the client.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. The diabetic client reports the presence of corns, and asks for information about preventing the condition. What is the best response by the nurse to the client's inquiry?

- a. "You will need to make sure that you select shoes that are appropriately fitted."
- b. "You can use corn pads to gradually remove the growths."
- c. "Corns are best treated by shaving them off."
- d. "You can use a mild abrasive soap to scrub the area to remove them."

Hint: Food Care Teaching Session

Strategy: Use the nursing process and the process of elimination to make the correct selection.

Objective: Explain the pathophysiology, risk factors, manifestations, and complications of type 1 and type 2 diabetes mellitus.

Answer: a

Rationale: Corns can be prevented by wearing correctly fitting shoes. Corn pads, scrubs, and shaving treatments to remove the corns are not options for the diabetic client.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

3. A client at risk for the development of type 2 diabetes mellitus asks why weight loss will reduce risk of the condition. Which of the following responses by the nurse is most correct?

- a. "The amount of foods taken in require more insulin to adequately metabolize them, resulting in diabetes."
- b. "Excess body weight impairs the body's release of insulin."
- c. "Thin people are less likely to become diabetic."
- d. "The physical inactivity associated with obesity causes a reduced ability by the body to produce insulin."

Hint: Risk Factors

Strategy: Utilize knowledge of diabetes and therapeutic communication to make the correct selection.

Objective: Explain the pathophysiology, risk factors, manifestations, and complications of type 1 and type 2 diabetes mellitus.

Answer: b

Rationale: Beta cells of the body release insulin. Their actions are hindered as the amount of adipose tissue in the body increases. While obesity is a risk factor for the development of diabetes, this does not meet the question posed by the client. Inactivity is directly linked to obesity, but it does not present a direct tie to the production of insulin.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

4. A client has been recently diagnosed with type 1 diabetes mellitus. The client is making statements that signal denial of the problem. The client states, "I am thin and eat all of the time, how can this mean I have diabetes?" Which of the following responses by the nurse is most appropriate?

- a. "Thin people are diabetic too."
- b. "Your condition makes it impossible for you to gain weight."
- c. "You are eating large quantities because your condition makes it difficult for your body to obtain energy from the foods taken in."
- d. "Your lab tests indicate the presence of diabetes."

Hint: Manifestations

Strategy: Utilize the principles of therapeutic communication and knowledge of diabetes to make the correct selection.

Objective: Explain the pathophysiology, risk factors, manifestations, and complications of type 1 and type 2 diabetes mellitus.

Answer: c

Rationale: The diabetic client is unable to obtain the needed glucose for the body's cells, due to the lack of insulin. Clients diagnosed with type 1 diabetes mellitus experience polyphagia, and are often thin. While the statement about diabetics being thin is correct, it does not answer the client. It is not impossible for diabetics to gain weight. Although the laboratory tests might indicate the presence of diabetes, it does not meet the client's needs for teaching.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

5. The nurse notes the laboratory testing performed on a 78-year-old client reveal a serum glucose level of 130 mg/dL. The nurse performs an assessment on the client and notes the absence of polyuria, polydipsia, or polyphagia. Which of the following impressions by the nurse is most correct?

- a. The client might have eaten a meal with high sugar content prior to the testing.
- b. The laboratory results might be erroneous.
- c. The client has type 1 diabetes mellitus.
- d. The client will need to be assessed for other manifestations.

Hint: Diabetes in the Older Adult

Strategy: Utilize knowledge of elder care and diabetes to make the correct selection.

Objective: Explain the pathophysiology, risk factors, manifestations, and complications of type 1 and type 2 diabetes mellitus.

Answer: d

Rationale: Older adults with diabetes might not present with the classic symptoms of polyuria, polyphagia, or polydipsia. Symptoms of diabetes in older clients can include hypotension, periodontal disease, infections, and strokes. A slight elevation in serum glucose level warrants further investigation. In an adequately functioning endocrine system, dietary intake is managed by the needed amounts of insulin produced by the pancreas. There is no reason to question the laboratory results at this time. There is inadequate information to make a diagnosis of type 1 diabetes mellitus.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Growth and Development throughout the Life span

COGNITIVE LEVEL: Analysis

6. A nurse is acting as a preceptor for a new graduate nurse. One of the patients assigned to their care is a 41-year-old client whose laboratory test results reveal a fasting serum blood glucose level of 125 mg/dL. The graduate nurse asks the nurse what this means. Which of the following statements by the nurse is most correct?

- a. "These results must be called to the physician."
- b. "This client has diabetes."
- c. "These results are normal."
- d. "The results are consistent with prediabetes."

Hint: Interdisciplinary Care

Strategy: Utilize knowledge of laboratory testing and diabetes to make the correct selection.

Objective: Explain the pathophysiology, risk factors, manifestations, and complications of type 1 and type 2 diabetes mellitus.

Answer: d

Rationale: Prediabetes is defined as a fasting serum glucose value of 100—126 mg/dL. While the physician will need to be made aware of the results, there is no indication the physician needs to be contacted immediately. The client has not met the criteria for a diagnosis of diabetes.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physical Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

7. A client recently diagnosed with diabetes reports hearing it is more economical to use urine dipsticks instead of monitoring blood levels with a glucometer. Which response by the nurse is most correct?

- a. "Urine dipstick testing is best when combined with serum testing."
- b. "Urine dipstick testing is not reliable."
- c. "You are right."
- d. "Would you like to switch to this method of monitoring?"

Hint: Monitoring Blood Glucose

Strategy: Employ knowledge of diagnostic testing and diabetes to select the correct answer.

Objective: Identify the diagnostic tests used for screening, diagnosis, and monitoring of diabetes mellitus.

Answer: a

Rationale: Urine dipstick testing is not reliable for the client who is newly diagnosed. Urine dipstick testing does not note the presence of glucose unless serum levels are in excess of 180 mg/dL. Advising the client the method of testing is not reliable is not entirely correct, and does not provide needed information to the client. Telling the client he is correct does not provide adequate information. It is inappropriate for the nurse to make such a suggestion about the method of testing to be utilized to the client.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

8. The nurse is caring for a client with type 1 diabetes mellitus. The client reports feeling "flu-like". The client reports he does believe he should take the scheduled morning insulin in light of these feelings. What action by the nurse is best at this time?

- a. Contact the physician.
- b. Encourage the client to take the insulin.
- c. Document the refusal and continue on with the planned care.
- d. Do nothing.

Hint: Insulin

Strategy: Utilize knowledge of diabetes and make the correct answer selection.

Objective: Discuss the nursing implications for insulin and oral hypoglycemic agents used to treat clients with diabetes mellitus.

Answer: b

Rationale: Taking the insulin is the best course of action. The client who has type 1 diabetes does not have any “self-made” insulin to manage glucose in the body.

Contacting the physician at this time is premature. Documentation of the client’s refusal is premature, as efforts have not been made to discuss the need for the medication.

Taking no action will allow the client’s glucose levels to become out of alignment with the treatment plan.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physical Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

9. A client recently diagnosed with diabetes has been hospitalized for insulin regulation. The client states he has begun to notice blurred vision, and is concerned about losing his sight as a result of his disease. What response by the nurse is most appropriate?

- a. “I will make an appointment for you to see an ophthalmologist.”
- b. “I will call the physician.”
- c. “It is nothing.”
- d. “This is a common reaction when insulin therapy is initiated.”

Hint: Insulin

Strategy: Utilize knowledge of insulin therapy and the process of elimination to make the correct selection.

Objective: Compare and contrast the manifestations and interdisciplinary care of hypoglycemia, diabetic ketoacidosis, and hyperosmolar hyperglycemic state.

Answer: d

Rationale: Vision changes are normal during the first weeks of insulin therapy. They will gradually resolve. It is beyond the scope of practice for the nurse to make a referral to another physician. Contacting the physician is premature. Telling the client it is “nothing” minimizes the concerns voiced, and does not provide adequate information to the client.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physical Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

10. The client reports feeling nervous and shaky. Upon assessment, the nurse notes the client is diaphoretic and the heart rate is 112 beats/minute. Which of the following actions by the nurse should be taken first?

- a. Provide the client with a snack of milk and crackers.
- b. Administer insulin utilizing the sliding scale dosages.
- c. Contact the laboratory and order a serum glucose level.
- d. Use the glucometer and obtain a glucose level reading.

Hint: Insulin

Strategy: Utilize knowledge of diabetes and the process of elimination to make the correct selection.

Objective: Identify the diagnostic tests used for screening, diagnosis, and monitoring of diabetes mellitus.

Answer: d

Rationale: The first action would be to verify the client’s blood glucose level. It would be more appropriate to use the nursing unit’s glucometer than to wait for the laboratory to obtain a reading. In addition, there is no indication an order for laboratory values exists. While the client is demonstrating manifestations consistent with hypoglycemia, obtaining the glucose levels first would be most beneficial. The client is hypoglycemic, so insulin administration would be incorrect, as it would only add to the problem.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physical Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

11. The nurse is preparing to administer pork insulin to an underweight client. Which of the following techniques should be observed when planning this therapy? Select all that apply.

- a. Inject insulin that is at room temperature.
- b. Make sure no air bubbles are present in the syringe.
- c. Massage the site of insertion.
- d. Rotation within sites
- e. Insert the needle at a 90-degree angle.

Hint: Preparing the Injection

Strategy: Utilize knowledge of insulin administration practices and the process of elimination to make the correct selection.

Objective: Discuss the nursing implications for insulin and oral hypoglycemic agents used to treat clients with diabetes mellitus.

Answer: a; b

Rationale: Insulin is used at room temperature. No air bubbles should be in the syringe. This will reduce complications and will aid in ensuring correct dosages. Massage of administration sites will alter absorption rates. Pork insulin sites are rotated. Human or purified pork insulin sites are rotated within. The thin individual will require an administration angle of 45 degrees.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physical Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

## Chapter 21

1. A teen client in an outpatient setting who is moderately overweight confides plans to the nurse to cut all fat from dietary intake. What initial action by the nurse is indicated?

1. Contact the physician.
2. Notify the client's parents.
3. Refer the client to a dietitian.
4. Discuss the role of fat in daily intake.

Answer: 4

Rationale: All individuals require some fat in the diet. It is important for the nurse to discuss this to the client. A discussion with the parents and physician is likely warranted, but can wait until after discussion with the client. The interaction will provide additional information concerning the client's knowledge of the needed dietary elements. A referral from the physician is needed to contact the dietitian.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential

COGNITIVE LEVEL: Application

2. A client reports to the clinic with skin lesions. The health history notes the client is currently on a strict diet to lose weight. Based upon your knowledge, which of the following dietary imbalances is the client experiencing?

1. The client is experiencing inadequate fat intake.
2. The client's intake of water-soluble vitamins is exaggerated.
3. The client's intake of fatty acids is elevated.
4. The client's intake of potassium-containing foods is too low.

Answer: 1

Rationale: A deficient intake of fat is associated with skin lesions. Excessive fat intake will result in elevations in cholesterol and weight gain. Excessive water-soluble vitamin intake is managed by excretion via urine. Inadequate potassium intake will result in muscle involvement.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

3. The client is planning to begin trying to conceive a child. What food should the nurse recommend be included in the client's daily intake?

1. Potatoes, tomatoes, and sweet potatoes
2. Dark green vegetables, lean beef, and eggs
3. Liver, legumes, and citrus fruits
4. Whole grains, yeast breads, and milk

Answer: 2

Rationale: To promote a healthy pregnancy, women planning to attempt conception are encouraged to increase their daily intake of folic acid. This will reduce the incidence of neural tube defects. Milk, potatoes, and tomatoes are sources of vitamin B6. Liver and legumes provide a source of biotin. Citrus fruits provide vitamin C, while whole grains are a source of folic acid, yeast bread is a source of panthenic acid, and milk is a source of calcium and vitamin D.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Growth and Development Through the Life Span

COGNITIVE LEVEL: Analysis

4. A client who is concerned about promoting skin health reports ingesting excessive amounts of vitamin A. What response by the nurse is indicated?

1. "This is a great idea."
2. "This will not be overly beneficial, as you will excrete it in your urine."
3. "What foods and supplements are you using?"
4. "Too much vitamin A can become toxic to your body."

Answer: 4

Rationale: Vitamin A is a fat-soluble vitamin. Excessive intake of fat-soluble vitamins is not managed by urinary excretion. Excessive intake of fat-soluble vitamins results in toxicity. A discussion of dietary plans is a positive idea, but it is not the primary concern at this time.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATGEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

5. A liver biopsy is scheduled. What should be included in the preoperative plan of care?

1. The client will be n.p.o. at least 8 hours prior to the procedure.
2. The client must eat a low-fat diet 1–3 days prior to the procedure.

3. Blood tests will be ordered prior to the procedure.
4. Activity will be limited for 4–6 weeks after the procedure.

Answer: 3

Rationale: The client will require blood-clotting studies prior to the procedure. The client will be n.p.o. before the test, but only for 4–6 hours. Dietary changes before the test are not indicated. Activity will be limited for 1–2 weeks.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

6. When taking the client's health history, which of the following questions will provide the greatest amount of information about the client's pattern of elimination?

1. "Are you having any bowel problems?"
2. "Have you had any recent difficulties with your stools?"
3. "Can you tell me about your usual bowel habits?"
4. "Are your bowel movements normal?"

Answer: 3

Rationale: Open-ended questions will provide the greatest amount of information. Questions that allow the client to respond with a yes or no can limit the amount of information you can gain.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

7. When performing an assessment of the abdomen, which of the following is the correct sequence of events?

1. Palpation, percussion, auscultation, inspection
2. Inspection, auscultation, percussion, palpation
3. Percussion, auscultation, inspection, palpation
4. Inspection, percussion, palpation, auscultation

Answer: 2

Rationale: The sequencing of the assessment is important to ensure the maximum amount of information is obtained by the examiner. The nurse should look at the abdomen for symmetry, contour, and general appearance prior to touching the abdomen. Next, the

abdomen should be assessed for the presence of bowel sounds. Percussion in each quadrant will follow. Palpation is the final step. It might result in discomfort, and should be completed last. This will ensure the maximum amount of assessment data are obtained.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

8. A client who has been on a recent diet undergoes an assessment of body mass index. The findings are  $22 \text{ kg/m}^2$ . Which of the following evaluations is most correct?

1. The client's recent weight reduction has been effective.
2. Further weight reduction is still needed to ensure health.
3. The client is mildly obese.
4. The client's body mass index is below normal.

Answer: 1

Rationale: The normal body mass index is  $20\text{--}25 \text{ kg/m}^2$ . The client does not need further reduction. Obesity is indicated by a body mass index of  $30 \text{ kg/m}^2$  or greater.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

9. The client reports disappointment when using height and weight charts. The client states she is "big-boned". She reports disappointment about this not being taken into consideration. What response by the nurse is indicated?

1. "A number of variables should be taken into consideration when reviewing your height and weight."
2. "You have to realize that the charts differ for men and women when reviewing your height and weight."
3. "You also have to assess your age in addition to your weight when reviewing the tables for height and weight."
4. "Do you think you are overweight?"

Answer: 1

Rationale: Body size charts utilize height, weight, age, and gender. The client is discouraged, and should be advised of these variables.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

10. Several older adult clients reported growing concerns about their dental health. They state they have been experiencing the need to have dental work done despite employing the same hygiene habits. They inquire about the underlying cause for these changes. What information should be given to these clients?

1. Dental health begins to decline with aging.
2. The loss of bone density with aging will result in tooth decay and breakage.
3. Increases in saliva production increase exposure of the tooth's enamel to corrosive agents.
4. Metabolism changes in aging contribute to dental destruction.

Answer: 2

Rationale: The changes in bone health from aging will impact dental health. Simply stating that aging causes problems does not meet the client's request for information on an underlying cause. Saliva production decreases with aging. Metabolic changes have not led to the changes.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATGORY: Growth and Development Through the Life Span

COGNITIVE LEVEL: Application

11. A client has been experiencing changes in bowel habits. A tumor is suspected. Which of the following tests will likely be ordered?

1. Liver biopsy
2. Cholecystography
3. Gastric emptying studies
4. Computed tomography

Answer: 4

Rationale: The computed tomography may be utilized to visualize the presence of a tumor. A liver biopsy will be done to assess for malignant cells in the liver. The cholecystography will be used to assess for gallbladder stones or tumors of the gall bladder, not of the bowel. Gastric emptying studies will be used to review the ability of the body to empty the stomach.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY:

CLIENT NEEDS SUBCATEGORY:

COGNITIVE LEVEL: Application

12. The client reports feeling pain in the right lower quadrant. Which of the following questions will be indicated in the data collection to gain related information?

1. "Can you tell me about your voiding habits?"
2. "Do you have a history of diabetes?"
3. "When you eat, do you experience any nausea?"
4. "Have your periods been normal?"

Answer: 1

Rationale: The right lower quadrant contains the kidneys. Discussing voiding is indicated. The client's potential history of diabetes has no bearing on this question. The stomach is located in the left upper quadrant, and is not impacted for this client. The uterus is located in the lower pelvic cavity, and is not impacted for this client.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY:

CLIENT NEEDS SUBCATEGORY:

COGNITIVE LEVEL: Analysis

13. An abdominal assessment is being performed on the client. When the client is turned on the side, a sound of dullness is heard with percussion. What is the best interpretation of this finding?

1. This is normal.
2. The client is exhibiting signs consistent with ascites.
3. The client is exhibiting signs consistent with a bowel obstruction.
4. The client is exhibiting signs consistent with hepatomegaly.

Answer: 2

Rationale: The client is demonstrating the presence of ascites. The dullness is present with position changes. Percussion of a side-lying client is not used to assess for a bowel obstruction or hepatomegaly. This is not a normal finding.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY:

CLIENT NEEDS SUBCATEGORY:

COGNITIVE LEVEL: Analysis

## Chapter 22

1. The nurse is caring for a teen who is hospitalized with a diagnosis of anorexia nervosa. When developing the plan of care for the client, which of the following should be included?

1. Serve the client three balanced meals per day.
2. Observe the client's activities for 15 minutes after eating.
3. Discuss weight-gain needs with the client.
4. Provide a variety of cold or room-temperature foods.

Answer: 4

Rationale: Cold or room-temperature foods are often more appealing to clients with anorexia nervosa. Three meals daily could be overwhelming in size to the client. Smaller, more frequent offerings will be better received by the client. A focus on gaining weight will promote fixation on pounds instead of health with this population. Anorexic clients will have a greater benefit with discussions relating to caloric instead of just observing the client.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

2. During a routine physical examination, a client is found to be above the recommended weight for her height. Her body mass index is  $33 \text{ kg/m}^2$ . When the nurse attempts to discuss the need to make dietary changes, the client states, "Why should I lose weight? I feel great." What response by the nurse is indicated?

1. "That is a wonderful attitude to have."

2. "Let me know if you change your mind."
3. "Making changes now will help you to maintain your health."
4. "You weigh more than is recommended."

Answer: 3

Rationale: The client's body mass index is well above the recommended maximum value. When considered along with the excessive body weight, dietary modifications are indicated. Making changes at this time will promote health during and after the weight loss. These factors need to be presented to the client to enhance buy-in. While it is admirable that the client demonstrates a positive body image, it is not healthful. The nurse's responsibility is toward promoting health. The client has asked why a change is needed. Deferring to when the client changes her mind is not appropriate. It does little to promote change to tell the client she is overweight.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

3. A nurse is planning an in-service geared toward young African-American women regarding nutrition. Which of the following concepts related to body image concerning this cultural group should the nurse be aware of when preparing the program?

1. A thin physique for women is embraced by this culture.
2. The culture has traditionally valued curvaceous women.
3. Activity is frequently integrated into most lifestyles.
4. There are few differences between the African-American-held images of attractiveness and those held by Caucasians.

Answer: 2

Rationale: While not all members of a group share the same values, traditionally the African-American culture values a curvaceous figure. Lifestyles frequently are more sedentary.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Application

4. An obese client has voiced an interest in taking the appetite suppressant phentermine to assist in a weight loss program. Based upon your knowledge, which of the following factors in the client's health history might restrict the client's ability to take the medication?

1. History of insomnia
2. A family history of thrombophlebitis
3. A body mass index of 31 kg/m<sup>2</sup>
4. Frequent use of alcohol

Answer: 4

Rationale: Alcohol use or abuse can be a contraindication for this medication. The medication could cause insomnia and be a related contraindication. A client's personal history for the development of cardiovascular problems could indicate an inability to take the medication. The distracter referring to the client's family is not applicable. Phentemine is indicated for body mass index greater than 30 kg/m<sup>2</sup>.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

4. After following a structured diet, a client finds that his blood glucose levels have decreased and oral medications are no longer needed. The client is curious about how this is possible. What information should be provided to the client?

1. Less body mass means less insulin is needed to maintain constant glucose levels.
2. Body mass reduces cellular resistance to insulin.
3. Reduced dietary intake of carbohydrates is responsible for the weight loss.
4. Reduced dietary intake results in a reduced need for insulin.

Answer: 1

Rationale: Insulin is needed by the body cells to facilitate glucose transport across cell walls. The greater the body's mass, the increase in likelihood the body's cells will become resistant to insulin. This will result in type 2 diabetes. The more mass in the body, the greater the resistance of the body's cells to insulin. The reduction in size has resulted in a lower body glucose level in response. Certainly, the client has reduced the amount of carbohydrates eaten to lose weight, but this response does not answer the question posed by the client.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

5. When developing the plan of care for the client with anorexia nervosa, which of the following will be the nursing diagnosis with the highest priority?

1. Nutrition, Imbalanced, Less than Body Requirements
2. Self-Esteem, Chronic Low
3. Powerlessness
4. Body Image, Disturbed

Answer: 1

Rationale: All of the listed nursing diagnoses are appropriate for the client with anorexia nervosa. The presence of nutritional imbalances is a risk for the development of physiological complications that might become life-threatening, making this goal with the highest priority.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Analysis

6. When taking the health history of a client, it is revealed that the client often eats excessive amounts of food when not hungry. When questioned, the client reported this often takes place when he feels alone, and afterward, there are intense feelings of self-disgust. The client denies purging after these episodes. Based upon your knowledge, which of the following is a potential complication of continued activities of this nature?

1. Type 2 diabetes mellitus
2. Type 1 diabetes mellitus
3. Dehydration
4. Electrolyte imbalances

Answer: 1

Rationale: The client is demonstrating a binge-eating disorder. The excessive eating eventually will result in weight gain. Individuals with a body mass index greater than recommended are at an increased risk for the development of type 2 diabetes mellitus. Type 1 diabetes mellitus is most often seen in children. Individuals who have type 1 diabetes mellitus are usually underweight. Dehydration and electrolyte imbalances are complications of anorexia nervosa and bulimia nervosa.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

7. The mother of a teen contacts the clinic with concerns about her daughter's nutritional status. She reports her daughter has been extremely concerned with losing weight over the past six months. She indicates her daughter has been weighing herself several times daily and at times eating huge meals. When further questioned, she indicates her daughter has not lost or gained much weight. The mother wonders aloud if her daughter has

anorexia nervosa. Based upon your knowledge, which of the following statements best describes your belief about the client?

1. The client is demonstrating behaviors consistent with early-onset anorexia nervosa.
2. The client is demonstrating behaviors consistent with binge-eating disorder.
3. The client is demonstrating behaviors consistent with bulimia nervosa.
4. The client is demonstrating behaviors consistent with a metabolic disorder.

Answer: 3

Rationale: Bulimia nervosa is a disorder in which clients eat large quantities of foods and then purge themselves by means of vomiting. Laxatives also may be employed. Anorexia nervosa clients display behaviors in which intake is avoided and excessive exercise rituals are initiated. Clients with binge eating disorders will eat large amounts of food. They are often overweight. There is no evidence to support the client's having a metabolic disorder.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

8. When providing education to a client regarding use orlistat (Xenical), which of the following statements by the client indicates the need for additional teaching?

1. "I will need to take supplements of vitamins A, D, E, and K daily."
2. "A low-calorie diet will need to be followed."
3. "I should take this medication 30 minutes before eating."
4. "This medication will reduce the amount of fat my body absorbs."

Answer: 3

Rationale: Orlistat (Xenical) is a lipase inhibitor. It is used to reduce the amount of fat absorbed from dietary intake. Fat-soluble vitamins will be excreted, and must be replaced by supplements. To maximize results, the client must incorporate a low-calorie, low-fat diet into his daily routine. The medication must be taken at mealtime or within the first hour of eating.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

9. The client planning to undergo bariatric surgery is discussing postoperative care with the nurse. Which of the following statements indicates the client understands the plan of care?

1. "I will need to take daily vitamin and mineral supplements."
2. "I will initially take in only liquids, such as grape juice."
3. "The foods I am allowed to eat gradually will be increased."
4. "Maintaining protein intake will be a priority in my recovery diet."

Answer: 2

Rationale: Liquids are initially the only intake allowed after bariatric surgery. Sugary beverages and fruit juices can be avoided. These products can promote dumping syndrome.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

10. When working with a client who is attempting to lose weight, which of the following suggestions might assist the client in being compliant with the prescribed diet?

1. Eat alone to reduce outside distractions.
2. Drink water or a diet beverage after eating to promote feelings of fullness.
3. Allow at least 45 minutes to 1 hour to promote full enjoyment of a meal.
4. Set aside small nonfood rewards when you meet a goal.

Answer: 4

Rationale: When dieting, a small nonfood reward can serve as an incentive for working toward a goal. Eating is a social activity. Talking with others during mealtime promotes involvement. Drinking a beverage before eating promotes feelings of fullness and reduces intake at mealtime. A meal should be slated to last only 20 minutes. Eating longer can promote eating more.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Application

11. The client is planning to start a diet. The client questions the best balance for the diet. What information should be provided to the client?

1. The diet should be between 750 and 1,000 calories per day, with less than 15% of the total calories coming from fat.
2. The diet should simply cut 500 calories per day from the normal intake.
3. The diet should reduce calories to 1,000–1,500 per day, with less than 15% of the total calories coming from fat.
4. The best diet will be between 1,250 and 1,500 calories per day, with 15% of the calories being sources of protein.

Answer: 3

Rationale: The best diet is a balance of all nutrients. Ideally, it should consist of 1,000–1,500 calories per day and consist of no more than 15% fat. Protein sources may consist of 15% of the daily intake.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

12. The client voices an interest in a very low-calorie diet (VLCD) for rapid weight reduction. The client is concerned about the safety of this diet. What information should be provided to the client?

1. VLCDs are relatively safe diet plans.
2. VLCDs result in significant losses of muscle mass in response to the protein restriction.
3. VLCDs are considered safe and acceptable alternatives for clients who have a lower body mass index and need to lose a small amount of weight rapidly.
4. VLCDs are safest for middle-aged and senior clients.

Answer: 1

Rationale: Very low-calorie diets (VLCDs) are indicated for clients having elevated body mass indexes greater than  $30 \text{ kg/m}^2$ . Adverse effects are minor. Older clients might experience greater risks with VLCDs, and are not typically good candidates for this weight loss option.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Analysis

13. A client reports she is concerned about her body weight. She asks if she is obese. Your assessment reveals the client is 5'5" and weighs 144 pounds. What information should be provided to the client?

1. "Yes, you are slightly obese for your height and weight."
2. "You are normal for your height and weight."
3. "You are slightly overweight."
4. "You are moderately obese."

Answer: 3

Rationale: Utilizing the body mass index table, the client has a body mass index of  $24 \text{ kg/m}^2$ . A body mass index greater than  $25 \text{ kg/m}^2$  is considered overweight.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

## Chapter 23

1. The client has been diagnosed with type 1 herpes simplex lesions on the mouth and face. Which of the following statements indicates the client's understanding of the information the nurse has discussed with him?

1. "I will have this condition for life."
2. "This has been caused by a bacterial infection."
3. "I have come into contact with some type of fungal infection."
4. "An antibiotic will help heal these sores in about three days."

Answer: 1

Rationale: Herpes simplex is a viral infection. There is no cure for the condition. When the sores heal, it will lie dormant in the body. The condition is not managed by antibiotic therapy.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

2. Acyclovir ointment has been prescribed for oral herpes lesions. The client has questions about the use of the medication. Which of the following should be included in the information provided to the client?

1. Acyclovir is an antibiotic medication.
2. Acyclovir can reduce the length of the herpes outbreak.
3. Acyclovir will cure the disorder.
4. Acyclovir acts as an anti-inflammatory agent.

Answer: 2

Rationale: Acyclovir is an antiviral agent. It is used to reduce the severity and length of an outbreak of herpes simplex. Herpes simplex is a viral condition that is not curable.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

3. A client presents to the ambulatory clinic with manifestations consistent with an oral fungal infection. The client's health history is unremarkable. Which of the following does the nurse anticipate initially being ordered to manage this condition?

1. Ampicillin
2. Nystatin
3. Anbesol
4. Fluconazole

Answer: 2

Rationale: Initial management of an oral fungal infection typically includes nystatin. The medication is administered as a "swish and swallow." If the medication does not resolve the infection, an oral medication such as fluconazole may be prescribed. Ampicillin is an antibiotic, and is used to manage bacterial infections. Anbesol is used to manage oral discomfort, which can accompany a mouth infection.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

4. An elderly client presents with a significant weight loss. The assessment reveals poorly fitting dentures, which have caused severe oral sores. When preparing the plan of care, which of the following interventions will be most beneficial to the client?

1. Provide analgesics as needed.
2. Determine the need for assistive devices.
3. Serve meals in an attractive environment.

4. Offer assistance to eat.

Answer: 1

Rationale: The client with oral ulcerations will be in discomfort. Eating will be difficult if pain management is not achieved. There is no indication the client is in need of assistive devices. An attractive environment is beneficial for all clients, but is not of the greatest physiological priority for this client. There is no indication this client is unable to eat without help.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

5. A client diagnosed with oral cancer has undergone surgery to manage the condition. The nurse is developing the plan of care. Which of the nursing diagnoses identified has the highest priority?

1. Body Image, Disturbed
2. Communication: Impaired, Verbal
3. Nutrition, Imbalanced: More than Body Requirements, Risk for
4. Airway Clearance, Ineffective

Answer: 4

Rationale: Each of the nursing diagnoses listed is appropriate for the client. Deferring to Maslow's hierarchy, the physiological diagnoses would have the highest priority.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

Cognitive Level: Analysis

6. The client has been diagnosed with gastroesophageal reflux (GERD) . The nurse is providing instructions to assist with managing the condition. What information should be included in the teaching \?

1. Limit oral intake half an hour before bedtime.
2. Sit upright for one hour after eating
3. Elevate the head of the bed on 6–8-inch blocks.
4. Take medications with tomato juice.

Answer: 3

Rationale: Elevating the head of the bed on blocks is helpful to clients with GERD. Intake should be limited at least three hours before bedtime. Clients are encouraged to sit upright for two hours after meals. Tomato juice is acidic, and could increase the discomfort associated with GERD, and should be avoided.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

7. A client taking an antacid reports experiencing muscle cramping. The client asks the nurse what could be causing the discomfort. What actions are indicated?

1. The nurse should notify the physician.
2. The nurse should review the client's diet history.
3. The nurse should review the client elimination patterns.
4. The nurse should provide reassurance to the client.

Answer: 1

Rationale: Antacids might cause the client to experience electrolyte imbalances.

Electrolytes involved can include sodium, calcium, and magnesium. The client might need to have serum electrolyte levels drawn and reviewed. There is no indication the client's dietary history or elimination patterns are of issue. Providing reassurance to the client at this time would be premature, as the complaints are being reported and not adequately reviewed.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

8. A client who has been experiencing nausea voices an interest in aromatherapy to manage the condition. What response by the nurse will be most therapeutic?

1. "Aromatherapy has shown very limited effectiveness with nausea."
2. "Aromatherapy allows the client to exert conscious control over physiologic processes."
3. "Why are you considering this method?"
4. "Ginger has been used with some success to manage nausea."

Answer: 4

Rationale: Ginger is an aromatic root. It has demonstrated success in managing nausea in some populations. Telling the client the substance has very limited effectiveness is discouraging to the client and further is not entirely true. Biofeedback is the nonpharmacologic method that allows conscious control to be exerted over a physiologic process. Questioning the client does not meet the client's request for information.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

9. A client is hospitalized with gastrointestinal bleeding. The nurse completes the shift assessment. Which findings indicate the client's condition is worsening?

1. Urinary output has increased 50 mL more than the previous hour.
2. Skin is warm, and dry. Cool and warm contradict each other, so I eliminated one.
3. The client reports feeling very tired.
4. Increased capillary refill time.

Answer: 3

Rationale: Alterations in level of consciousness can signal an increase in blood loss. This warrants further investigation. Urinary output should remain greater than 30 mL per hour. Skin characteristics including coolness, warmth, and dryness are normal. Capillary fill time will decrease not increase with increased blood loss.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

10. During a follow-up visit four weeks after gastric bypass surgery, a client reports experiencing cramping, nausea, and diarrhea within 10 minutes after eating. What information should be given to the client?

1. "This is a normal occurrence, and will subside in a few months."
2. "Try to eat slower."
3. "Smaller, frequent meals might reduce the incidence of this phenomenon."
4. "Try drinking a small amount of fluid prior to eating."

Answer: 3

Rationale: The client is experiencing dumping syndrome. Most clients do eventually work through this event, but this response does not provide adequate information to the client. Eating slower could help, but reducing meal size will be most beneficial. Drinking before eating actually might increase the problem.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

11. Discharge teaching for the client with peptic ulcer disease is being planned. Which of the following should be included in the information provided to the client?

1. Eat a small snack before bedtime.
2. Follow a bland diet.
3. Avoid ingestion of any alcohol.
4. Discontinue cigarette use.

Answer: 4

Rationale: Smoking slows healing. Eating before bedtime increases night pain experienced by the client with peptic ulcer disease. A bland diet is no longer a widely accepted method of treatment for peptic ulcer disease. Alcohol use is not completely restricted; alcohol may be used in moderation.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential

COGNITIVE LEVEL: Application

12. The nurse is providing emotional support to the spouse of a client recently diagnosed with terminal esophageal cancer. The spouse voices feelings of anger and confusion. The spouse questions why his partner did not seek help sooner. What response by the nurse is indicated at this time?

1. "Unfortunately, the early symptoms are often vague, and often not recognized as something serious."
2. "Your spouse was probably afraid of getting bad news."
3. "You will never know."
4. "It is not important to know that right now."

Answer: 1

Rationale: The manifestations of esophageal cancer are often vague. Difficulty swallowing does not result until approximately 60% of the esophagus is affected. By this time, the condition is often terminal. It is inappropriate for the nurse to make assumptions about the motivations and feelings of the individual with cancer. It is inappropriate for the nurse to decide what is important for the client's spouse to know at this time.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Application

13. The client has reported to the clinic with complaints of heartburn, reflux, and belching. Which of the following diagnostic tests do you anticipate being utilized to further investigate the client's concerns?

1. Upper GI series
2. Colonoscopy change to EKG
3. Barium enema
4. Chest x-ray

The above changes would make it an Analysis question rather than an easy application.

Answer: 1

Rationale: An endoscopic exam will be ordered to view the upper gastrointestinal tract. A hiatal hernia is consistent with the symptoms being reported. The colonoscopy and barium enema would be used to review concerns of the lower gastrointestinal tract. The x-ray would not provide the information needed.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

14. The client has presented with complaints of mouth soreness. A review of the client's medical health history reveals gastric bypass surgery one year ago. During the assessment, the nurse notes the client's tongue is beefy, red, and smooth. Based upon your knowledge, what do you anticipate will be included in the diagnostic workup ordered for the client?

1. Vitamin B<sub>12</sub> levels
2. Iron levels
3. Vitamin B<sub>6</sub> levels
4. Potassium levels

Answer: 1

Rationale: Vitamin B<sub>12</sub> deficiency is associated with gastric bypass surgery. A deficiency of vitamin B<sub>12</sub> levels will result in pernicious anemia. This deficiency will manifest as pallor, jaundice, and weakness, and a beefy, smooth red tongue. Iron-deficiency anemia will manifest with weakness and fatigue. Vitamin B6 deficiencies are not typically seen with gastric bypass surgeries and are not manifested with a beefy, red, smooth tongue. The client's reports are not consistent with a potassium deficiency.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

15. While providing care for a client who had gastric surgery five days ago, the color of the gastric fluid is noted as red. The client's vital signs are temperature 98°F; heart rate 104; respirations 23; blood pressure 105/69. What action by the nurse is indicated?

1. Document the findings and notify the physician.
2. Document the findings and reassess the client in four hours.
3. Review the client's most recent laboratory results.
4. Document the findings and review the nasogastric suction settings.

Answer: 1

Rationale: The client's assessment is consistent with an early hemorrhage. The situation warrants contacting the physician. Reassessment of the physician in four hours would allow too much time to pass before the client was reevaluated. The laboratory values might yield useful information, but would be secondary to a consultation with the physician. The nasogastric suction settings can be reviewed, but the physician will still require notification.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS CATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

## Chapter 24

1. The nurse should instruct the client who is at risk for cholelithiasis to make which lifestyle modification?

1. Reduce sodium intake.
2. Increase fluids.
3. Decrease smoking.
4. Decrease fat consumption.

Answer: 4

The client who is experiencing cholelithiasis should be instructed on the relationship between increased fat consumption and the severity of pain associated with cholelithiasis. While all clients should be instructed to reduce sodium intake, decreasing sodium will not assist in reducing cholelithiasis or its pain. Increasing fluids will not assist in reducing cholelithiasis or its pain. While all clients should cease smoking, there is no relationship to cholelithiasis.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Planning

2. When assessing a client who is experiencing hepatocellular failure, which of these findings would indicate to the nurse the client is developing ascites?
  1. Accumulation of fluid in the abdomen
  2. Yellow-tinged skin
  3. Bleeding and bruising easily
  4. Gallbladder pain

Answer: 1

Ascites is the accumulation of the fluid in the abdomen, and is a result of hepatocellular failure. Jaundice is manifested as yellow-tinged skin, and is the result of hepatic disorders. The client experiencing hepatic problems might have bleeding and bruising issues due to inadequate vitamin K. Obstructed biliary flow could be the cause of gallbladder pain.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

3. A client with hepatitis is taking alpha interferon. Which of these manifestations would indicate to the nurse that the client is experiencing an untoward effect?
  1. Jaundice
  2. Flu-like syndrome
  3. Gallbladder pain
  4. Clay-colored stools

Answer: 2

The client who is receiving alpha interferon will experience flu-like syndrome. Jaundice is a yellow-tinged skin as a result of hepatitis. Gall bladder pain is the result of stones in the gall bladder. Clay-colored stool are associated with liver or biliary disease.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Evaluation

4. In order to prevent hepatitis B; the nurse should instruct the client to:
  1. Wash hands frequently, as the disease is transmitted fecal–orally.
  2. Avoid alcohol.
  3. Avoid contact with blood and body fluids.
  4. Avoid contaminated food and water.

Answer: 3

Hepatitis B is contracted through contaminated blood and body fluids.

Hepatitis A is transmitted via the fecal–oral route. Laënnec’s cirrhosis is the result of alcohol and hepatitis B and C. Contaminated food and water causes hepatitis A, not B.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Implementation

5. When a client who has portal system encephalopathy is being treated with Neomycin (neomycin sulfate), which of these manifestations would indicate to the nurse that the client’s condition is improving?
  1. An increase in the potassium level
  2. Asterixis
  3. Jaundice
  4. Increased level of consciousness

Answer: 4

The client experiencing portal encephalopathy will have decreased judgment, confusion, disorientation, and incoherence. Administering Neomycin (neomycin sulfate) should reduce ammonia levels; elevated levels are the cause of the decreased consciousness. Neomycin (neomycin sulfate) causes diarrhea, which will decrease potassium, and not hyperkalemia. Asterixis is a hand flap, and is a sign of portal encephalopathy, which should decrease with administration of Neomycin (neomycin sulfate). Jaundice is a symptom of hepatic disorders.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: evaluation

6. The client with ascites has had a paracentesis. The nurse should assess the client for which complication?
  1. Pneumothorax
  2. Ruptured spleen
  3. Punctured bladder

#### 4. Hepatitis

Answer: 3

The client undergoing a paracentesis should be instructed prior to the procedure to empty the bladder to avoid puncture. A pneumothorax is associated with blunt, open trauma of the chest or increased intrathoracic pressure. A ruptured spleen is not a complication of a paracentesis but rather the result of trauma. Hepatitis can cause ascites, but is not a complication of a paracentesis.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

7. In the client who has undergone a liver transplant, the nurse should instruct the client to:

1. Eat a high-protein diet.
2. Take anti-rejection every other day.
3. Take acetaminophen (Tylenol) if fever develops.
4. Report any signs of infection to the healthcare provider.

Answer: 4

The client who has undergone a liver transplant should be instructed to report any signs of infection that could indicate signs of organ rejection. The client should be instructed to eat a low-to-moderate-protein diet to decrease workload of the liver in terms of protein metabolism. Anti-rejection drugs are taken every day, and may not be omitted.

Acetaminophen (Tylenol) should not be taken, as it is liver-toxic.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Teaching and Learning

8. The client with pancreatitis asks the nurse “Why are my stools so frothy and smelly?”

The nurse’s best response is:

1. “You are developing pancreatic cancer.”
2. “The stools are frothy and smelly due to decreased pancreatic enzymes.”
3. “You have hepatitis.”
4. “You may be developing diabetes mellitus.”

Answer: 2

Steatorrhea is fatty, frothy, smelly stools associated with pancreatitis. Telling the client that she is developing pancreatic cancer is inaccurate, and is not a therapeutic response to the question. Hepatitis can produce clay-colored stools. Diabetes mellitus causes increased urine production, and could be the result of Pancreatitis, but does not affect stool characteristics.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Teaching and Learning

9. The client experiencing pancreatitis whose amylase level has returned to normal should be instructed by the nurse to adhere to what type of diet?

1. Low-residue diet with no alcohol
2. Low-fat diet with no alcohol
3. Low-fat and -fiber diet
4. Mechanical soft diet

Answer: 2

The client experiencing pancreatitis after the serum amylase level returns to normal levels should be instructed to consume a diet low in fat with no alcohol. Low-residue diet is prescribed for those clients experiencing bowel disorders. Almost all clients should consume a low-fat diet, but most clients need increased fiber. A mechanical soft diet is reserved for the client who needs to conserve energy or has a mouth or dentition disorder.

Cognitive Level: Application

Test Plan: Health Promotion and Maintenance

Integrated Process: Teaching and Learning

10. The nurse is assessing the client with pancreatitis day one and interprets a serum amylase level of 369 units/L to be:

1. Within normal level.
2. Below expected levels.
3. Above normal levels.
4. A resolving problem.

Answer: 3

A normal level for serum amylase is between 0 and 130 units/L. An amylase level of 369 units/L is above normal levels. The lowest level for an amylase level is 0 units/L. In pancreatitis, the serum amylase rises 2–3 times the normal level and remains elevated for 3–4 days. The patient is day one pancreatitis; therefore, it is not a resolving problem.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Diagnosis

11. A client experiencing esophageal varices has had a Sengstaken-Blakemore tube inserted to control bleeding. The most important complication that the nurse should assess the client for is:

1. Blood clots.
2. Inflammation.
3. Hypoxia.
4. Diarrhea.

Answer: 3

The client with a Sengstaken-Blakemore tube is at risk for hypoxia, as the tube has two balloons, which are used to tamponade the esophageal bleeding. One balloon is in the stomach and the other is in the esophagus, and if the tube migrates, the airway can be obstructed. The client might expel blood clots due to the bleeding in the esophagus. The varices and tube do not cause inflammation. The tube does not cause diarrhea, but the client might experience diarrhea due to the large amount of blood that is ingested.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Assessment

12. With the client with cirrhosis, the nurse should evaluate which diagnostic studies to prevent complications associated with bleeding? Select all that apply.

1. Complete blood count
2. Coagulation studies
3. Albumin
4. Ammonia levels
5. Liver functions studies

Answer: 1; 2

The complete blood count (CBC) is performed to evaluate red blood cells, hemoglobin, and hematocrit, as well as the platelet count. When the lab values of the CBC are low, this is associated with bleeding. Albumin levels are obtained to reflect liver impairment. Ammonia levels are elevated due to the liver's inability to convert ammonia to urea for renal excretion. Liver functions are elevated, reflecting liver impairment.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Diagnostic

13. A client has been admitted to the Emergency Department with a diagnosis of Cholelithiasis, and has a history of liver failure. The nurse assesses jaundice, increased abdominal girth, and dyspnea. The nurse should address which of these findings immediately?

1. Cholelithiasis
2. Jaundice
3. Increased abdominal girth
4. Dyspnea

Answer: 4

Dyspnea should always be addressed first. The client's dyspnea is most likely due to ascites from the liver failure. Cholelithiasis will be addressed, possibly when the client is stable and not in respiratory distress. Jaundice will take some time to resolve, and is not a medical emergency. The increased abdominal girth will need to be addressed if it is due to ascites, but administering oxygen and positioning the client upright take priority.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Planning

14. A nurse assesses a client with cirrhosis who is experiencing hypertension, edema, and shortness of breath. For which diagnosis should the nurse develop a plan of care?

1. Fluid Volume, Deficient
2. Tissue Perfusion, Ineffective
3. Fluid Volume, Excess
4. Skin Integrity, Impaired

Answer: 3

The client experiencing shortness of breath, edema, and hypertension should have a care plan for fluid volume excess. Hypertension, shortness of breath, and edema are manifestations of fluid excess. Hypotension and dry mucous membranes are associated with fluid volume deficit. Ineffective would be the appropriate diagnosis for a client experiencing cyanosis or tissue necrosis. Edema can cause an alteration in skin integrity, but there is no evidence of such problems with this client.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Diagnosis/Planning

15. The nurse should conclude that the client who has a liver abscess is at risk for developing:

1. Fluid volume excess.
2. Fluid volume deficit.
3. Alteration in breathing patterns.
4. Disturbed body image.

Answer: 2

The client with a liver abscess is at risk for developing dehydration due to fever, nausea, and vomiting as a result of the infection. It is important that the nurse assess for signs of dehydration. Fluid volume excess is not associated with infection. The client with liver abscess should not be in respiratory distress. There should be no body image disturbances, as the infection is on the liver.

Cognitive Level: Analysis

Test Plan: Health Promotion and Maintenance

Integrated Process: Nursing Process: Diagnosis/Planning

## **Chapter 26**

1. The nurse is planning the diet for the client who will be having a barium enema in two days. What should be included in the diet?

1. There are no restrictions.
2. Full diet today, then clear liquids tomorrow.
3. Full liquids today, and then n.p.o. tomorrow.
4. Clear liquids both today and tomorrow.

**Answer:** 2

**Rationale:** Prior to undergoing a barium enema, clients will be asked to follow a clear liquid diet for 24 hours before the examination.

**NURSING PROCESS STEP:** Planning

**CLIENT NEEDS CATEGORY:** Physiological Integrity

**CLIENT NEEDS SUBCATEGORY:** Reduction of Risk Potential

**COGNITIVE LEVEL:** Application

2. The client will be having a sigmoidoscopy to remove two benign polyps. Discharge teaching should include with of the following instructions?

1. Contact physician if large amounts of flatus result.
2. Avoid heavy lifting for two weeks after procedure.

3. Report abdominal pain, fever, or chills.
4. Eat foods high in fiber, beginning the evening of the procedure.

Answer: 3

Rationale: The client who has a sigmoidoscopy must report potential complications. Complications can manifest as abdominal pain, fever, or chills. Flatus after the procedure is anticipated, and does not warrant contacting the physician. Heavy lifting is to be avoided for only one week. High-fiber foods are to be avoided for 1–2 days.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

3. A 70-year-old client reports noticing an increasing lack of awareness of the need to defecate. What information should the nurse provide to the client?

1. “This is a normal part of aging due to slowed intestinal absorption.”
2. “As you age, the rectum loses tone, and there is a reduced sensation to defecate.”
3. “Have you had a colonoscopy in the past year to evaluate the condition?”
4. “Reduced vitamin K absorption is associated with this condition.”

Answer: 2

Rationale: The loss of muscle tone is responsible for the client’s clinical manifestations. Intestinal absorption does slow with aging, but is not responsible for the concerns raised by the client. Yes, a colonoscopy should be performed on the client, but it does not address the client’s primary concerns voiced to the nurse. Vitamin K absorption is reduced with aging, but is not responsible for the changes being reported.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Growth and Development Through the Life Span

COGNITIVE LEVEL: Analysis

4. The client comes to the physician’s office with reports of changes in bowel habits. The nurse is collecting data from the client. Which of the following statements/questions will elicit the most beneficial question relating to the client’s reported concerns?

1. Can you describe your activities in a normal day?
2. Do you have rectal pain?
3. Have your bowel changes created stress for you?
4. Describe the consistency of your bowel movements.

Answer: 4

Rationale: All of the questions may be utilized for data collection when a client reports with concerns related to gastrointestinal function. Questions or statements that are open-ended will allow the client to provide the greatest amount of information.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

5. A colonoscopy is ordered. The nurse is discussing the pre- and post-procedural care with the client. Which of the following statements by the client indicates the need for further teaching?

1. "The procedure will only take about one hour."
2. "It might be quite painful."
3. "I will likely have medications that will make me drowsy during the test."
4. "The physician might take tissue samples for further analysis."

Answer: 2

Rationale: The colonoscopy is not a painful examination.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

6. The nurse is planning care for the patient who will be having a barium enema the next morning. What should be included in the plan of care?

1. Enemas after the procedure
2. Full-liquid diet for 24 hours before the procedure
3. Position the patient on the right side during the procedure.
4. The patient will be n.p.o. for eight hours prior to the procedure.

Answer: 4

Rationale: The pre-procedural care for the colonoscopy requires the client to be n.p.o. for eight hours. Enemas or laxatives are administered before the procedure, not after. Full-liquid intake is recommended for two days before the procedure. The client will be positioned on the left side before the procedure.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

7. During the admission assessment, the nurse finds the client is having her menstrual period. Which of the ordered tests could be impacted by this information?

1. Small bowel series
2. Barium enema
3. Stool culture
4. Colonoscopy

Answer: 3

Rationale: The stool culture collects stool immediately after defecation. If a client is having vaginal bleeding, it is possible that menstrual blood could mix with the stool during defecation. The small bowel series, barium enema, and colonoscopy will not be impacted by menstrual bleeding.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

8. A 64-year-old client reports feeling weak. The physical assessment notes that the client is slightly pale. The physician diagnoses the client as begin mildly anemic. The physician recommends dietary changes. During the counseling session, the client reports frustration, as she feels she regularly eats a balanced diet. What response by the nurse is indicated?

1. "You might not be eating as well as you think."
2. "This happens as you get older."
3. "As we age, the amount of iron absorbed by your body is decreased."
4. "Menopause is responsible for these changes."

Answer: 3

Rationale: A reduction in the absorption rate of ingested iron is a normal part of aging. Dietary modifications might be indicated to counteract life span-related changes. Telling the client dietary intake is not what she believes it to be is potentially argumentative, and does not provide education regarding the underlying cause of the problem.

Yes, the iron deficiency is indirectly related to aging, but it is the responsibility of the nurse to provide as much information as possible. The client is likely well past menopause, and blaming this life event for the difficulty being experienced does not meet the responsibility of the nurse.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUB CATEGORY: Growth and Development Through the Life Span

COGNITIVE LEVEL: Application

9. During the assessment of the client's abdomen, frequent pulsations are noted. What action by the nurse is indicated?

1. Document the findings as hyperactive bowel sounds.
2. Review the client's medical records for signs and symptoms of cirrhosis, as these findings are indicative of ascites.
3. Assess the time when the client last voided, as the bladder is apparently full and becoming distended.
4. Notify the physician related to potential signs consistent with an aortic aneurysm.

Answer: 4

Rationale: Clients having an aortic aneurysm present with pulsations as described in the question. Bowel sounds are audible, not visible. Bladder distention is not manifested as a pulsation. Bladder distention can be observed by palpation. Ascites is the collection of fluid.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

10. The client presents with a diagnosis of acute diverticulitis. During the assessment, which of the following findings will most support this diagnosis?

1. Right lower quadrant pain
2. Left lower quadrant pain
3. Upper middle abdominal pain
4. Back pain and tenderness

Answer: 2

Rationale: Diverticulitis in the acute stage presents with changes in elimination and lower left abdominal pain. Right lower quadrant pain is noted with appendicitis. Upper middle abdominal pain is seen with acute pancreatitis. Back pain and tenderness are manifestations most commonly seen with kidney disorders.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

11. The client presents with pain, nausea, and vomiting. The assessment reveals the discomfort is in the mid-upper abdomen. After completion of the assessment, which of the following diagnoses can the nurse likely anticipate?

1. Appendicitis
2. Peritonitis
3. Pancreatitis
4. Crohn's disease

Answer: 3

Rationale: The pancreas is located in the mid-upper abdominal region. Appendicitis presents as lower abdominal pain and tenderness. Peritonitis is consistent with rebound tenderness and generalized abdominal pain. Crohn's disease is consistent with diarrhea and lower abdominal discomfort.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

12. An unconscious client is brought to the Emergency Department. The assessment reveals the client has a scaphoid abdomen. Based upon your knowledge, what information can you make about the client?

1. The client likely has type 2 diabetes mellitus.
2. The client likely suffers from Crohn's disease.
3. The client is malnourished.
4. The client is likely suffering from diverticulosis.

Answer: 3

Rationale: A scaphoid abdomen is one that appears sunken and thus malnourished. There are no indications from the information provided the client has a history or manifestations consistent with diabetes, Crohn's disease, or diverticulosis.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

13. The nurse is providing teaching to the client planning to have a small bowel series. Which of the following statements by the client indicates the need for further education?

1. "I might experience constipation for a few days after the procedure."
2. "I will need to increase my fluid intake the first few days after the procedure."
3. "I might have a laxative prescribed after the procedure."
4. "The barium will be inserted through my rectum."

Answer: 1

Rationale: The barium instilled during the procedure must be evacuated after the procedure. The client will experience white, chalky stools for the first few days. An increase in fluid intake and laxative use will facilitate the stool's evacuation. Barium in a small bowel series is administered via the bowel or endoscopically.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

14. The physician suspects the presence of an abdominal mass in a client. An abdominal ultrasound is ordered. Which of the following should be included in instructions provided to the client prior to the procedure?

1. Advise the technician if you suspect you are pregnant.
2. Drink 1–2 quarts one hour before the procedure.
3. Do not eat or drink anything 8–12 hours before the procedure.
4. Take a laxative the evening before the procedure.

Answer: 3

Rationale: The client will need to avoid oral intake 8–12 hours before the procedure. The presence of a pregnancy is not a contraindication for this test. When an ultrasound is done in early pregnancy or to view a uterine/pelvic mass, water may be ingested. Laxative use is not needed for this procedure.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

15. During data collection, the client reports concerns with constipation. Which of the following findings could signal a source of the problem being reported?

1. Vicodin (hydrocodone) taken twice daily for a recent back injury
2. Acetaminophen used daily for a recent back injury
3. Infrequent use of over-the-counter medications to manage insomnia
4. The use of oral contraceptives to regulate the menstrual cycle

Answer: 1

Rationale: Narcotic medications are associated with constipation. They slow peristalsis. Acetaminophen, over-the-counter medications for insomnia, and oral contraceptives do not impact elimination patterns.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

## **Chapter 26**

1. The client has a virus, and has been experiencing diarrhea. The client questions when it will be advisable to add foods back into the diet. What information should be provided to the client?
  1. Withholding foods for the first 12 hours after acute diarrhea is recommended.
  2. Add milk products to the diet first, as they can soothe the stomach.
  3. It is safe to blend a home preparation of water, salt, sugar, and lemon extract for drinking to begin the process of rehydration.
  4. Vegetable soup is helpful during the recovery process.

Answer: 3

Rationale: The home preparation will provide a hydrating blend of electrolytes that might have been lost during the diarrhea. Foods are withheld during the first 24 hours of the acute diarrhea phase. Milk products are added to the diet last. Vegetables are gaseous, and should be avoided during the recovery process.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. The physician has ordered kaolin to manage the client's diarrhea. The nurse provides teaching to the client concerning use of the medication. What statement to the nurse concerning its use indicates the need for further teaching?

1. "I should continue to take this medication daily until my bowels are firm and dry."
2. "If I start to have a fever, I need to contact my physician about continuing to take this medication."
3. "I will need to take the medication after each loose stool."
4. "If my diarrhea does not get better within two days, I will need to call my physician for further advice."

Answer: 1

Rationale: If constipation results, the client will have another issue for resolution. The other statements are correct.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

3. A client reports to the ambulatory clinic with reports of frequent diarrhea. A food diary is reviewed. Which of the following items poses the greatest concern and warrants further discussion with the client?

- a. Breakfast consisting of bran muffins and applesauce
- b. Lunch consisting of cottage cheese, peaches, and a turkey sandwich
- c. Dinner consisting of baked chicken, yeast rolls, and a small salad
- d. Snack consisting of popcorn

Answer: b

Rationale: Dairy products can contain lactose, which might be difficult for certain clients to digest, resulting in diarrhea. The remaining selections are not associated with diarrhea.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential  
COGNITIVE LEVEL: Application

4. A client is admitted to the clinical facility with acute abdominal pain. The physician determines that the client has appendicitis. An appendectomy is scheduled to take place in three hours. While waiting for the surgery, the client reports the pain has subsided. What initial action by the nurse is indicated?

1. Determine when the client can be medicated for pain again.
2. Contact the physician.
3. Contact the surgery department.
4. Notify the nursing supervisor.

Answer: 2

Rationale: The pain relief being experienced by the client is consistent with rupture of the appendix. The physician should be notified. If the appendix has ruptured, the risk of peritonitis will increase. The next time the client can be medicated for pain is not relevant for this client. Notification of the surgery department and the nursing supervisor should not be completed before contact with the physician.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

5. Dietary management has been recommended for a client who has been experiencing pain, bloating, and diarrhea after eating. The client's assessment reveals intestinal gas levels are not above normal. Which of the following dietary recommendations should be provided to the client?

1. Limit intake of decaffeinated coffee, tea, and soft drinks.
2. Increase intake of legumes, oats, and barley.
3. Chew gum after eating to reduce nausea and bloating.
4. Increase intake of cruciferous vegetables.

Answer: 2

Rationale: The manifestations being described are consistent with irritable bowel syndrome. Dietary management for this condition includes increasing fiber intake. Legumes, oats, and barley are good sources of soluble fiber. Fiber will increase stool bulk and reduce diarrhea. Caffeine is a source of irritation for sufferers of irritable bowel syndrome. Decaffeinated sources of beverages are permitted. Chewing gum contains sorbitol, and is a potential source of problems for the client with irritable bowel syndrome. Cruciferous vegetables include broccoli, cauliflower, and cabbage. These vegetables are associated with gas formation.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

6. The client is admitted to the acute care facility through the Emergency Department after presenting with complaints of an elevated temperature, elevated white blood cell count, nausea, and pain and tenderness in the lower right lower quadrant of the abdomen. Analgesics were administered upon arrival to the Emergency Department, and are not due for administration for at least another two hours. What response by the nurse is most correct?

1. "I will need to review your assessment with the physician first."
2. "Let's try a heating pad or warm blanket."
3. "I do not have any medications ordered for you at this time."
4. "Why don't you try to rest for a while longer until it is time?"

Answer: 1

Rationale: The client's inability to achieve comfort will need to be reported to the physician. The reported manifestations are consistent with appendicitis. The use of heat to manage the client is contraindicated due to the risk of perforation. Advising the client that no medications are available at this time and encouraging rest do not meet the concerns being presented by the client.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction or Risk Potential

COGNITIVE LEVEL: Analysis

7. During the postoperative assessment of a client who had an appendectomy 36 hours ago, the nurse is unable to hear any bowel sounds. The client denies passing flatus. What action by the nurse is indicated?

1. Encourage the client to increase fluid intake to promote peristalsis.
2. Encourage the client to increase solid food intake to promote peristalsis.
3. Withhold food and fluid intake until intestinal motility has returned.
4. Encourage the client to slow the amount of oral intake.

Answer: 3

Rationale: After abdominal surgery, the risk of a paralytic ileus exists. An ileus results when the bowel is not experiencing peristalsis. Oral intake must be withheld during this time.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential  
COGNITIVE LEVEL: Application

8. The client diagnosed with peritonitis has reported pain unrelieved by the prescribed medications. The client asks if there are any other means to assist with managing this discomfort. Which of the following recommendations may be made to the client?

1. Place the client in low Fowler's position.
2. Elevate the knees and the foot of bed.
3. Assist the client to side-lying position.
4. Assist the client to prone position.

Answer: 2

Rationale: The client with peritonitis will be most comfortable in Fowler's or semi-Fowler's position with the knees and feet elevated. Side-lying or prone positions will not promote comfort for the client diagnosed with peritonitis.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Application

9. A client presents with right-sided pain, cramping, nausea, and increased frequency of defecation. Acute diverticulitis is diagnosed. What course of treatment can the nurse anticipate will be recommended for the client?

1. Surgery to resect the diseased portion of bowel
2. A high-fiber diet to promote bulking of the stool
3. A diet high in insoluble fiber
4. The client will be made n.p.o.

Answer: 4

Rationale: Making the client n.p.o. will allow the bowel to rest. The client then will be restarted on foods gradually, beginning with liquids. Surgery is a treatment option reserved for clients having a condition complicated by peritonitis or an abscess. A high-fiber diet is used to manage diverticulitis after the acute phase has passed. Insoluble fiber is to be avoided by the client with diverticulitis.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

10. The nurse is answering questions posed by a client who has a colostomy. The client is concerned about continued problems with stool odor. The nurse asks the client to recall foods eaten during the previous day. Which of the following meals should be discussed with the client with regard to the concerns voiced?

1. Breakfast consisting of cold cereal, milk, toast, and peaches
2. Lunch consisting of a cod fish sandwich, potato chips, and a pickle spear
3. Dinner consisting of baked chicken, a poppy seed roll, baked potato, and sliced tomatoes
4. Snack consisting of cheese and crackers

Answer: 2

Rationale: Fish is an odor-producing food. The remaining choices are not associated with odor or gas production.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Analysis

## Chapter 27

1. The nurse assesses a client admitted to the medical–surgical unit for uncontrolled type I diabetes mellitus and notes that the client’s urine is cloudy and foul-smelling. Which of the following diagnostic tests does the nurse anticipate will be ordered based on this finding?
  - a. Blood urea nitrogen (BUN)
  - b. Creatinine clearance
  - c. Residual urine
  - d. Urine culture and sensitivity (C&S).

Answer: d

*Urine culture and sensitivity (C&S)* is correct because cloudy and foul-smelling urine indicates a urinary tract infection. The diagnostic test to identify the organism responsible is a urine C&S. Blood urea nitrogen (BUN) measures the amount of urea (end product of protein metabolism) in the blood plasma. It does not identify infection. Creatinine clearance is a 24-hour urine test used to identify renal function; it will not identify an infection. Residual urine measures the amount of urine left in the bladder after voiding, and does not identify an infection.

Cognitive Level: Application

Nursing Process: Planning

Client Need Category: Physiological Integrity: Reduction of Risk Potential

2. When preparing a client for an intravenous pyelogram (IVP), the nurse reviews diagnostic data, noting all of the following. Which of these findings requires notification of the physician before proceeding with the test?
  - a. Blood urea nitrogen (BUN) 55 mg/dl
  - b. Serum creatinine 1.3 mg/dl
  - c. Urine culture <10,000 organisms/ml
  - d. Residual urine of 80 ml

Answer: a

*Blood urea nitrogen (BUN) 55 mg/dl* is correct because this level is elevated, indicating that there might be a problem of renal function. The physician will need to be notified because an IVP involves the injection of dye that must eventually cleared by the kidney, and if there is already compromised renal function, the test may not be administered.

*Serum creatinine 1.3 mg/dl, urine culture <10,000 organisms/ml, and residual urine of 80 ml* are all incorrect because these values are all within the normal range, and therefore will not require physician notification.

Cognitive Level: Analysis

Nursing Process: Implementation

Client Need Category: Physiological Integrity: Reduction of Risk Potential

3. The postoperative client has voided a small amount of urine, and then reports to the nurse feeling like she has to void but is unable to do so. The physician orders the nurse to obtain residual urine for which of the following reasons?
- To determine renal function
  - To detect the presence of abnormal substances in urine
  - To evaluate the amount of urine in bladder post-voiding
  - To measure the total amount of bladder capacity

Answer: c

*To evaluate the amount of urine in bladder post-voiding* is correct because this diagnostic test is ordered in order to determine urinary retention or incomplete bladder emptying, which could be a consequence of the operative experience. *To determine renal function* and *to detect the presence of abnormal substances in urine* are incorrect responses because a residual urine only measures the amount of urine left in the bladder after voiding. *To measure the total amount of bladder capacity* is incorrect because the test is not measuring bladder capacity; a cystometric test is required for this.

Cognitive Level: Comprehension

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

4. Because of normal changes due to aging, the nurse anticipates that a 75-year-old client's serum creatinine level might be which of the following?

- Higher than normal
- Lower than normal
- Variable with fluid status
- Within normal range

Answer: b

*Lower than normal* is correct because serum creatinine level reflects the by-product of muscle breakdown, and an older adult with less muscle mass can be expected to have a lower-than-normal level. *Higher than normal, variable with fluid status*, and *within normal range* are all incorrect because the question is asking for the expected change due to the aging process, and that is less muscle mass, and therefore less serum creatinine.

Cognitive Level: Analysis

Nursing Process: Assessment

Category of Client Need: Health Promotion and Maintenance

5. The nurse collects all of the following data on a male client scheduled for a CT scan of the kidneys. Which of the findings will necessitate cancellation of the procedure at this time?

- a. Allergy to iodine and seafood
- b. Urinary output of 1,200 ml in 24 hours
- c. Last bowel movement one day ago
- d. Height 5'8" and weight 160 pounds

Answer: a

*Allergy to iodine and seafood* is correct because a CT scan of the kidneys requires the injection of a radiopaque dye that contains iodine. A client who is allergic to iodine or seafood will be unable to have this test. *Urinary output of 1,200 ml in 24 hours, last bowel movement one day ago, and height 5'8" and weight 160 pounds* are all incorrect because these are all normal findings, and therefore do not require that the physician be notified.

Cognitive Level: Application

Nursing Process: Planning

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

6. A client tells the nurse conducting a health assessment interview related to urinary structure and function that she has noted red-tinged urine. Which of the following questions will the nurse ask next?

- a. “Are you allergic to any food or drugs?”
- b. “Do you wake up at night to void?”
- c. “How many times a day do you usually void?”
- d. “What medications do you take?”

Answer: d

“*What medications do you take?*” is correct because several common medications can cause the urine to become red-tinged. Red-tinged urine that occurs in the absence of medications can indicate hematuria, and will need further investigation. Red-tinged urine is not related to allergies. “*Do you wake up at night to void?*” and “*How many times a day do you usually void?*” are both incorrect because these questions will elicit data regarding frequency of urination, not red-tinged urine.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Health Promotion and Maintenance

7. A female client, age 68, tells the nurse that she is unable to hold her urine and frequently finds that she has voided involuntarily. The nurse analyzes this finding as which of the following?

- a. An abnormal finding requiring further testing
- b. An indication of the presence of a urinary infection
- c. A normal outcome of the aging process
- d. The result of having several children

Answer: a

An *abnormal finding requiring further testing* is correct because incontinence is not a normal part of the aging process, and therefore will require further investigation to identify the cause. An *indication of the presence of a urinary infection* is incorrect because although frequency and urgency can be symptoms of a urinary tract infection, a culture and sensitivity test is necessary in order to determine infection. A *normal outcome of the aging process* and a *result of having several children* are incorrect because incontinence is not normal, and is it not necessarily the result of having had several children.

Cognitive Level: Analysis

Nursing Process: Assessment

Category of Client Need: Health Promotion and Maintenance

8. All of the following diagnostic tests are ordered on a client with renal disease. The nurse understands that which one will help evaluate the client's glomerular filtration rate (GFR)?

- a. Blood urea nitrogen (BUN)
- b. Creatinine clearance
- c. Intravenous pyelogram (IVP)
- d. Renal ultrasound

Answer: b

Creatinine clearance is correct because this study (a 24-hour urine) measures the ability of the kidney to clear a given amount of creatinine out of the plasma within a given time period. Creatinine is a substance produced from the breakdown of muscle and is cleared by the kidney at a constant rate. This test is used to determine the glomerular filtration rate or the ability of the kidney to clear substances out of the plasma. Blood urea nitrogen (BUN) measures the amount of urea in the plasma and, although it is reflective of kidney function, it can be affected by both protein intake and fluid balance. Intravenous pyelogram (IVP) identifies the structures of the urinary system, not the function. Renal ultrasound identifies renal or perirenal masses or obstructions.

Cognitive Level: Analysis

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

## Chapter 28

1. The nurse in an emergent care center assesses a 40-year-old female client who has presented with a fever of 101.2°F and complaints of urinary frequency and urgency. Which of the following questions does the nurse ask to elicit further data indicative of suspected urinary tract infection (UTI) cystitis?
  - a. “Do you have any upper abdominal pain or cramping?”
  - b. “Do you have any symptoms of menopause?”
  - c. “Have you experienced painful urination or blood in your urine?”
  - d. “How long have you had a fever, and have you had chills with this?”

Answer: c

*“Have you experienced painful urination or blood in your urine?”* is correct because the classic symptoms of cystitis include dysuria or painful urination, urinary frequency and urgency, and bloody urine or hematuria. *“Do you have any upper abdominal pain or cramping?”* is incorrect because pain from cystitis is typically suprapubic, not upper abdominal. *“Do you have symptoms of menopause?”* is incorrect because this is a 40-year-old client who presents with a fever and urinary frequency. These are not symptoms of menopause. *“How long have you had a fever, and have you had chills with this?”* is incorrect because this question is not specific to suspected cystitis, and does not elicit information related to urinary symptoms.

Cognitive Level: Application

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

2. The nurse best evaluates teaching for a female client with a urinary tract infection who has been treated with a three-day course of oral trimethoprim-sulfamethoxazole (TMP-SMZ) has been effective if the client does which of the following?
  - a. Increases intake of fluids, especially citrus juice.
  - b. Practices Kegel exercises on daily basis.
  - c. Returns within 10 days for a follow-up urine culture.
  - d. States she will wear underwear made from cotton materials.

Answer: c

*Returns within 10 days for a follow-up urine culture* is correct because it is essential to validate eradication of infection with a follow-up culture that is negative. *Increases intake of fluids, especially citrus juice* is incorrect because citrus juices will not increase acidity of urine, and therefore is not recommended when a client has a UTI. *Practices Kegel exercises on a daily basis and states she will wear underwear made from cotton materials* are both useful in prevention of future urinary tract infections, but they are not the best evaluation of effectiveness of teaching.

Cognitive Level: Application

Nursing Process: Evaluation

Category of Client Need: Physiological Integrity: Pharmacological and Parenteral

Therapies

3. The nurse practices strict aseptic technique when inserting an indwelling urinary catheter, and also does which of the following to reduce the risk of catheter-associated infection?
  - a. Inflates a balloon while the catheter is in the urethra.
  - b. Instructs client not to void around the catheter.
  - c. Irrigates the catheter with sterile saline on a daily basis.
  - d. Uses an anesthetic lubricating gel during insertion.

Answer: d

*Uses an anesthetic lubricating gel during insertion* is correct because, unless contraindicated, this additional step promotes comfort and protects fragile urethral tissues from trauma, and therefore reduces risk for a catheter-associated UTI. *Inflates a balloon while the catheter is in the urethra* is incorrect because the balloon is not inflated until the catheter is in the bladder, in order to prevent trauma to the urethra and therefore decrease the risk of infection. *Instructs the client not to void around the catheter* is incorrect because although this will decrease bladder spasms, it will not help reduce infection. *Irrigates the catheter with sterile saline on a daily basis* is incorrect because this can introduce infection by allowing bacteria to enter the closed urinary drainage system.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Safe, Effective Care Environment: Safety and Infection Control

4. The nurse identifies which of the following clients as having the greatest risk for urinary stones?
  - a. 70-year-old male with a recent history of myocardial infarction
  - b. 45-year-old female with paraplegia from an auto accident
  - c. 60-year-old male with type II diabetes mellitus
  - d. 30-year-old female with several episodes of urinary infection

Answer: b

*45-year-old female with paraplegia from an auto accident* is correct because this client has prolonged immobility, which will increase calcium loss from bones and therefore increase the chance of calcium stones precipitating in the urinary system. *70-year-old male with a recent history of myocardial infarction, 60-year-old male with type II diabetes mellitus, and 30-year-old female with several episodes of urinary infection* do not have great risk because they do not have prolonged immobility.

Cognitive Level: Analysis

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

5. A client with several episodes of urinary calculi has been found through analysis to have stones composed of calcium phosphate. The nurse teaches this client to reduce intake of which of the following foods?
  - a. Flour, milk, and milk products
  - b. Organ meats, sardines, and seafood
  - c. Tomatoes, fruits, and nuts
  - d. Chicken, beef, and ham products

Answer: a

*Flour, milk, and milk products* is correct because these foods have high calcium levels, and therefore are recommended to be reduced to decrease risk of further episodes of calcium-containing calculi. *Organ meats, sardines, and seafood, tomatoes, fruits, and nuts, and chicken, beef, and ham products* are not high in calcium, and therefore do not need to be restricted for this client.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Health Promotion and Maintenance

6. A newly admitted client to the medical–surgical unit is found to have ureteral calculi. The nursing diagnosis having priority is which of the following?
  - a. Pain, Acute
  - b. Fluid Volume, Deficient
  - c. Knowledge, Deficient
  - d. Skin Integrity, Risk for Impaired

Answer: a

*Pain, Acute* is correct because ureteral calculi will cause severe pain (renal colic) as the narrow ureter is obstructed by the stone. *Fluid Volume, Deficient* is incorrect because although decreased fluids can increase the risk of calculi, this will not be the priority diagnosis for this client. *Knowledge, Deficient* is incorrect because this client will have acute pain until treatment is instituted, and therefore client teaching will be of lesser

importance until the pain is under control. *Skin Integrity, Risk for Impaired* is incorrect because there is no reason or any data given that this client is at risk for this problem.

Cognitive Level: Analysis

Nursing Process: Diagnosis

Category of Client Need: Physiological Integrity: Physiological Adaptation

7. The nurse assesses that a client who had a radical cystectomy with creation of an ileal conduit two days ago because of bladder cancer has a urinary output of 100 ml for the past six hours. The nursing diagnosis established is Urinary Elimination, Impaired. Which of the following is the most appropriate nursing action?
  - a. Continue to monitor the urinary drainage on hourly basis.
  - b. Encourage the client to increase oral intake of fluids.
  - c. Record the output on the flow sheet.
  - d. Report the urinary output to the physician.

Answer: d

*Report the urinary output to the physician* is correct because the client with an ileal conduit should have continuous urinary output of at least 30–60 ml per hour. Output less than this can indicate postoperative complications such as postoperative edema or low vascular volume or even renal insufficiency. This requires notification of the physician and prompt action to prevent renal failure. *Continue to monitor urinary drainage on hourly basis, encourage the client to increase oral intake of fluids, and record the output on the flow sheet* are all incorrect responses because this client could have serious postoperative complications that require physician-directed intervention.

Cognitive Level: Application

Nursing Process: Intervention

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

8. The nurse evaluates the client with a neurogenic bladder for which of the following results of the administered anticholinergic medication oxybutynin (Ditropan)?
  - a. Decreased urinary incontinence
  - b. Increased urinary output within 30 minutes
  - c. Decreased complaints of bladder pain
  - d. Increased frequency of urination

Answer: a

*Decreased urinary incontinence* is correct because the anticholinergic medication oxybutynin (Ditropan) will act to increase bladder capacity and therefore reduce urinary incontinence. *Increased urinary output within 30 minutes* and *decreased complaints of bladder pain* are both incorrect because this medication does not cause urinary output

within 30 minutes or affect bladder pain. *Increased frequency of urination* is incorrect because this medication is an anticholinergic drug, and will cause urinary retention, not frequency.

Cognitive Level: Application

Nursing Process: Evaluation

Category of Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies

## Chapter 29

1. The nurse assessing a client newly admitted to the medical–surgical unit with glomerulonephritis expects to find which of the following classic manifestations of this disorder?
  - a. Acute flank pain, nausea, and vomiting
  - b. Hematuria, proteinuria, and edema
  - c. Headache, fever, dehydration
  - d. Weight loss, anemia, and fatigue

Answer: b

Hematuria, proteinuria, and edema are the classic signs of glomerular disease because this disorder affects the structure and function of the glomerulus, disrupting glomerular filtration. This increased permeability in the glomeruli leads to plasma proteins being lost in the urine as well as red blood cells. Edema occurs because of the loss of plasma proteins, namely albumin. *Acute flank pain, nausea, and vomiting* are incorrect because these symptoms are more characteristic of renal calculi. Headache, fever, dehydration,

weight loss, anemia, and fatigue are non-specific symptoms that can occur with many disorders, but not typically with glomerulonephritis.

Cognitive Level: Application

Nursing Process: Assessment

Category of Client Needs: Physiological Integrity: Reduction of Risk Potential

2. The nursing diagnosis established for a client with acute glomerulonephritis is Fluid Volume, Excess related to plasma protein deficit and sodium and water retention. Which of the following assessments provides the most accurate indication of fluid balance for this client?
  - a. Daily weight
  - b. Intake and output records
  - c. Serum sodium levels
  - d. Vital signs

Answer: a

Daily weight provides the most accurate indication of fluid balance because the pathophysiology of acute glomerulonephritis. Albumin is lost, causing decreased osmotic pressure and then fluid shifting into the interstitial spaces. Accurate weights will provide data to indicate that treatments are effective in pulling fluids from interstitial spaces into the vascular system and then out via kidneys that are working. Intake and output records, serum sodium levels, and vital signs will all provide data indicating fluid balance; however, they are not as important as daily weight for determining fluid balance.

Cognitive Level: Comprehension

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

3. A client returns to the medical–surgical unit following a right nephrectomy, and is receiving oxygen via nasal cannula at a rate of 2 l/minute. The nurse assesses the following: respiratory rate 12/min, shallow breathing with inadequate lung expansion, and client complaint of shortness of breath. Which nursing intervention has the highest priority at this time?
  - a. Continue to monitor vital signs and respiratory status.
  - b. Encourage the client to deep-breathe and use an incentive spirometer.
  - c. Increase oxygen flow rate to at least 5 l/min.
  - d. Position the client with HOB elevated 15 degrees.

Answer: b

*Encourage client to deep-breathe and use an incentive spirometer* is the correct response because the client is demonstrating the common postoperative problem of shallow

breathing related to having a high-flank incision site that causes pain when deep-breathing. In order to prevent respiratory complications, the nurse will intervene early. *Continue to monitor vital signs and respiratory status* is incorrect because the nurse needs to intervene at this time in order to prevent respiratory complications. *Increase oxygen flow rate to at least 5 l/minute* is incorrect because the problem is not inadequate flow rate but inadequate chest expansion. Positioning the client with 15 degrees' head elevation is incorrect because this position will not aid in respiratory expansion. The client should be in semi-Fowler's position.

Cognitive Level: Analysis

Nursing Process: Implementation

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

4. The nurse evaluates the therapeutic effect of the drug sodium polystyrene sulfonate (Kayexalate) in a client in chronic renal failure by assessing whether which of the following is present?
  - a. Decreased serum potassium.
  - b. Increased stool excretion
  - c. Decreased serum sodium
  - d. Increased urine-specific gravity

Answer: a

*Decreased serum potassium* is correct because the client in chronic renal failure is unable to excrete potassium, and therefore the drug sodium polystyrene sulfonate (Kayexalate) is utilized in order to exchange sodium for potassium in the large intestine. *Increased stool excretion* is incorrect because although the client might have increased stools, the therapeutic effectiveness of the drug is measured by monitoring the serum potassium. *Decreased serum sodium* and *increased urine-specific gravity* are both incorrect because this drug does not affect either the sodium level or the specific gravity.

Cognitive Level: Analysis

Nursing Process: Evaluation

Category of Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies

5. Which of the following laboratory data does the nurse anticipate for the client with chronic renal failure prior to hemodialysis?
  - a. Increased urine osmolality
  - b. Decreased phosphorus
  - c. Decreased potassium
  - d. Increased creatinine

Answer: d

*Increased creatinine* is correct because the damaged kidney is unable to excrete waste products, including creatinine. *Increased urine osmolality* is incorrect because the damaged kidney is unable to excrete solutes, therefore the serum osmolality will be increased and the urine osmolality will be decreased. *Decreased phosphorus* and *decreased potassium* are incorrect because both of these electrolytes are increased in renal failure due to the inability of the kidney to excrete them.

Cognitive Level: Application

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

6. The nurse administering calcium acetate two tablets p.o. with each meal to the client with chronic renal failure understands the rationale for this treatment as which of the following?
  - a. Decreases serum creatinine.
  - b. Lowers serum phosphate.
  - c. Neutralizes gastric acid.
  - d. Stimulates appetite.

Answer: b

*Lowers serum phosphate* is correct because the client in renal failure has elevated phosphate levels due to the inability of the damaged kidney to excrete this electrolyte. Calcium acetate, when given with meals, will bind serum phosphorus and therefore lower the serum level. Calcium acetate has no effect on serum creatinine. Although when given between meals calcium acetate can act as an antacid and neutralize gastric acid, this is not the reason it is given to a client with renal failure. This medication has no effect on appetite stimulation.

Cognitive Level: Application

Nursing Process: Application

Category of Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies.

7. The nursing diagnosis established for the client in chronic renal failure (CRF) is Injury, Risk for related to significant osteodystrophy. Which of the following is the most appropriate outcome for this client?
  - a. Absence of bone fractures
  - b. Decreased joint deformities
  - c. Increased intake of dietary calcium
  - d. Increased exercise tolerance

Answer: a

The client in CRF with significant osteodystrophy (osteoporosis, or calcium loss from the bones) is at high risk for fractures; therefore, preventing this is the most appropriate outcome. The problem of osteodystrophy is related to loss of calcium from the bones, and does not cause joint deformities. Although increased calcium is desirable, the client in CRF has an inability to absorb dietary calcium from the GI tract due to the decreased vitamin D synthesis from the damaged kidney. Although exercise will help preserve bone density in the normal client, in the client with renal failure, the problems are the inability to absorb dietary calcium and the subsequent stimulation from the parathyroid glands, which will cause calcium from the bones to be lost to the blood serum in the attempt to elevate serum calcium levels.

Cognitive Level: Analysis

Nursing Process: Planning

Category of Client Need: Physiology Integrity: Reduction of Risk Potential

8. The nurse notes the presence of a cloudy dialysate return for a client in acute renal failure receiving peritoneal dialysis. Which of the following actions does the nurse initiate after notifying the physician?
  - a. Culture the dialysate return.
  - b. Chart the cloudy dialysate.
  - c. Measure abdominal girth.
  - d. Slow dialysate instillation.

Answer: a

The return should be clear. The presence of cloudy drainage might indicate peritonitis, and the nurse should culture the return in order to help identify the presence and type of organism that could be causing the infection. Charting the cloudy dialysate and nursing actions taken would be necessary, but is not the next-priority action. Measurement of abdominal girth is performed prior to the dialysis procedure, and although increased girth could indicate peritonitis, culturing the return is more important. The instillation part of the procedure is completed prior to the collection of the dialysate return, and the rate of the instillation has no relationship to the development of an infection.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Safety and Infection Control

9. The nurse plans to reinforce dietary teaching for the client in renal failure, emphasizing that protein foods selected should be those that are complete proteins, having high biological value. Which of the following foods will the nurse explain meet this criteria?
  - a. Eggs
  - b. Legumes
  - c. Nuts

- d. Vegetables

Answer: a

Eggs are an excellent source of essential amino acids, and are recommended as part of the diet for a client with renal failure who is on a protein-restricted diet. Legumes, nuts, and vegetables do contain protein, but they are incomplete proteins, and are not as good protein sources as are eggs.

Cognitive Level: Application

Nursing Process: Planning

Category of Client Need: Basic Care and Comfort

10. Which of the following assessments made by the nurse on a client that has a left forearm arteriovenous (AV) fistula indicates that the fistula is patent?

- a. Increase in vein size in the forearm
- b. Hand that is cold to the touch
- c. Presence of an audible bruit
- d. Radial pulse that is palpable

Answer: c

An AV fistula is formed by the anastomosis of an artery and a vein in order to distend the vein for cannulation at the time of hemodialysis. Assessment of a bruit via auscultation as well as palpation of a thrill indicates turbulent blood flow and a patent fistula. Increase in vein size in the forearm occurs when in an AV fistula, but this observation does not indicate patency of the vessel. A hand that is cold to the touch could indicate “steal” syndrome, in which the arterial blood normally flowing to the hand is diverted to the fistula and, therefore, the hand does not receive adequate blood supply. This is not the best assessment of a patent site. A radial pulse that is palpable is a normal assessment that is unrelated to the patency of the AV fistula.

Cognitive Level: Application

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

## CHAPTER 30

1. A priority nursing assessment prior to a client having a CT (computed tomography) scan with contrast of the chest would include noting:

- a. A history of claustrophobia.
- b. A history of smoking.
- c. Allergies to iodine or seafood.
- d. A history of tuberculosis.

Answer: C

Rationale: The contrast medium might invoke an allergic response in clients who already have an allergic sensitivity to iodine. Iodine can be found in seafood as well.

Claustrophobia is more likely an issue with an MRI (magnetic resonance image). A history of smoking or tuberculosis is not a priority to this test.

Application; Assessment; Physiological Integrity

2. When a client is diagnosed with Marfan's syndrome, routine follow-up appointments are important to assess for serious effects on which body system?

- a. Musculoskeletal
- b. Cardiovascular
- c. Urinary
- d. Gastrointestinal

Answer: B

Rationale: In Marfan's syndrome, a dilated aorta, or aortic aneurysm, can be common. The skeleton and eyes also can be affected with this genetic disorder, but these are not as serious as the cardiovascular effects.

Analysis; Implementation; Health Promotion and Maintenance

3. When doing a thorough cardiac history assessment on a client, it would be important to document which of the following statements regarding rest practices? Select all that apply.

- a. "I sleep in the recliner."
- b. "I use three pillows when I sleep."
- c. "I still wake up at 7:00 a.m. each day."
- d. "I sleep 5–6 hours at night."

Answer: A; B; D

Rationale: These comments indicate that changes in the cardiovascular system have affected the client's ability to get restful sleep. The awakening time has remained consistent, and is not of concern.

Analysis; Assessment; Physiological Integrity

4. A 75-year-old client reports having to rest between activities during the day. Which effect of aging on the cardiovascular system would best explain this?

- a. Decreased cardiac output
- b. Increased blood pressure
- c. An elongated and dilated aorta
- d. Increased stroke volume

Answer: A

Rationale: All are effects of aging on the cardiac system, but the decreased cardiac output is a result of decreased efficiency and contractility of the myocardium. Rest could be required after each activity that puts physiological stress on the heart. Less blood is pumped from the heart to the rest of the body with a decreased cardiac output, and this has the most direct effect on the activity level that can be tolerated.

Analysis; Evaluation; Health Promotion and Maintenance

5. The nurse is completing a physical exam focused on the cardiovascular system of a client. When an increased pulsation is palpated at the aortic area, this could indicate:

- a. A thrill.
- b. The apical impulse.
- c. A cardiomyopathy.
- d. An aortic aneurysm.

Answer: D

Rationale: An increased pulsation at the aortic area might suggest an aortic aneurysm. A thrill would be felt as a vibration. The apical impulse is typically a visible pulsation in the midclavicular line at the left 5<sup>th</sup> intercostal space.

Application; Assessment; Health Promotion and Maintenance

6. A client's radial pulse is palpated simultaneously while auscultating the apical pulse. The radial pulse is felt after the apical pulse is heard. This finding would be considered:

- a. A common finding.
- b. A pulse deficit.
- c. A dysrhythmia.
- d. A murmur.

Answer: B

Rationale: When a palpated radial pulse falls below the auscultated apical pulse, this is a pulse deficit. It can be caused by a weak, ineffective contraction of the left ventricle. It is not common, and is not a rhythm problem or a murmur.

Application; Assessment; Health Promotion and Maintenance

7. When auscultating cardiac sounds, the nurse decided to listen for S1 first. The best location to auscultate this would be at the:

- a. Pulmonary valve.
- b. Aortic valve.
- c. Base.
- d. Apex.

Answer: D

Rationale: The apex of the heart is where S1 is the loudest. The base is the loudest site for S2 sounds. Extra heart sounds should not be heard over the valves during systole or diastole.

Comprehension; Assessment; Health Promotion and Maintenance

8. A murmur has been auscultated on a client during a nursing assessment. The nurse goes back to palpate the area where the murmur was heard. This is done to:

- a. Help diagnose the type of murmur.
- b. Determine any thrill at the site.
- c. Determine how strong the murmur is.
- d. Palpate for an aneurysm.

Answer: B

Rationale: Grade IV, V, and VI murmurs often are accompanied by the palpation of a thrill. The intensity of murmurs is graded from I to VI, with VI being the most significant. A physician will need to diagnose the murmur.

Analysis; Assessment; Health Promotion and Maintenance

9. A lipid profile is ordered for a client with a cardiac disorder. Nursing care would include:

- a. Teaching that no food or fluids except water should be consumed 12 hours prior to the test.
- b. No special preparation is needed.
- c. Caffeine should be avoided for 24 hours prior to the test.
- d. No food or fluids should be consumed 6 hours prior to the test.

Answer: A

Rationale: Fasting for 12 hours (except for water) prior to the test is recommended. No alcohol intake for the 24 hours prior to the test is also recommended. There is no need to avoid caffeine prior to the test.

Application; Implementation; Physiological Integrity

10. Following a pericardiocentesis, the nurse would anticipate which client response?

- a. Increased heart rate
- b. Decreased heart rate
- c. Decreased blood pressure
- d. Increased blood pressure

Correct answer: D

Rationale: During a pericardiocentesis, fluid is removed from the pericardial sac for diagnosis or therapeutic purposes. It also may be done in an emergency during cardiac tamponade. The blood pressure would increase as the pressure on the heart decreases as the fluid is removed. There is not an anticipated response from the heart rate.

Analysis; Evaluation; Physiological Integrity

## CHAPTER 31

1. Health counseling is being provided to a group of employees in a factory. The nurse is discussing coronary heart disease risk factors. Which of the are modifiable risk factors? Select all that apply.

- a. Hypertension
- b. Hormone replacement therapy
- c. Heredity
- d. Diabetes mellitus

Answer: A; B; D

Rationale: A person can make a choice to modify hypertension, diabetes mellitus, and the need for hormone replacement therapy by controlling them through medications, weight control, diet, and exercise. Hereditary effects on coronary heart disease cannot be changed.

Application; Implementation; Health Promotion and Maintenance

2. A client is being evaluated in the office before starting a weight loss program. The program is to be initiated due to abdominal obesity, hypertension, and elevated fasting glucose. The client understands that these are qualities specific to:

- a. Acute coronary syndrome.
- b. Angina.
- c. Metabolic syndrome.
- d. Peripheral vascular disease.

Answer: C

Rationale: Abdominal obesity, abnormal blood lipids, hypertension, elevated fasting blood glucose, clotting tendencies, and inflammatory factors are consistent with metabolic syndrome and increased risk for premature coronary heart disease.

Application; Assessment; Health Promotion and Maintenance

3. A client has a history of myocardial infarctions. The nurse discussing discharge teaching emphasizes the need for the client to stop smoking. The client states “I have been smoking for 35 years already. It won’t make a difference now.” The best response by the nurse would be:

- a. “It will reduce your risk of lung cancer.”
- b. “Your risk of continued coronary heard disease will decrease by half when you stop.”
- c. “It will decrease any complications you might develop.”
- d. “It will enhance the effects of your medications.”

Answer: B

Rationale: Smoking cessation reduces the risk for coronary heart disease by 50% no matter how long the person has smoked. It will reduce lung cancer, decrease complications, and possibly enhance medication effects, but the primary focus for this client is the effect on coronary heart disease.

Analysis; Implementation; Health Promotion and Maintenance

4. After being admitted to an outpatient chest pain unit, a client is told he will need further testing. Which of the following diagnostic tests would the nurse anticipate will be ordered to determine this client's coronary heart disease status?

- a. Stress electrocardiography
- b. Echocardiography
- c. Coronary angiography
- d. Radionucleotide testing

Answer: C

Rationale: The gold standard for evaluating coronary arteries is coronary angiography. Visualization of the arteries is allowed with this method. The other tests may be used, but are not the primary, most direct ones.

Application; Planning; Physiological Integrity

5. Aspirin has been prescribed for a client following a myocardial infarction. Teaching about this should include:

- a. Take at a different time of day than warfarin (Coumadin).
- b. Report any itching after seven days of taking.
- c. Do not skip any scheduled appointments to have blood drawn for labs.
- d. Check with your healthcare provider before taking herbal remedies.

Answer: D

Rationale: Herbal remedies such as evening primrose oil, garlic, gingko biloba, or grapeseed extract can increase the effect of the aspirin. Itching is not a common side effect of aspirin therapy. Aspirin and Coumadin are not to be taken concurrently. No lab appointments will be made just for aspirin therapy.

Application; Implementation; Physiological Integrity

6. Preoperatively, a client is taught that during coronary bypass graft surgery (CABG), the cardiopulmonary bypass pump is used as a response to:

- a. Cardioplegia.
- b. Deep sedation.

- c. Risk of bleeding.
- d. Risk of clotting.

Answer: A

Rationale: Cardioplegia (stopping of the heart) is necessary during the CABG procedure. The bypass pump maintains the perfusion of the rest of the organs during the surgery. Deep sedation and risk of bleeding or clotting are not reasons why the pump is used.

Application; Implementation; Physiological Integrity

7. The nurse is assessing a client who is 6 hours postoperative from coronary artery bypass graft (CABG) surgery. The heart rate is 120, blood pressure is 90/50, urine output is decreased, chest tube output is decreased, heart sounds are muffled, and peripheral pulses are diminished. What action should be taken by the nurse first?

- a. Recheck vital signs in 15 minutes.
- b. Notify the physician immediately.
- c. Reposition the client.
- d. Increase the intravenous fluids.

Answer: B

Rationale: The client is exhibiting signs of cardiac tamponade. This is a medical emergency, and the physician must be notified immediately. Delaying the response by waiting 15 minutes or repositioning the client will be ineffective. No change in intravenous fluids should be made until a physician order is given to do so. Cardiac tamponade is a life-threatening postoperative complication that can lead to cardiogenic shock and possibly cardiac arrest.

Analysis; Implementation; Physiological Integrity

8. After climbing the stairs to her office following lunch, a 33-year-old female experiences epigastric pain, nausea, and shortness of breath. She calls her healthcare provider's office. Which response is the most appropriate for her to follow?

- a. "Wait 30 minutes to see if the complaints subside."
- b. "Make an appointment to have your gallbladder evaluated."
- c. "Take an aspirin and make an appointment for tomorrow."
- d. "Have someone take you to the Emergency Department immediately."

Answer: D

Rationale: Women are more likely than men to have a "silent" or unrecognized heart attack. Early recognition and aggressive treatment are crucial to a successful outcome. Waiting to be evaluated for any length of time could lead to further, permanent damage that could be life-threatening.

Application; Implementation; Physiological Integrity

9. During an office visit, a 55-year-old female client asks why she has not been prescribed a daily dose of aspirin. Her 56-year-old husband has been advised by the physician to take a daily aspirin. What can the nurse explain is the most likely reason for this?

- a. Aspirin is not recommended for women.
- b. This must have been an oversight.
- c. She has other medications that could interfere.
- d. Women are not typically prescribed aspirin therapy before 65 years of age.

Answer: D

Rationale: In women, the benefit of low-dose aspirin in reducing the risk for coronary heart disease is not clear prior to 65 years of age.

Application, Implementation, Health Promotion and Maintenance

10. When in the cardiology office for a follow-up appointment after a myocardial infarction, the client states “My friends tell me to add more garlic to my diet and start drinking red wine each evening.” The nurse’s best response to this comment would be:

- a. “I wouldn’t do that if I were you.”
- b. “Discuss your idea with the physician to see what would benefit you.”
- c. “You should also add ginkgo biloba for cardiovascular health.”
- d. “That sounds fine. See how they work.”

Answer: B

Rationale: Complimentary therapies could be helpful. They should be added only after discussion with a healthcare provider who is familiar with the client’s history and current medication/allergy list. Interactions between herbal preparations and prescribed medications are common. The client has taken an interest in her health and in discussing it with her friends. Ignoring her comment or discouraging her would not be beneficial. The nurse should not add or approve any other complimentary therapies unless directed so by the physician.

Analysis; Implementation; Health Promotion and Maintenance

## CHAPTER 32

1. Which of the following individuals is at the greatest risk for heart failure?

- a. White male
- b. African-American
- c. White female
- d. Asian male

Answer: B

Rationale: African-Americans have a higher prevalence of hypertension. This contributes significantly to their risk and incidence of heart failure.

Assessment: Health Promotion and Maintenance: Application

2. An older adult has been diagnosed with congestive heart failure (CHF). There are many physiological findings associated with CHF. Select all that apply.

- a. Weakness
- b. Dependent edema
- c. Respiratory crackles
- d. Disorientation

Answer: A; B; C; D

Rationale: Any or all of the above findings can be present in CHF. Other presenting signs and symptoms include fatigue, dyspnea, somnolence, confusion, and worsening dementia.

Assessment: Physiological Integrity: Analysis

3. A client diagnosed with left-sided cardiac failure would be most comfortable in which sleeping position?

- a. On her side, with the head of the bed up 30 degrees
- b. In a recliner with 2–3 pillows under her head
- c. On her left side, with the head of the bed up 30 degrees
- d. In a recliner with 2–3 pillow under her feet

Answer: B

Rationale: The client with left-sided cardiac failure could develop orthopnea (difficulty breathing while lying flat). This is a result of the pulmonary congestion and decreased cardiac output. Being in an upright position will ease the work of breathing. Propping the lower legs up while in a sitting position can help decrease dependent edema, but 2–3 pillows are not needed for this for sleep.

Planning: Physiological Integrity: Application

4. During a hospitalization for congestive heart failure (CHF), the client awakens during the night frightened and short of breath. This client most likely is experiencing:

- a. Multisystem heart failure.
- b. Cardiomyopathy.
- c. Paroxysmal nocturnal dyspnea.
- d. High-output failure.

Answer: C

Rationale: Paroxysmal nocturnal dyspnea occurs when edema fluid that has accumulated during the day is reabsorbed into the circulation at night. This causes fluid overload and pulmonary congestion. The client awakens at night short of breath and frightened.

Assessment: Physiological Integrity: Application

5. While in the office for a follow-up appointment, a client with a history of heart failure complains of a dry, persistent cough. Which of the following areas of assessment or review would provide the most information related to the cause of this?

- a. Lab results
- b. Medication list
- c. Vital signs
- d. Surgical history

Answer: B

Rationale: Some medications, especially angiotensin-converting enzyme (ACE) inhibitors, can cause a dry, persistent cough to develop. Clients with heart failure commonly are prescribed ACE inhibitor medications. There are no indications the client's laboratory values would be abnormal. Assessing the client's vital signs is not supported by the data presented. Surgical history would not cause a dry, persistent cough.

Assessment: Physiological Integrity: Analysis

6. A nurse is preparing to administer a client's morning digoxin (Lanoxin). He assesses the apical pulse for one minute. With which value should the nurse choose not to administer the medication?

- a. 72
- b. 68
- c. 54
- d. 70

Answer: C

Rationale: The apical pulse rate must be greater than or equal to 60 beats per minute before digoxin may be administered. The medication can cause the heart rate to slow, so being below 60 would put the client at risk for problems to slow the heart rate even more.

7. BiDil (hydralazine and isosorbide combination) has been prescribed for an African-American male with heart failure. An important teaching point related to this drug will be:

- a. Take the drug with milk or food.
- b. Obtain a home blood pressure monitor to assess for hypertension.
- c. Monthly labs will need to be obtained for monitoring.
- d. Impotence drugs such as Viagra (sildenafil) must be avoided.

Answer: D

Rationale: As BiDil can cause hypotension, it should not be taken with impotence drugs, as this could cause an extreme drop in blood pressure. This could lead to fainting, chest pain, or a heart attack.

Implementation: Health Promotion and Maintenance: Application

8. A client has had a heart transplant. Nursing care will focus on monitoring for which complication in the immediate postoperative period? Select all that apply.

- a. Bleeding
- b. Liver failure
- c. Renal failure
- d. Rejection

Answer: A; D

Rationale: Bleeding is a major concern during the immediate postoperative period. Rejection can develop immediately after a transplant, even though this is a rare occurrence. Liver and renal function would be impacted later in the client's progress.

Implementation: Physiological Integrity: Analysis

9. Which of the following changes noted by the nurse during the morning assessment of a client hospitalized with heart failure would need to be reported to the physician?

- a. Weight gain of two pounds from the previous day
- b. A productive cough of pink, frothy sputum
- c. Temperature of 99.9°F
- d. Nausea

Answer: B

Rationale: When a client with heart failure has excess fluid volume, he might exhibit air hunger, a feeling of panic, tachypnea, severe orthopnea or a productive cough of pink, frothy sputum. Acute pulmonary edema is a medical emergency that can develop rapidly and needs immediate intervention. Fluid retention would warrant further assessment, not an immediate consultation with the physician. The temperature presented is not elevated enough to notify the physician. Nausea is a vague complaint that would require further review by the nurse.

Implementation: Physiological Integrity: Analysis

10. A health promotion factor that will be taught to the client with mitral valve prolapse is:

- a. The need for prophylactic antibiotics prior to dental procedures.
- b. Fluid restriction breakdown for each day.
- c. The need for daily steroids.
- d. The need for yearly cardiac catheterization.

Answer: A

Rationale: Clients with mitral valve prolapse are at risk for infective endocarditis. Prevention of this with prophylactic antibiotics before any dental or invasive procedures will be necessary to decrease this risk. Clients with mitral valve prolapse are typically able to conduct their lives with minimal inconvenience. There is no indication to promote fluid restrictions, steroid therapy, or cardiac catheterization.

Implementation: Health Promotion and Maintenance: Application

## Chapter 32

1. The nurse is aware that which of the following represents the most common red blood cell disorder?
  1. Polycythemia
  2. Hemolysis
  3. Anemia
  4. Erythropoiesis

Answer: 3

Rationale: Anemia is the most common red blood cell disorder, involving a low count and decreased hemoglobin content. Polycythemia is an abnormally high RBC count. Hemolysis represents the process of RBC destruction, while erythropoiesis is the term for RBC production.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Physiological Integrity Reduction of Risk Potential (Laboratory Values)

2. A client has a hematocrit (Hct) of 32%. The nurse interprets this to mean:

1. The blood is very viscous.
2. Bleeding disorders are likely.
3. 32% of the blood is plasma and plasma products.
4. The client has fewer red blood cells than is normal.

Answer: 3

Rationale: Hematocrit represents the percent volume of red cells in whole blood. The normal value is 37–45%. The blood would not be viscous or necessarily contain fewer RBCs. Bleeding disorders are associated with the platelet count.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Physiological Integrity Reduction of Risk Potential (Lab Values)

3. The nurse assesses that a client's pulse pressure is decreasing. Evaluating this would be accomplished by calculating the:

1. Difference between the apical and radial rates.
2. Degree of ventricular contraction in relation to output.
3. Force exerted against an arterial wall.
4. Difference between systolic and diastolic readings.

Answer: 4

Rationale: Pulse pressure is obtained by subtracting the diastolic from the systolic readings after the blood pressure has been recorded. The difference between apical and radial rates is only a partial factor in determining pulse pressure. The degree of ventricular contraction in relation to output is known as pulse deficit. The force exerted against an arterial wall has nothing to do with calculating pulse pressure.

Cognitive Level: Comprehension

Nursing Process: Evaluation

NCLEX: Physiology Adaptation: Pathophysiology

4. Teaching clients with peripheral vascular disease about the effects of smoking is important, since nicotine:

1. Constricts the superficial vessels while dilating the deep vessels.
2. Dilates the peripheral vessels, which causes a reflex constriction of visceral vessels.
3. Dilates the superficial vessels while constricting the collateral circulation.
4. Constricts the peripheral vessels and increases the force of flow.

Answer: 4

Rationale: Constriction of the peripheral blood vessels and the resulting increase in blood pressure impair circulation and limit the amount of oxygen being delivered to body cells, especially in the extremities. Nicotine constricts all peripheral vessels, not just superficial ones, and does not dilate any.

Cognitive Level: Analysis

Nursing Process: Implementation

NCLEX: Health Promotion and Maintenance

5. Postoperative clients should have pedal pulses assessed by the nurse every shift. The important characteristics of pedal pulses are:

1. Contractility and rate.
2. Color of skin and rhythm.
3. Amplitude and symmetry.
4. Local temperature and visible pulsations.

Answer: 3

Rationale: Assessment of the pedal pulse should include strength (rated 0–4+), along with noting whether the circulation is equal in both extremities by comparing the symmetry of the pulses. Contractility and rate would be characteristics of the heart. Color and rhythm relate to assessing radial and apical pulses. Local skin temperature and visible pulsations are not measured with pedal pulses.

Cognitive Level: Application

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

6. A client with a BP of 128/84 would be classified as having:

1. Normal blood pressure.
2. Prehypertension.
3. Stage I hypertension.
4. Stage II hypertension.

Answer: 2

Rationale: The classification for blood pressure in adults is as follows:

Normal is less than or equal to 120 mm Hg over less than or equal to 80 mm Hg.

Prehypertension is 120–139 mm Hg systolic and 80–90 mm Hg diastolic. Stage I hypertension is considered 140–159 mm Hg systolic and 90–99 diastolic, with stage II systolic reading greater than or equal to 160 mm Hg and diastolic greater than or equal to 100 mm Hg.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

7. While performing a physical assessment, the nurse hears a blowing, murmur-type sound over one of the client's carotid arteries. What should the nurse do next?

1. Count the apical heart rate for one full minute.
2. Have another nurse to listen to validate the finding.
3. Ask the client about history of heart disease.

4. Contact the client's health provider to report the finding.

Answer: 3

Rationale: The nurse has likely heard a bruit over the carotid artery, which indicates narrowing of the vessel, most commonly related to atherosclerosis. Therefore, further assessment through asking about heart disease is warranted. The apical rate can be regular despite the finding. All assessment data should be collected before asking another caregiver to validate the finding or contacting the health provider.

Cognitive Level: Application

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

8. A client develops thrombophlebitis postoperatively. The sign that would be present to the nurse would be:

1. Intermittent claudication.
2. Severe pain with extending the extremity.
3. Localized warmth and tenderness of the extremity.
4. Pitting edema of the lower extremities.

Answer: 3

Rationale: Thrombophlebitis, or deep vein thrombosis, is inflammation of a vein that occurs with formation of a clot. Signs include pain, redness, warmth, tenderness, and edema to the area. Intermittent claudication is pain when walking due to tissue ischemia associated with peripheral vascular disease. Pain occurs with flexion of the foot, also known as Homans' sign. Swelling to the area is common, but pitting edema isn't a classic sign.

Cognitive Level: Analysis

Nursing Process: Evaluation

NCLEX: Physiologic Integrity

9. A nurse would perform which of the following to detect varicose veins in a client?

1. Trendelenburg test
2. Arteriography
3. Romberg test
4. Babinski test

Answer: 1

Rationale: The Trendelenburg test evaluates the backflow of blood through defective valves. After raising the legs to empty the veins, the client stands, and if the veins fill from above the site of suspected varicosity, the diagnosis is positive. A nurse cannot perform an arteriogram. The Babinski test is used to determine injury of the pyramidal tract in adults through firmly stroking the lateral aspect of the sole of the foot. The Romberg test assesses for position sense; the client loses balance when standing erect with feet together and eyes closed.

Cognitive Level: Application

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

10. Choose the priority nursing diagnosis for a client with a platelet count of 24,000:

1. Gas Exchange, Impaired
2. Fatigue
3. Injury, Risk for
4. Infection, Risk for

Answer: 3

Rationale: The normal platelet count is 150,000–400,000. Therefore a report of 24,000 would put the client at risk for injury related to bleeding. Impaired gas exchange might be applicable for low hemoglobin. Fatigue would be expected with a low red blood count, and an elevated white blood count would put the client at risk for infection.

Cognitive Level: Analysis

Nursing Process: Nursing Diagnosis

NCLEX: Physiological Integrity: Reduction of Risk Potential

## Chapter 34

1. What actions should the nurse anticipate taking first when a young female's lab findings come back with microcytic and hypochromic red blood cells (RBCs)?
  1. Place the client on 'nothing by mouth' (n.p.o.) status in anticipation of emergency surgery due to an acute hemorrhagic event.
  2. Start an IV for replacement fluids, such as D5W or D5NS.
  3. Consult with the dietitian to develop a diet that is high in iron products.
  4. Assess the past history further for previous risks of bleeding or menstrual changes.

Answer: 4

The nurse should do additional health history assessment to identify the source of chronic bleeding. Questions related to length and amount of menstrual flow, color of stools, and any upper gastric bleeding/conditions that might be contributing to the potential bleeding should be asked before any other actions are taken. Emergency surgery is not the first action, since microcytic and hypochromic RBCs reflect a chronic bleeding condition and not an acute one. An acute bleeding condition would have normocytic cells in fewer numbers in relationship to the length of the acute bleeding episode. Fluid replacement alone with D5W or D5NS would not address the decreased ability of the body to carry oxygen, since the ability of the RBC to carry oxygen is dependent on the hemoglobin, which requires iron to be present. The microcytic (small) and hypochromic (pale) descriptors of RBCs reflect the decreased amount of hemoglobin present in the cell that occurs with a chronic bleeding condition, which depletes the iron storage in the body. Although a dietitian might be called in to assist the client in understanding which foods are high in iron, this would not be the first action for the nurse. Further assessment is needed to identify the cause, since this is not an emergency condition.

Bloom's: Analysis

Nursing Process: Interventions

Client Needs: Physiological Integrity: Physiological Adaptation

2. A client's lab shows larger, oval-shaped, macrocytic red blood cells (RBCs) with thin membranes present. In addition, the client is complaining of paresthesia and proprioception. Which therapy would the nurse expect to be included in the discharge plan?
1. A diet higher in green, leafy vegetables; broccoli; wheat germ; and asparagus
  2. A daily multivitamin with extra iron
  3. Instructions about subcutaneous injections of erythropoietin for a few weeks
  4. Instructions about intramuscular parenteral injections of B<sub>12</sub> (Anacobin) or Cyanocobalamin for the rest of her life

Answer: 4

The macrocytic and oval-shaped RBCs with thin membranes are caused by B<sub>12</sub> deficiency, typically because the gastrointestinal (GI) tract is permanently unable to make the intrinsic factor that is needed to absorb the B<sub>12</sub> from foods. Therefore, an alternate absorption method (intramuscular) is needed for the body to be able to absorb the B<sub>12</sub> while bypassing the GI tract. Thus, the intramuscular treatments are lifelong. Green, leafy vegetables; broccoli; wheat germ; and asparagus are foods high in folic acid but not high in B<sub>12</sub>. Larger macrocytic and oval-shaped RBCs with thin membranes, paresthesia, and proprioception are symptoms of a deficiency of B<sub>12</sub>, which is needed for DNA synthesis and normal maturation of RBCs. Paresthesia (altered sensations, such as numbness or tingling) and proprioception (the sense of one's position in space) are a result of damage of spinal cord and central nervous system from the decrease in B<sub>12</sub> elements. Iron deficiency will result in microcytic and hypochromic RBCs, not oval-shaped macrocytic RBCs with thin membranes, which are related to a B<sub>12</sub> deficiency. Therefore, extra iron and vitamins will not correct the symptoms.

Erythropoietin stimulates new RBC production by the bone marrow, but if B<sub>12</sub> is not present in the body to manufacture the DNA, the RBCs will not have the shape or size of normal RBCs.

Bloom's: Analysis

Nursing Process: Planning

Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

3. A client is admitted with the diagnosis of sickle-cell crisis. Which of these tasks would the nurse perform first based upon the following clinical findings: temperature 102°F, O<sub>2</sub> saturation of 89%, and complaints of severe abdominal pain?

1. Give Tylenol (acetaminophen) grains X (650 mg).
2. Apply oxygen per nasal cannula @ 3L/minute.
3. Administer morphine sulfate grain ¼ intramuscular.
4. Assess and document peripheral pulses.

Answer: 2

Hypoxia is often the cause of sickling crisis from the clumping of damaged RBCs, which creates an obstruction and hypoxia distal to the clumping. Administering the

oxygen will improve the pain and increase the oxygen saturation of body tissues. Therefore, applying the oxygen should be the first action by the nurse. Although the temperature is elevated, and will increase oxygen demands in the body by increased basal metabolic activity, this is not the first action the nurse should take, because sickling crisis is caused by oxygen deprivation in tissues, not by the fever. Morphine sulfate is a narcotic for pain, but it should be given after the oxygen is started, since the symptoms are caused by hypoxia. The morphine will decrease the pain and decrease metabolic oxygen needs by decreasing basal metabolic rates; therefore, supply is increased and demand is

increased. Full body assessment, including peripheral pulses, is significant to identify the location of the potential obstruction, but this is secondary to treating the hypoxia that is known to be present from the sickling of the cells during sickle-cell crisis.

Bloom's: Application

Nursing Process: Intervention

Client Need: Physiological Integrity: Physiological Adaptation

4. After several doses of chemotherapy, a client complains of fatigue, pallor, progressive weakness, exertional dyspnea, headache, and tachycardia. Which NANDA nursing diagnosis would the nurse list as the first priority?
1. Nutrition, imbalanced: less than body requirements
  2. Activity Intolerance
  3. Powerlessness
  4. Coping, Ineffective

Answer: 2

The symptoms (fatigue, pallor, progressive weakness, exertional dyspnea, headache, and tachycardia) are caused by aplastic anemia from bone marrow suppression, which is a side effect of the chemotherapy drugs. Decreased red blood cells cause less oxygen to be delivered to body tissues, resulting in tissue hypoxia. Tachycardia is a compensation mechanism to speed up the delivery of oxygen that is available in the fewer number of cells that are present. Tissue hypoxia will result in muscle fatigue, and the symptoms that are related to aplastic anemia will decrease endurance and ability to perform activities. Thus, this NANDA diagnosis should be the first priority. Nutrition or iron deficiency is not the cause of the symptoms, which are related to tissue hypoxia. Powerlessness is the lack of control over current situations, but this is not the client's current problem. Her needs/symptoms are physical, and according to Maslow's theory must be met prior to emotional needs. Although the client might be having coping issues, the physical symptoms are her greatest complaints; therefore, coping is not the top priority in planning her care. Again, physiological needs must be met prior to self-actualization needs.

Bloom's: Analysis

Nursing Process: Planning

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

5. When evaluating a client's understanding about dietary needs following a dietary consult that covered home management of dietary deficiency anemia, which statement by the client would indicate a need for additional teaching?
1. "I will eat more fruits, vegetables, especially green, leafy ones, to get more B<sub>12</sub> in my diet."
  2. "I will take vitamins with extra iron in addition to eating a balanced diet with meat to correct my anemia."
  3. "I will add food high in vitamin C to improve my absorption of iron in both my vitamins."
  4. "I will need to include more protein foods in my diet such as meats, dried beans, and whole-grain breads."

Answer: 2

The problem is that the client has made a statement that is incorrect, and additional teaching or clarification of what was taught for accurate understanding by the client is needed from the nurse. "*I will eat more fruits, vegetables, especially green, leafy ones, to get more B<sub>12</sub> in my diet*" is incorrect, and does need additional teaching for better home management: Adding B<sub>12</sub> to the diet (more fruits and vegetables, especially green, leafy ones) will not correct the dietary deficiency anemia. The lack of iron is the problem that needs to be addressed. "*I will take vitamins with extra iron in addition to eating a balanced diet with meat to correct my anemia*" is correct, and does not require additional teaching. Extra iron is needed to help replace RBCs and treat the dietary deficiency anemia. "*I will add food high in vitamin C to improve my absorption of iron in both my vitamins*" is correct, and does not require additional teaching. Vitamin C will increase the absorption of iron and help the body replace RBCs from dietary deficiency anemia. "*I will need to include more protein foods in my diet such as meats, dried beans, and whole-grain breads*" is correct, and does not require additional teaching. Protein foods such as meats, dried beans, and whole-grain breads do contain iron that will help dietary deficiency anemia.

Bloom's: Application

Nursing Process: Evaluation

Client Needs: Health Promotion and Maintenance

6. When assessing a client for acute myeloid leukemia (AML), the nurse would include which action in the plan of care to minimize the risk of complications?
1. Extra precautions when "handling" the client and "strict hand hygiene"
  2. Additional nutrition spaced frequently throughout the day to increase caloric intake
  3. Restriction of fluids and salts to decrease edema

4. Regulation of the thermostat for a cooler environment

Answer: 1

AML results in neutropenia (decreased neutrophils = risk of infection) and thrombocytopenia (decreased platelets which leads to increased risk of bleeding). Therefore, actions to minimize these risks include caution when moving or assisting the client to move, as well as strict hand hygiene to prevent possible cross-contamination. Weight loss is a symptom of chronic myeloid leukemia (CML), not AML. Therefore, dietary needs are not increased with AML. Restriction of fluids and salt are not needed. The client with AML does not have a problem with fluid shifts or edema that would require these restrictions. Fluids are encouraged to remove wastes that occur with chemotherapy treatment and cellular breakdown. Heat intolerance is a symptom of CML, not AML. CML has heat intolerance due to hypermetabolism state present with the condition.

Bloom's: Application

Nursing Process: Planning

Client Needs: Safe, Effective Care Environment: Safety and Infection Control

7. A client who has just been diagnosed with chronic myeloid leukemia (CML) is discussing anticipatory grieving. Which action by the nurse would be inappropriate at this time?

1. Establish open communication and encourage sharing of feelings to discuss grieving.
2. Make referrals for support or bereavement groups.
3. Identify role changes and family stress management strategies.
4. Encourage the client to get affairs “in order” now to avoid waiting until it is too late.

Answer: 4

Anticipatory grieving is identifying emotional losses or potential losses such as function, independence, appearance, friends, self-esteem, and self prior to actual events related to death. The question is asking which topic is not to be addressed at this time, since the client was just diagnosed with CML. Encouraging the client to get affairs “in order” now to avoid waiting until it is too late is not appropriate at this time: Although this topic is helpful to prepare for the actual death, this is not the time because this removes all hope. Once the client has expressed a concern about getting affairs “in order,” the nurse can offer additional information or resources that are available. Establishing open communication and encourage sharing of feelings to discuss grieving is appropriate at this time: The nurse should establish a rapport and use therapeutic communication to allow the client to express feelings and emotions about the new diagnosis of CML. Making referrals for support or bereavement groups is appropriate at this time: Offering information and resources about agencies that deal with grieving is an option to show the

client that she is not alone and agencies are out there to assist when the need is felt or when the client is ready to use them. In addition, this helps the client understand that anticipatory grieving is a normal process that occurs. Identifying role changes and family stress management strategies is appropriate at this time: Exploring possible role changes, stressors, and strategies associated with the disease progression will give the client a realistic approach to understanding the disease process and its consequences. This also helps the client begin to share with the family to build a foundation for mutual understanding and trust.

Bloom's: Application

Nursing Process: Planning

Client Needs: Psychosocial Integrity

8. When assessing a client with malignant lymphoma, which understanding by the nurse would be correct when trying to identify related symptoms?

1. Hodgkin's has multiple nodes, including mesentery involvement.
2. Non-Hodgkin's pattern of spread is diffuse and unpredictable.
3. Hodgkin's has early extranodal involvement.
4. No weight loss is noted in non-Hodgkin's.

Answer: 2

Non-Hodgkin's lymphomas do spread diffusely and in an unpredictable manner. Therefore, assessment should include a whole body assessment for node involvement. Both sides of the body (left and right) and both body spheres (upper and lower planes) could have symptoms present upon assessment. A Hodgkin's lymphoma is localized in one node or down a single chain with lymphadenopathy, and rarely has extranodal involvement. Therefore, additional assessment beyond the original area of complaint would not be required. Weight loss is extensive with non-Hodgkin's lymphomas and not generally a factor in Hodgkin's lymphomas. Therefore, a history of weight loss would be assessed, but weight loss would not be expected with Hodgkin's lymphomas.

Bloom's: Application

Nursing Process: Assessment

Client Need: Physiological Integrity: Physiological Adaptation

9. When a client has a bleeding tendency, such as with heparin-induced thrombocytopenia or hemophilia, which nursing action would be most appropriate?

1. Avoid invasive procedures, such as rectal temperatures, urinary catheterizations, and parenteral injections.
2. Apply pressure to puncture sites for 3–5 minutes for arterial blood gases aspiration.
3. Give enemas to avoid straining when having a bowel movement.

4. Encourage client to brush teeth thoroughly and rinse with alcohol-based mouthwash after each meal.

Answer: 1

With bleeding disorders, any trauma carries the risk of extensive bleeding from platelet agglutination, which results in prolonged bleeding due to removal of platelets by phagocytosis. Arterial puncture sites require holding from 15 to 20 minutes, and venous punctures require 3–5 minutes to make sure a clot has formed in the client who has a prolonged clotting time, such as the heparin-induced thrombocytopenia or hemophilia clients. An enema is an invasive procedure, and the risk of bleeding from trauma is increased. Therefore, the client should be given stool softeners to avoid straining during a bowel movement, but not enemas when there is an increased risk of bleeding present. Brisk toothbrushing and alcohol-based mouthwash are too strong, and can lead to bleeding of the gums; therefore, neither is recommended in the client with a tendency to bleeding.

Bloom's: Application

Nursing Process: Intervention

Client Need: Physiological Integrity: Reduction of Risk Potential

10. According to evidence-based practice for clients undergoing stem cell transplants, which NANDA nursing diagnoses would be appropriate? Select all that apply.

1. Coping, Ineffective
2. Fatigue
3. Family Processes, Interrupted
4. Infection Risk for
5. Fluid Imbalance, Excess

Answer: 1; 2; 3; 4

Due to the long-term commitment (6–8 weeks) in isolation and the uncertainty of treatment's outcomes, coping mechanisms often become ineffective due to the variety of physical, mental, and financial issues that are faced during this life-threatening process. Role strain, depression, pain, loss of independence, and severe fatigue all contribute to difficulties in coping. Fatigue occurs with stem cell transplants from the complete bone marrow suppression, which causes anemia and decreased RBC to carry the oxygen needed for cellular functioning. Emotional stressors also create a fatigue while dealing with the entire treatment process. Major depression is not uncommon post-transplant. Family commitment and role changes are needed while hospitalized, since strict isolation occurs during the transplant treatment process. Children might not be allowed to visit, causing further separation by family members. Job roles (family dynamics) might be changed during hospitalization and recovery. Prior to transplant with stem cells, the client receives total body chemotherapy, causing bone marrow suppression. Therefore, the WBCs are depleted prior to the transplant, and the ability to fight off an infection is decreased significantly, creating the need for strict isolation for the client. With chemotherapy, there often is a tendency for nausea and vomiting, leading to fluid loss and

not fluid retention. Therefore, the client is more likely to have a “deficit” rather than an “excess” when receiving stem cell transplants. Steroid treatment can cause a fluid shift, but usually not an “excess fluid balance.”

Bloom's: Application

Nursing Process: Planning

Client Need: Safe, Effective Care Environment: Management of Care

## Chapter 35

1. The clinic nurse plans a program for clients newly diagnosed with hypertension entitled “Lifestyle Modifications for Hypertension.” Which of the following points are included in this presentation?
  - a. Avoid milk, eggs, and cheese.
  - b. Engage in daily aerobic exercise.
  - c. Maintain a potassium-restricted diet.
  - d. Use weight training to lose weight.

Answer: b

*Engage in daily aerobic exercise* is correct because this activity has multiple benefits for clients with hypertension, including reducing blood pressure, contributing to weight loss, and increasing sense of well-being. *Avoid milk, eggs, and cheese* and *Maintain potassium-restricted diet* are both incorrect because the recommended diet for hypertension, the DASH diet, recommends the use of nonfat/low-fat dairy products (2–3 servings a day) as well as increased fruits and vegetables (4–5 servings of each per day), which are high in potassium. *Use weight training to lose weight* is incorrect because isometric exercise is not recommended due to the fact that it can raise systolic blood pressure.

Cognitive Level: Analysis.

Nursing Process: Planning.

Category of Client Need: Health Promotion and Maintenance.

2. A client admitted to the medical–surgical unit for uncontrolled hypertension has a history of chronic obstructive pulmonary disease (COPD) as well as asthma. Which of the following medications ordered by the physician does the nurse question because of the client’s pulmonary problems?
  - a. Amlodipine (Norvasc)
  - b. Captopril (Capoten)
  - c. Hydrochlorothiazide (HydroDiuril)
  - d. Propranolol (Inderal)

Answer: d

*Propranolol (Inderal)* is correct because this beta blocker antihypertensive medication is contraindicated when the client has COPD and/or asthma related to the fact that it will cause bronchial constriction and therefore increase lung problems. *Amlodipine (Norvasc)*, *captopril (Capoten)*, and *hydrochlorothiazide (HydroDiuril)* are incorrect because these antihypertensive medications are not beta blockers, and therefore are allowed for this client.

Cognitive Level: Analysis.

Nursing Process: Planning.

Category of Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies.

3. The nursing diagnosis *Noncompliance related to unknown factors* is established for a client with hypertension who admits to taking his antihypertensive medications only occasionally. The most therapeutic nursing attitude when talking with this client about the reasons for his noncompliance is:
  - a. Confrontational.
  - b. Directive.
  - c. Indifferent.
  - d. Non-judgmental.

Answer: d

*Non-judgmental* is correct because the nurse who listens to the client openly and non-judgmentally will both validate the client's self-esteem and communicate the idea of partnership in the treatment plan for the client. a. *Confrontational* is incorrect because the client is not likely to respond positively to the nurse who confronts regarding why he is noncompliant. *Directive* is incorrect because when the nurse tells the client what to do without listening non-judgmentally to the problems encountered when taking medications, the client is not likely change his behavior. *Indifferent* is incorrect because the nurse who communicates indifference is communicating non-caring, and this will decrease the client's sense of self-esteem.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Psychological Integrity

4. A client with an abdominal aortic aneurysm is admitted to the medical–surgical unit prior to the scheduled surgery for repair. Which of the following nursing implementations is most important to reduce the risk of the aneurysm rupturing?
  - a. Allow the client to rest in a chair for 20 minutes at a time.
  - b. Encourage the client to cough and deep-breathe hourly.
  - c. Elevate the client's legs on one pillow when in bed.
  - d. Instruct the client to avoid holding her breath when moving.

Answer: d

*Instruct the client to avoid holding her breath when moving* is correct because holding her breath when moving promotes Valsalva's maneuver, which will increase blood pressure and therefore the risk of rupturing the aneurysm. *Allow the client to rest in a chair for 20 minutes at a time and elevate the client's legs on one pillow when in bed* are both incorrect because the client needs to be on strict bedrest with legs flat in order to prevent constriction of peripheral blood flow and then increased pressure in the aorta, which can lead to rupture. *Encourage the client to cough and deep-breathe hourly* is incorrect because, although deep-breathing is acceptable, coughing will increase abdominal pressure and can therefore increase the risk of rupture.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

5. The nurse on the medical–surgical unit performs an admission assessment for the client with arterial peripheral vascular disease and asks the client which of the following questions in order to determine whether the client has intermittent claudication?
  - a. “Do you get pain in your calves or thighs with activity?”
  - b. “Do you feel burning sensations in your legs at night?”
  - c. “Do you notice any paleness in your legs when you elevate them?”
  - d. “Do you have any numbness or tingling sensations in your legs?”

Answer: a

“*Do you get pain in your calves or thighs with activity?*” is correct because this is the classic sign of arterial peripheral vascular disease called intermittent claudication. “*Do you feel burning sensations in your legs at night?*” is incorrect because this question will determine if the client has rest pain, also characteristic of PVD. “*Do you notice any paleness in your legs when you elevate them?*” is incorrect because this question will help determine if the client has pallor when elevating legs, which indicates decreased arterial blood supply to the periphery. “*Do you have any numbness or tingling sensations in your legs?*” is incorrect because this question will elicit information regarding paresthesia, also a symptom of PVD.

Cognitive Level: Application

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

6. The nursing diagnosis of: *Tissue Perfusion, Ineffective, Peripheral related to decreased arterial flow to extremities* is established. Which of the following measures does the nurse teach the client in order to improve blood flow?
  - a. Cross the legs at the knees when seated.
  - b. Elevate the feet while reclining.

- c. Position with the extremities dependent.
- d. Use a heating pad to increase warmth.

Answer: c

*Position with the extremities dependent* is correct because gravity promotes arterial flow to the dependent extremity, increasing tissue perfusion. *Cross the legs at the knees when seated* is incorrect because this position compresses partially obstructed arteries and impairs blood flow. *Elevate the feet while reclining* is incorrect because elevating the feet is working against gravity, and will further impede blood flow. *Use a heating pad to increase warmth* is incorrect because external heating devices should be avoided to decrease risk of burns in a client with impaired circulation, and therefore decreased sensation.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

7. Which of the following is most essential for the nurse to recommend to the client who has been newly diagnosed with thromboangiitis obliterans (Raynaud's disease)?
  - a. Avoid alcohol.
  - b. Buy shoes in the morning.
  - c. Walk in bare feet when indoors.
  - d. Stop smoking.

Answer: d

*Stop smoking* is correct because if the client smokes, the attacks of this disease become more frequent and intense, and increase the risk for ulceration and gangrene to the extremities. *Avoid alcohol* is incorrect because, although moderation in alcohol use is always recommended as a general health measure, there are no specific data indicating that alcohol must be avoided with this disorder. *Buy shoes in the morning* is incorrect because the time when the foot is most swollen is the afternoon, and this is when shoes should be purchased in order to avoid buying tight shoes that can compromise circulation in a client who already has circulation problems to the extremities. *Walk in bare feet when indoors* is incorrect because the client with this disease should not go barefoot due to the fact that this can increase risk for foot injury, and therefore ulceration and infection.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

8. Which of the following clients does the nurse identify as having the greatest risk for deep venous thrombosis?

- a. The client admitted with new-onset type II diabetes mellitus.
- b. The client admitted with community-acquired pneumonia.
- c. The postoperative client following knee replacement surgery.
- d. The postoperative client following laparoscopic gallbladder surgery.

Answer: c

*The postoperative client following knee replacement surgery* is correct because deep venous thrombosis develops in more than 50% of clients having orthopedic surgery related to the nature of the surgery itself as well as the prolonged immobility occurring after surgery. *The client admitted with new-onset type II diabetes mellitus, the client admitted with community-acquired pneumonia, and the postoperative client following laparoscopic gallbladder surgery* are all incorrect because none of these clients has prolonged immobility, and therefore they are not at the greatest risk.

Cognitive Level: Analysis

Nursing Process: Assessment

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

9. A client being treated for deep venous thrombosis by intravenous heparin therapy puts the call light on and complains to the nurse about having severe chest pain and shortness of breath. The nurse suspects pulmonary embolism, and therefore does which of the following actions first?
- a. Increases the rate of heparin infusion.
  - b. Initiates oxygen and elevates the head of the bed.
  - c. Reassures the client and calls family members.
  - d. Takes pulse, respirations, and blood pressure.

Answer: b

*Initiates oxygen and elevates the head of the bed* is correct because these actions will promote ventilation and gas exchange in those alveoli that are well perfused, helping maintain tissue oxygenation. *Increases the rate of heparin infusion* is incorrect because the situation does not provide any information on the client's aPTT level, nor does it provide any information on the physician's order regarding regulating the infusion according to the aPTT level. *Reassures the client and calls family members* is incorrect because although these measures are designed to decrease the client's anxiety, the priority is to begin oxygen therapy and elevate the head of the bed to increase oxygenation to the tissues. *Takes pulse, respiration, and blood pressure* is incorrect because these actions will be performed following the initiation of oxygen therapy and bed elevation.

Cognitive Level: Application

Nursing Process: Implementation

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

10. The home health nurse teaches the client with chronic lymphedema of the left arm secondary to treatment for breast cancer the importance of removing the intermittent pressure device used for the affected arm at least every eight hours. The best rationale for this teaching measure is because this device does which of the following?
- Causes pain in the affected extremity, and when removed periodically, client comfort is promoted.
  - Compresses small vessels, and without periodic removal, tissues nourished by these vessels can break down. \*\*\*
  - Exerts continuous pressure, and can cause a rebound effect and lead to more lymphatic fluid if not interrupted.
  - Moves edema from the distal to proximal area of the arm, and periodic removal will increase effectiveness of treatment.

Answer: b

*Compresses small vessels, and without periodic removal, tissues nourished by these vessels can break down* is correct because this device will compromise small vessel circulation, and unless periodically removed, tissues will receive less oxygen and therefore are prone to breakdown. *Causes pain in the affected extremity, and when removed periodically, client comfort is promoted* is incorrect because use of the compression device itself will promote comfort due to movement of edematous fluids from tissues into vessels. *Exerts continuous pressure, and can cause a rebound effect and lead to more lymphatic fluid if not interrupted* is incorrect because this statement is untrue; there is not a rebound effect from tissue compression itself. *Moves edema from distal to proximal area of the arm, and periodic removal will increase effectiveness of treatment* is incorrect because although the movement of edema does flow from distal to proximal, the periodic removal is for the purpose of nourishing tissues fed by small vessels that are compressed when the device is left on continuously.

Cognitive Level: Analysis

Nursing Process: Application

Category of Client Need: Physiological Integrity: Reduction of Risk Potential

## CHAPTER 36

1. When preparing a client for a pulmonary function test, the nurse will inform the client:

- a. "You will be sedated for the test."
- b. "We will give you anti-nausea medication prior to the test."
- c. "You will wear a nose clip during the test."
- d. "You might need oxygen for a while after the test."

Answer: C

Rationale: A nose clip is placed on a non-sedated client during the pulmonary function testing. Nausea is not a common issue with the tests. Oxygen is typically not needed after the test.

Implementation: Physiological Integrity: Application

2. Older clients can be at risk for problems related to the volume of air remaining in the lungs. One reason for this might be:

- a. Elasticity of lungs decreases with age.
- b. Older adults have a more rapid respiratory rate.
- c. There is a tightening of the diaphragm with age.
- d. Intercostal muscles become weaker with age.

Answer: D

Rationale: As a person ages, the intercostal muscles become weak. This reduces the movement of the chest wall. Elasticity of the diaphragm, not necessarily of the lungs, is lost, and the diaphragm flattens, or tightens. The respiratory rate of well older adults slows, not increases, with age.

Assessment: Health Promotion and Maintenance: Application

3. A client has lost a moderate amount of blood following a motor vehicle accident. The nurse applies oxygen upon the client's arrival to the Emergency Department. The primary reason for this is:

- a. To ease the work of breathing.
- b. To compensate for the reduction in circulating oxygen.
- c. As a comfort measure.
- d. To prevent shock.

Answer: B

Rationale: As blood volume is lost, hemoglobin is lost. Oxygen is carried from the respiratory system to the cells by hemoglobin in the blood. Breathing might be easier, the client might be more comfortable, and the risk of shock might be decreased through the oxygen administration, but these are additional benefits, and not the primary reason.

Implementation: Physiological Integrity: Analysis

4. After a fall from a 10-foot platform, a client is diagnosed with multiple fractured ribs. The nurse anticipates that a major potential problem might be:

- a. Decreased lung expansion.
- b. Increased respiratory rate.
- c. Prolonged expiratory phase.
- d. Low arterial carbon dioxide level.

Answer: A

Rationale: Due to the rib fractures, it might be difficult for the client to have full rib cage expansion related to the pain. The respiratory rate might tend to be slower and more shallow than usual. As a result, the carbon dioxide would be high instead of low. The expiratory phase might be shortened due to the pain.

Planning: Physiological Integrity: Analysis

5. A client has been admitted with probable emphysema. Diagnostic tests have been ordered. Which of the tests will provide the most accurate indicator of the client's acid-base balance?

- a. Bronchoscopy
- b. Sputum studies
- c. Pulse oximetry
- d. Arterial blood gases (ABGs)

Answer: D

Rationale: ABGs are done to assess alterations in acid-base balance caused by respiratory disorders, metabolic disorders, or both. A bronchoscopy provides visualization of internal respiratory structures. Sputum studies can provide specific information about bacterial organisms. Pulse oximetry is a noninvasive test that evaluates the oxygen saturation level of blood.

Evaluation: Physiological Integrity: Application

6. While preparing a client for a bronchoscopy, the nurse checks the suction equipment in the room. The primary reason for this is:

- a. There is a high risk of a reaction to medications used for sedation.
- b. Laryngospasm and respiratory distress could follow this test.
- c. Equipment should always be checked prior to a test.
- d. Pulmonary emboli is a complication following this test.

Answer: B

Rationale: Anesthetics given for the procedure might suppress the cough and gag reflexes. Secretions might be difficult for the client to expectorate without assistance. If the secretions are not removed, respiratory distress can occur. The suction equipment would be used to remove the secretions, so it must be ready to go before the procedure even starts. A potential reaction to medications used for anesthesia or sedation would be assessed prior to the test. It is ideal to check all equipment prior to a test, but this is not the most specific answer for this situation. Pulmonary emboli development is not a commonly anticipated complication of a bronchoscopy.

Planning: Physiological Integrity: Analysis

7. Nursing care following a bronchoscopy would include: (Select all that apply.)

- a. Instruct the client to avoid eating and drinking for two hours after the test.
- b. Report dark blood-tinged respiratory secretions to the physician.
- c. Instruct the client that a mild fever 24 hours following the test is expected.
- d. Administer pain medications immediately following the procedure.

Answer: A; C

Rationale: A client should not eat or drink for approximately two hours after a bronchoscopy, or until he is fully awake with an intact cough and gag reflex. Eating or drinking sooner can increase the risk of aspiration. A mild fever is common 24 hours following the procedure. Dark-tinged blood, especially if biopsies were collected, is common after the procedure. The presence of grossly bloody sputum could indicate a perforation, and would be reported to the physician. There is commonly minimal discomfort following this procedure, so an immediate administration of pain medication would not be indicated.

Implementation: Physiological Integrity: Analysis

8. The client asks the nurse why she is undergoing a positron emission tomography (PET) scan instead of a computed tomography (CT) scan. The nurse was present in the room when the physician discussed the test. What is the best response by the nurse?

- a. "Your doctor prefers to order PET scans."
- b. "Why are you concerned about this test?"
- c. "PET scans have less radiation than CT scans."
- d. "You will still need a CT scan also."

Answer: C

Rationale: There is a great difference between the amount of radiation in a PET scan and in a CT scan. A PET scan is used more specifically to identify lung cancers. Making a personal reference to the physician is not professional. The client did not express concern about the test merely by asking the question. A CT scan would not typically be indicated in addition to or following a PET scan.

Implementation: Safe, Effective Care Environment: Application

9. The nurse is educating a client on sputum collection. When would the greatest chance be for the specimen to be collected?

- a. After a meal
- b. Upon awakening from a nap
- c. Before a meal
- d. Upon awakening in the morning

Answer: D

Rationale: There is the greatest opportunity to obtain a sputum specimen in the morning. Respiratory secretions pool more during sleep. Clients with respiratory illness cough more when awakening, so sputum collection would be best before daily activities are

initiated. There might not be the same opportunity after a nap due to the shortened time frame. Before a meal would not produce the same results, and can tire a client. Collecting a specimen after a meal would not produce a specimen, and could induce vomiting.

Planning: Physiological Integrity: Application

10. What factors related to aging can predispose an older adult to pneumonia? Select all that apply.

- a. Slower respiratory rate
- b. Less effective cough
- c. Immobility
- d. Increased pain response

Answer: B; C

Rationale: Skeletal muscle strength is lost in the thorax and diaphragm with aging. This contributes to a less effective cough and the ability to remove respiratory secretions. The secretions can pool in the lungs if the client is not mobile, providing an environment for pneumonia to develop. Respiratory rate does not contribute to the risk of pneumonia. It is a myth that older adults have an increased pain response, and this would not directly contribute to the development of pneumonia.

Assessment: Health Promotion and Maintenance: Analysis

## CHAPTER 37

1. A review of a client's medication list is an important part of an assessment prior to any addition of new medications. A client has been advised to take an over-the-counter decongestant. Which other class of medications that the client is currently taking would possibly contraindicate the use of a decongestant?

- a. Nonsteroidal anti-inflammatory drug (NSAID)
- b. Anticoagulant
- c. Antihypertensive

d. Antihistamine

Answer: C

Rationale: If the client has hypertension and is on an antihypertension drug, the use of a decongestant might be contraindicated. Decongestants stimulate the sympathetic nervous system. This increases the peripheral vascular resistance, blood pressure, and pulse. The use of NSAIDs, anticoagulants, or antihistamines is not considered a contraindication. Antihistamines are frequently combined with decongestants.

Assessment: Physiological Integrity: Analysis

2. An older adult is hospitalized with a respiratory illness. Labs are drawn and a chest x-ray is completed. The white blood cell (WBC) count is elevated. What type of infection does this most likely indicate?

- a. Bacterial
- b. Viral
- c. Fungal
- d. Atypical

Answer: A

Rationale: White blood cells increase in number to fight bacterial infections. When a client has a viral infection, WBCs are usually low. There is not an expected change in WBC count related to fungal or atypical infections.

Assessment: Physiological Integrity: Application

3. The nurse is preparing an educational program for the community prior to the influenza (flu) season. The primary focus will be on:

- a. Recognition of signs and symptoms of influenza.
- b. Promotion of yearly flu vaccine.
- c. Use of antiviral drugs such as Tamiflu if exposed.
- d. Complimentary therapies that are recommended.

Answer: B

Rationale: The yearly flu vaccine is the single most important action to prevent or decrease symptoms of the flu. Prevention is better than recognition. Reliance on antiviral drugs should not be the focus. Complimentary therapies might be beneficial, but are not the primary focus.

Planning: Health Promotion and Maintenance: Analysis

4. During an office visit, the nurse is collecting data regarding a client's health history and current medication list. The client states "I can't seem to stop coughing since I have this cold." The nurse anticipates a cough suppressant will be prescribed with which of the following directions for frequency?

- a. Take in the morning before beginning activities.
- b. Take at mealtimes and before bed.
- c. Take in the evening before bedtime.
- d. Take in the morning and before bed.

Answer: C

Rationale: Cough suppressants may be prescribed if a client is unable to get rest due to coughing. They are not recommended for use during the day, since coughing aids in removal of respiratory secretions.

Planning: Physiological Integrity: Application

5. Following sinus surgery, a client might have a nursing diagnosis of Nutrition, Imbalanced: Less than Body Requirements. Common contributing factors for this diagnosis can include: (Select all that apply.)

- a. Presence of nasal packing.
- b. Mouth discomfort.
- c. Numbness of upper teeth.
- d. Side effects of antibiotics.

Answer: A; B; C

Rationale: Following sinus surgery, the nasal packing can cause a decrease in the sense of smell and appetite. Mouth pain can result from an incision. The upper teeth might be numb for several months. The client will have been on antibiotics before surgery to eliminate the infection that led to the surgery. Starting postoperative antibiotics is not one of the primary causes of this nursing diagnosis.

Planning: Physiological Integrity: Analysis

6. When providing discharge instructions to a client diagnosed with streptococcal pharyngitis, what information should be stressed?

- a. "Make your follow-up appointment for two weeks from today."
- b. "Take all of your antibiotic until gone."
- c. "The only medication you need is over-the-counter pain medication."
- d. "You will need a repeat CBC (complete blood count) in seven days."

Answer: B

Rationale: The full course of prescribed antibiotics must be encouraged. Clients who do not complete the antibiotics are at risk for unresolved bacterial infections. They are also at increased risk of complications that include acute glomerulonephritis and rheumatic fever. No follow-up appointment or lab work is typically needed. Over-the-counter pain medication in addition to the antibiotics might be needed.

Implementation: Health Promotion and Maintenance: Application

7. A parent asks when his teenager with a diagnosis of bacterial pharyngitis can return to school. The best response by the nurse would be:

- a. "Once the full course of antibiotics is complete."
- b. "Your physician will check her throat at the follow-up appointment and tell you then."
- c. "Once she has been on antibiotic therapy for 24 hours."
- d. "After her fever returns to normal."

Answer: C

Rationale: A client is no longer contagious once she has had antibiotic therapy for 24 hours, not the full course of therapy. The client might still have a low-grade fever, but is no longer contagious after 24 hours of antibiotics. A follow-up appointment is typically not necessary.

Implementation: Physiological Integrity: Application

8. A client presents with a two-day history of sore throat, painful swallowing, drooling, and stridor. A diagnosis of epiglottitis is suspected. What would it be important for the nurse to communicate to the nurses on the next shift?

- a. The throat should not be visualized using a tongue blade.
- b. Oxygen should be applied only by nasal cannula.
- c. The client will most likely go to surgery after the diagnosis is confirmed.
- d. Any visitors need to wear a mask when entering the room.

Answer: A

Rationale: Visualization of the oropharynx should be done using a flexible fiber optic laryngoscope by a physician, not a tongue blade by the nurse. Using a tongue blade could trigger laryngospasm and airway obstruction. Oxygen might be needed, but can be delivered by nasal cannula or by mask. No surgery is recommended for epiglottitis, although intubation might be necessary. No infection control precautions are implemented with this diagnosis.

Implementation: Safe, Effective Care Environment: Application

9. The nurse caring for a client notes a grayish membrane covering the pharynx. A diagnosis of diphtheria is made by the physician. Infection control measures are implemented after the diagnosis. The nurse will need which of the following due to the exposure to diphtheria?

- a. Antitoxin
- b. Booster immunization shot
- c. Epinephrine
- d. Antibiotics

Answer: B

Rationale: The nurse would have been required to be up-to-date on immunizations if providing client care. Booster immunization shots are given to people who have not been immunized within the past five years, and to those exposed to the infection. People who are not immunized would need the immunization and antibiotics. Diphtheria antitoxin is given to clients with a diagnosis of diphtheria. Epinephrine is readily available if the client experiences an anaphylactic reaction to the antitoxin.

Assessment: Health Promotion and Maintenance: Analysis

10. During a sporting event, a client gets hit with a ball in the nose. The injury is severe enough to require medical attention. After the bleeding is stopped, the nurse notes a clear, watery fluid dripping from the nose. What should the nurse do first?

- a. Lower the head of the bed.
- b. Apply some of the fluid to a glucose test strip.
- c. Call the physician.
- d. Have the client blow his nose.

Answer: B

Rationale: Cerebrospinal fluid (CSF) might be leaking through the nose due to the injury. By applying some of the drainage to a glucose test strip, the nurse can determine if glucose is present in the fluid. A positive result indicates the presence of CSF. It would be best to check this before calling the physician. The head of the bed should remain up to decrease the risk of aspiration. Having the client blow his nose would be contraindicated until it is determined whether the fluid is CSF.

Evaluation: Physiological Integrity: Analysis

## CHAPTER 38

1. A client has been diagnosed with bacterial pneumonia. The nurse prepares anticipatory teaching for this diagnosis. Which of the following classes of medications is expected to be prescribed? Select all that apply.

- a. Antibiotics
- b. Steroids
- c. Bronchodilators
- d. Antiemetics

Answer: A; C

Rationale: Antibiotics are indicated in a bacterial infection. Bronchodilators are commonly prescribed to decrease bronchospasm and increase ventilation. Steroids are recommended in inflammatory, not bacterial, disorders. Antiemetics are not typically indicated for bacterial pneumonia.

Planning: Physiological Integrity: Application

2. When giving directions for the collection of a sputum specimen, the nurse must stress to the client:

- a. That she must blow her nose first.
- b. That secretions are needed from the lower respiratory tract.
- c. That taking a drink of water will assist with the collection.
- d. That she will be n.p.o. (nothing by mouth) for six hours before the collection.

Answer: B

Rationale: Secretions from the lower respiratory tract, not the mouth or nasal passages, are needed for a sputum culture and sensitivity. Blowing the nose or drinking water is not necessary or helpful. Having the client remain n.p.o. is not a recommended practice for this specimen to be collected.

Implementation: Physiological Integrity: Application

3. A client with pneumonia has thick, viscous mucous secretions. A non-pharmacological measure that can improve this would be:

- a. Application of oxygen by mask.
- b. Increasing fruit intake.
- c. Increasing fluid intake.
- d. Decreasing carbohydrate intake.

Answer: C

Rationale: Increasing fluid intake to 2,500–3,000 milliliters or more per day can help secretions to be more liquefied. This will make the secretions easier to cough up and remove. The application of oxygen, increasing fruit, and decreasing carbohydrate intake will not have this effect on the secretions.

Implementation: Physiological Integrity: Application

4. A clinic is being conducted to provide influenza (flu) and pneumonia vaccines for adults. Prior to administration of a flu vaccine, the nurse must assess for:

- a. Current antibiotic therapy.
- b. Pulse oximeter saturation level.
- c. Allergy to mercury.
- d. Allergy to eggs.

Answer: D

Rationale: Assessing for an allergy to eggs or previous influenza vaccines is necessary prior to administration. A hypersensitivity to egg protein may be invoked after administration of the influenza vaccine due to additives in the vaccine. Pulse oximeter reading is not taken before the vaccine is administered. Current antibiotic therapy would not have a direct bearing on the vaccine.

Assessment: Health Promotion and Maintenance: Analysis

5. The client with a nursing diagnosis of Airway Clearance, Ineffective has a nursing intervention listed to assess respiratory status. Specific nursing assessments that would be done related to this would include: (Select all that apply.)

- a. Assess skin color at least every four hours.
- b. Assess breath sounds at least every four hours.
- c. Assess oxygen saturation level at least every four hours.
- d. Assess vital signs at least every four hours.

Answer: A; B; C; D

Rationale: When monitoring a client with a respiratory illness that induces secretions, the client must be monitored for ineffective airway clearance. By assessing the skin, vital signs, breath sounds, and oxygen saturation levels at least every four hours, the nurse will be able to detect subtle changes that could indicate impending changes with the client.

Assessment: Physiological Integrity: Application

6. A client has a diagnosis of severe acute respiratory syndrome (SARS). The client is in a medical-surgical unit. The nurse caring for the client is assessing for any early signs of respiratory failure. Early signs that would need to be reported include: (Select all that apply.)

- a. Nasal flaring.
- b. Restlessness.
- c. Anxiety.
- d. Decreased level of consciousness.

Answer: A; B; C; D

Rationale: The above signs are all early indicators of respiratory failure or inability to maintain ventilatory effort. Other early signs include tachypnea, tachycardia, use of accessory muscles, intercostal retractions, and cyanosis.

#### Assessment: Physiological Integrity: Analysis

7. An older adult is a resident in a long-term nursing care facility. He begins to develop symptoms that include a cough, weight loss, anorexia, and periodic fevers. The nurse notes the change in the client's status and reports it to the physician. The nurse would anticipate which of the following actions as a result?

- a. The client would be transferred to an acute-care facility.
- b. The client would be started on antibiotics.
- c. The client would have a tuberculin skin test.
- d. The client would have a CBC (complete blood count) drawn.

Answer: C

Rationale: Residents of nursing homes are at risk for acquiring tuberculosis. The symptoms listed are vague, but indicative of possible tuberculosis. A transfer to an acute-care facility would not be indicated at this time. Antibiotics would not be implemented until diagnostic testing was performed and the diagnosis was made. A CBC may be ordered at a later time, but is not diagnostic for this disorder.

#### Planning: Physiological Integrity: Analysis

8. Medications prescribed for the treatment of tuberculosis have many side effects that can also affect the client's health. A side effect that would need to be reported by the client who has been prescribed INH and rifampin would be:

- a. Fever.
- b. Yellow tint to the skin.
- c. Episodic pain in the left upper quadrant.
- d. Diarrhea.

Answer: B

Rationale: INH and rifampin can cause hepatitis. Jaundice could indicate hepatitis. A fever or diarrhea would not indicate hepatitis. The pain from hepatitis is on the right upper quadrant, not the left.

#### Implementation: Physiological Integrity: Application

9. A client with tuberculosis is found to be resistant to INH medication. The physician plans to start the client on ethambutol (Myambutol) as a replacement to the INH. Prior to initiating this drug therapy, the nurse tells the client she will have to:
- Be assessed for an allergy to eggs.
  - Have a baseline visual exam.
  - Have an influenza (flu) vaccine.
  - Have a baseline ECG (electrocardiogram).

Answer: B

Rationale: Before starting on ethambutol (Myambutol), a baseline visual examination is indicated. Eye exams also may be scheduled during the course of treatment. This medication can produce a toxic effect of optic neuritis. This is reversible. Assessment of an allergy to eggs or administration of a flu vaccine or an ECG is not warranted prior to the implementation of this medication.

#### Implementation: Physiological Integrity: Analysis

10. While assisting a client to move up in bed, the nurse realizes that the chest tube was caught on the bed rail. The tube was dislodged from the client. The first response by the nurse would be to:
- Notify the physician.
  - Call for help.
  - Place a sterile occlusive gauze over the wound.
  - Raise the head of the client's bed.

Answer: C

Rationale: The wound of a chest tube insertion site must be covered immediately with a sterile, occlusive gauze and taped on three sides to prevent a tension pneumothorax from developing. Air would be prevented from entering the wound during inhalation, but allowed to escape during exhalation. The gauze is recommended to be lined with a substance such as petroleum jelly. The nurse may then call for help and then notify the physician. Raising the head of the bed is not directly indicated for this situation.

#### Implementation: Physiological Integrity: Analysis

## Chapter 39

1. Which findings would indicate immediate action by the nurse when assessing a client with a respiratory disorder, such as asthma?
  1. Tachycardia, tachypnea, prolonged expirations
  2. Diffuse wheezing and the use of accessory muscles when inhaling
  3. Retractions, fatigue, anxiety
  4. Inaudible breath sounds, reduced wheezing, and an ineffective cough

Answer: 4

Rationale: During an asthma attack, tachycardia, tachypnea, and prolonged expirations are common. These would be early symptoms of the disease process that can easily be addressed without urgency. A progression of symptoms would include diffuse wheezing and the use of accessory muscles when inhaling. But airflow is still occurring; therefore, these are not as urgent as other symptoms presented. Retractions, fatigue, and anxiety are also a progression of symptoms that occur with an asthma attack that represent a more severe episode. But they are not the worst or most serious set of symptoms listed, because air is still moving and exchanging. Inaudible breath sounds, reduced wheezing, and ineffective cough reflect that little or no air movement into and out of the lungs is taking place. Therefore, this set of symptoms represents the most urgent need, which requires immediate intervention by the nurse to open up the lungs with drug management to prevent total respiratory failure.

Cognitive Level: Application

Nursing Process: Evaluation

Client Needs Category: Physiological Integrity: Physiological Adaptation

2. Which statement by a client with asthma would reflect a need for additional teaching by the nurse when discussing home management?
  1. “I should hold my breath while compressing the multi-dose metered inhaler when using a spacer, after which I can exhale fully.”
  2. “I should wait 20–30 seconds between the first and second puff of the same medication.”
  3. “Dry powder inhalers (PDI) should not be refrigerated or placed in a humid environment, such as a bathroom.”

4. “I should rinse my mouth and brush my teeth after each dosage to prevent yeast infections in my mouth from the corticosteroid inhalers.”

Answer: 1

The question is asking which information is incorrect and requires additional teaching by the nurse. *“I should hold my breath while compressing the multi-dose metered inhaler when using a spacer, after which I can exhale fully”* is incorrect, and requires additional teaching by the nurse to correct the error in the client’s thinking: The inhalation phase should occur for 3–5 seconds with the compression of the inhaler to bring in all of the medication possible; then the breath should be held for 10 seconds; and finally one can exhale after removing the mouthpiece from the lips. *“I should wait 20–30 seconds between the first and second puff of same medication”* would be correct; by waiting for 20 to 30 seconds between puffs, a greater absorption of the medication into the bloodstream is likely to occur. *“Dry powder inhalers (PDI) should not be refrigerated or placed in a humid environment, such as a bathroom”* would be correct; moisture introduced into the PDI will cause clogging or clumping of medication that will not allow small particle distribution of the medication and therefore will alter absorption in the lungs. *“I should rinse my mouth and brush my teeth after each dosage to prevent yeast infections in my mouth from the corticosteroid inhalers”* would be correct; corticosteroids will alter the pH of the oral cavity, and can increase the risk of yeast developing if not removed by brushing the teeth and rinsing the mouth after inhalation.

Bloom’s: Application

Nursing Process: Evaluation

Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies

3. A client with chronic obstructive pulmonary disease (COPD) has the following symptoms: a pulse oximetry reading of 93%, polycythemia, increase in WBC bands count, temperature of 101°F, pulse 100, respirations 35, and a chest x-ray reporting a flattened diaphragm with infiltrates noted. Which order would the nurse question for this client?
1. Antibiotic therapy
  2. Initiation of oxygen by nasal cannula at 3–4 L/minute
  3. Bronchodilators (adrenergic stimulating drugs such as methylxanthines or anticholinergic agents)
  4. Nonsteroidal anti-inflammatory agents

Answer: 2

Rationale: This question focuses upon the inappropriate order that requires clarification before the nurse follows it. So the “correct” response is the answer option that needs additional clarification. “Incorrect” answer response means the information is an appropriate order for the client described in the stem. The nurse should question the order for initiation of oxygen by nasal cannula at 3–4 L/minute for a COPD client. This amount of oxygen is too much for a COPD client. The COPD client’s breaths are stimulated by a

hypoxic drive and they are CO<sub>2</sub> retainers. If you give oxygen to a client at 3–4 L/minute (normal) levels, you can increase his PaCO<sub>2</sub> levels, leading to respiratory failure. Therefore, if oxygen is ordered, it is ordered at a lower rate of flow, such as 1–2 L/minute, with close assessments of the client's breathing status. The nurse would not question the order for antibiotic therapy, since the fever and increase in WBC bands indicate potential infection. Bronchodilators will open up the alveoli and increase exchange of oxygen and carbon dioxide more effectively. Therefore, this is an expected order for this client. Nonsteroidal anti-inflammatory agents are commonly ordered to decrease the inflammation and swelling of lung tissues to maximize oxygen and carbon dioxide exchange and to improve symptoms. Therefore, the nurse should expect this drug order for this client.

Bloom's: Analysis

Nursing Process: Evaluating

Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies

4. A nurse should expect which NANDA-approved nursing diagnosis statement for a client with cystic fibrosis? Select all that apply.

1. Airway Clearance, Ineffective
2. Anticipatory Grieving
3. Nutrition, Imbalanced: Less than Body Requirements
4. Noncompliance
5. Caregiver Role Strain

Answer: 1; 2; 3; 5

Airway Clearance, Ineffective is related to the thickened mucus production of the respiratory tract that makes it difficult to expectorate. The life span and lifestyle of client with cystic fibrosis are limited. Grieving for lack of independence, financial burdens, constant need for medical assistance, risks of early death, and the inability to reach expected potentials are all topics for the client to anticipate or experience a perceived (or actual) loss. Due to the pancreatic enzyme deficiency and impaired digestion, nutrition is altered even with medication to improve the process. If the client does not comply with her medical regime, then death from respiratory failure and nutrition deficit is likely. Therefore, noncompliance is not expected in the clients with cystic fibrosis. Family support requires a constant vigilance over the client for medications, breathing treatments, and prevention of infections, which can increase stress and create a caregiver role strain.

Bloom's: Application

Nursing Process: Planning

Client Need: Safe, Effective Care Environment: Management of Care

5. Which of the following topics would be appropriate for a teaching plan for a client with occupational lung disease? Select all that apply.

1. Teaching the client methods to conserve energy expenditure and increase rest
2. Restricting fluids due to increased edema
3. Counseling for caregiver role strain from chronic disease management
4. Teaching to avoid air pollutants and cigarette smoke

Answer: 1; 3; 4

Teaching the client methods to conserve energy expenditure and increase rest would apply to this client; with progressive lung damage from asbestos, chemicals, coal, or other irritants, the client would have less tissue available to exchange air. Therefore, energy conservation would decrease the oxygen demand in the body when at rest by decreasing the basal metabolic requirements of the cells of the body. Caregiver role strain is a common problem, and should be discussed, especially since role changes are expected due to the progressive decline of the client, and increasing activity intolerance occurs as more lung tissue is damaged by the onset of the complication of COPD.

Avoidance of air pollution and smoking will minimize additional damage and maximize airflow for a greater period of time. Therefore, this topic should be included by the nurse. Restricting fluids due to increased edema is contraindicated for lung-diseased clients: Hydration is needed to keep the lung tissue moist and flexible for maximum air exchange and to liquefy secretions for easier expectoration.

Bloom's: Application

Nursing Process: Planning

Client Need: Health Promotion and Maintenance

6. The client has a femur fracture, and the nurse finds the following upon entering the room: sudden dyspnea, pleuritic chest pain, syncope with movement, cyanosis, tachycardia, and tachypnea. What would be the nurse's first action?

1. Raise the head of the bed (HOB).
2. Administer oxygen per nasal cannula for the cyanosis and dyspnea.
3. Provide reassurance and keep the client calm by staying with the client.
4. Evaluate urinary output to assess cardiac output.

Answer: 1

Raising the HOB to a high Fowler's position facilitates maximum lung expansion and reduces venous return to the right side of the heart, lowering pressure put on the vascular system. Therefore, this is the first action the nurse should take. Oxygen therapy will increase the availability of air to the client, but lung expansion from raising the HOB will maximize the exchange while limiting venous return. Therefore, this should be the second nursing action. Staying with the client will minimize the stress of the situation; additional assistance can be called for through the intercom system. By keeping the client calm, the oxygen demand is reduced due to a decrease in heart rate caused by fear of

unknown and stress of symptoms. Cardiac output will be helpful to assess, but urinary output must be measured by hourly volumes, and unless a catheter is in place, this action is the least important approach to managing cardiac and pulmonary status from possible emboli. Other assessments of blood pressure and neck vein distention would be better assessments at this point.

Bloom's: Analysis

Nursing Process: Intervention

Client Need: Physiological Integrity: Reduction of Risk Potential

7. In a client with a spinal cord injury, which of the following symptoms would reflect acute respiratory failure syndrome?

1. Arterial oxygen level ( $\text{PaO}_2$ ) less than 50 mm Hg
2. Arterial  $\text{CO}_2$  ( $\text{PaCO}_2$ ) less than 40 mm Hg
3. Hyperventilation
4. Bradypnea

Answer: 1

A decrease in oxygen below 50 mm of Hg is evidence of a decline in respiratory efforts, and leads to subsequent respiratory failure. Normal range is  $\text{PaO}_2 = 75\text{--}100$  mm Hg. Normal arterial  $\text{CO}_2$  ( $\text{PaCO}_2$ ) levels = 35–45 mm Hg. Therefore, increasing  $\text{PaCO}_2$  indicates respiratory acidosis from COPD from alveolar hyperventilation, not hypoventilation associated with respiratory failure. Respiratory failure can result from inadequate alveolar ventilation (hypoventilation), not hyperventilation. Increased respiratory rates (tachypnea) result from compensation mechanisms to reduce  $\text{CO}_2$  buildup by blowing off  $\text{CO}_2$  at a faster rate. Therefore, bradypnea (slower rate) would not be associated with respiratory failure.

Bloom's: Analysis

Nursing Process: Evaluation

Client Need: Physiological Integrity: Physiological Adaptation

8. A client is intubated and on a synchronized intermittent mandatory ventilator (SIMV). Which order should the nurse question?

1. Administration of histamine H<sub>2</sub>-receptor blocker q.i.d
2. Total parenteral nutrition (TPN) at 125 mL/hour
3. Perform endotracheal suctioning q 4 hours @ 200 mm Hg pressure.
4. Keep the endotracheal cuff pressure @ 20–25 mm Hg.

Answer: 3

Endotracheal suctioning should be questioned by the nurse. The placement of the endotracheal tube becomes an irritant, and creates increased secretions. Suctioning should

not be scheduled every four hours but performed as needed (p.r.n.). Suctioning pressures should run only 80–100 mm Hg and never higher, or there is the risk of damage to lung tissue from too much pressure. Increased secretions that are not removed will limit the amount of air perfusion and lead to the risk of atelectasis. Administration of histamine H<sub>2</sub>-receptor blocker q.i.d is a correct action, and should not be questioned. The risk of stress ulcers in the gastrointestinal tract from mechanical ventilation is increased, and histamine H<sub>2</sub>-blocking drugs are often ordered as a prophylactic measure to prevent gastrointestinal stress ulcers. Total parenteral nutrition is a correct action, and should not be questioned. Long-term ventilation will require additional calories and an alternate form of supplying nutrition. A J tube, G tube, or NG tube might be used also to supply nutrition over the long-term. The effort of breathing increases the metabolic requirements, and additional calories should always be considered for respiratory clients. Keeping the endotracheal cuff pressure @ 20–25 mm Hg is a correct action, and it should not be questioned. A tight seal around the endotracheal tube by a pressure of 20–25 mm Hg is needed to prevent air leakage around the tubing for maximum exchange and inflation of lungs by the ventilator. Deflation of the cuff is needed periodically for a short time to prevent necrosis of tracheal tissue.

Bloom's: Application

Nursing Process: Planning

Client Need: Physiological Integrity: Reduction of Risk Potential

9. Which action would be appropriate for the nurse to include in the discharge teaching plan of a client with acute respiratory distress syndrome (ARDS)? Select all that apply.

1. Avoid smoking and air pollution.
2. Include examples of lifestyle modifications to decrease oxygen demands.
3. Restriction of fluids to prevent congestive heart failure (CHF)
4. Encourage the client and family to take immunizations for pneumococcal pneumonia and influenza annually.

Answer: 1; 2; 3

Pollution and smoke can further damage already traumatized lung tissue, and therefore should be avoided. Lifestyle modifications to conserve energy and oxygen demands are needed, since lung tissues are still trying to recover from the damage of the disease processes. Exertional dyspnea will continue to increase if additional demands are made on the pulmonary and cardiovascular system that has been impacted by the damage from ARDS. Role changes, increased rest, and decreased activities are needed. Immunizations (for pneumonia and flu) are encouraged to minimize additional insults to lung tissue, since the entire physical status of lung tissue will require up to six months to recover. Fluids are needed to rehydrate lung tissue and to increase renal functions to dilute wastes from tissue repair. CHF from right-sided failure is possible, but not usually in the recovery phase (after discharge from the hospital).

Bloom's: Application

Nursing Process: Planning

Client Need: Health Promotion and Maintenance

10. In a community health promotion class presentation for clients with respiratory diseases, the nurse would include which of the following topics? Select all that apply.

1. Smoking and exposure to tobacco smoke are the greatest risks for causing chronic obstructive lung disease (COPD).
2. Stopping smoking will reverse the damage that is already present in COPD clients.
3. Increased fluids and calories are needed for most respiratory clients due to increased respiratory efforts and increased basal metabolic rates (BMR).
4. Pulmonary hypertension will lead to right-sided failure, and clients should be assessing their blood pressures to watch for changes.
5. Immunizations for influenza and pneumonia are needed only by clients who are out and about in the community when people are sick.

Answer: 1; 3; 4

Smoking and tobacco exposure are the greatest risk of damage to lung tissue, and should be avoided. Even secondhand smoke has proven to be as great a risk to lung damage as direct exposure. Due to increased efforts to breathe and exchange air in diseased lung tissue, additional calories are burned and moisture is lost with increased breathing rates. Additional fluids and calories are required for most respiratory clients. Pulmonary hypertension can occur in long-term respiratory clients due to pulmonary congestion causing a backup in the right side of the heart. Regular blood pressure checks should be done to follow the progression of cardiac functioning. Tissue that is damaged or scarred by disease will not become healthy again once smoking is stopped. Stopping smoking will prevent or reduce changes to lung tissue from past exposure. Immunizations are needed as a preventive measure for all respiratory clients to minimize additional stress caused by infection in already damaged lung tissue. Therefore, all clients should receive the immunizations each year.

Bloom's: Application

Nursing Process: Planning

Client Need: Health Promotion and Maintenance

## Chapter 40

1. A school nurse is reviewing properties of skeletal muscle cells with a sports team. Which comment made by a student indicates that further teaching is necessary?

1. "Excitability refers to the ability to receive and respond to a stimulus."
2. "Contractility is a response to a stimulus by forcibly lengthening a muscle."
3. "Extensibility is a response to a stimulus by extending and relaxing a muscle."
4. "Elasticity is the ability to resume resting length after shortening a muscle."

Answer: 2

Choices 1, 3, and 4 are correctly defined terms related to functional properties of skeletal muscles cells. Contractility actually refers to a response to a stimulus by forcibly shortening the skeletal muscle.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Physiological Adaptation

2. Choose the normal movements allowed by synovial joints: (Select all that apply.)

1. Abduction
2. Extension
3. Pronation
4. Inversion
5. Protraction
6. Articulation

Answer: 1; 2; 3; 4; 5

Rationale: All of the movements listed are normal with the exception of articulation. This term is describing the word *joint*: the point where two bones meet.

Cognitive Level: Knowledge

Nursing Process: Assessment  
NCLEX: Health Promotion and Maintenance

3. What would the nurse ask a client during a functional health pattern interview to elicit data pertaining to health perception/health management of the musculoskeletal system?
1. "How has having this condition affected your relationship with others?"
  2. "Describe your usual activities for a 24-hour period."
  3. "Has having this condition created stress for you?"
  4. "Do you take any herbal supplements for musculoskeletal problems?"

Answer: 4

Rationale: Asking about herbal supplements or over-the-counter medications is part of the health perception/health management pattern. How a condition affects relationships with others would be the role/relationship pattern. Describing activities falls under the activities/exercise pattern. Stress incurred with a musculoskeletal condition would be part of the coping/stress pattern.

Cognitive Level: Comprehension  
Nursing Process: Assessment  
NCLEX: Health Promotion and Maintenance

4. In what area of the physical assessment would the nurse expect to find crepitus when examining the musculoskeletal system?
1. Body posture assessment
  2. Range-of-motion assessment
  3. Joint assessment
  4. Gait assessment

Answer: 3

Rationale: Crepitus is a grating sound and/or sensation heard and/or palpated when assessing joints (commonly with the knees). Body posture assessment would entail inspecting the client upright, then bending and sitting to observe for the presence of spinal curvature. Gait assessment includes observing the client for smooth and steady

ability to walk. Range-of-motion involves asking the client to perform activities specific to each joint, such as flexion, extension, and abduction.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

5. When assessing the fingers during a musculoskeletal examination, the nurse notes swollen fingers with a white chalky discharge, and documents this as:

1. Osteoporosis.
2. Chronic gout.
3. Carpal tunnel syndrome.
4. Rheumatoid arthritis.

Answer: 2

Rationale: A swollen finger with a chalky discharge is a sign of chronic gout caused by an inflammatory response to the production or excretion of uric acid. This finding would not be present with osteoporosis, carpal tunnel syndrome, or rheumatoid arthritis.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

6. The nurse teaching a class on the musculoskeletal system would emphasize that compact bone is stronger than spongy bone due its greater:

1. Density.
2. Size.
3. Volume.
4. Weight.

Answer: 1

Rationale: The greater density of compact bone makes it stronger than cancellous (spongy) bone. Overall size does not determine strength. Volume is not related to strength, and weight alone is not a factor.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

7. Of the following clients scheduled for an MRI, for which would the nurse have no cause for concern related to safety during the test?

1. A client with a pacemaker for three years
2. A client with shrapnel from a military assault
3. A client with an open abdominal wound
4. A client with external hardware following a fracture repair

Answer: 3

Rationale: Magnetic resonance imaging (MRI) uses radio waves and magnetic fields to detect musculoskeletal disorders. The nurse must screen clients prior to the exam for metal on clothing or metallic implants such as pacemakers, shrapnel, or clips on aneurysms. The presence of an open abdominal wound (presumably packed and bandaged) would not cause concern for injury.

Cognitive Level: Analysis

Nursing Process: Evaluation

NCLEX: Physiological Integrity: Reduction of Risk Potential

8. The nurse is aware of musculoskeletal changes associated with aging such as:  
(Select all that apply.)

1. Decreased bone mass and minerals.
2. Increased calcium reabsorption.
3. Muscle fibers atrophy.
4. Vertebrae elongate.
5. Decreased range of motion.
6. Development of bone spurs.

Answer: 1; 3; 5; 6

Rationale: With aging, decreased bone mass and calcium absorption contribute to bones that are thinner and weaker. Muscle fibers atrophy, leading to loss of muscle mass, strength, and agility. The vertebrae shorten and height decreases. Range of motion declines, and as cartilage on bone surfaces in joints deteriorates, bone spurs can develop.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

9. A health-conscious young adult female asks the nurse what diagnostic test might help predict the likelihood for developing osteoporosis. The nurse recommends:

1. Arthroscopy.
2. An electromyogram (EMG).
3. Somatosensory evoked potential (SSEP).
4. Dual energy x-ray absorptiometry (DEXA).

Answer: 4

Rationale: The DEXA can calculate the size and thickness of bone. Osteoporosis is diagnosed if the peak bone mass level is below  $> 2.5$  standard deviations. Arthroscopy is an endoscopic examination of a joint. The electromyogram measures electrical activity of skeletal muscles at rest and during contraction, while the SSEP measures nerve conduction.

Cognitive Level: Comprehension

Nursing Process: Assessment

NCLEX: Health Promotion and Maintenance

10. The nurse would document “unable to assess” for which of the following clients in relation to performing Phalen’s test?

1. A client with a long leg cast
2. A client with an above-the-elbow amputation
3. A client wearing compression stockings
4. A client with osteoarthritis of the hips

Answer: 2

Rationale: Phalen’s test involves holding the wrists in acute flexion against one another for 60 seconds, which isn’t possible following upper extremity amputation. Numbness and burning in the fingers could indicate carpal tunnel syndrome. The presence of a leg cast, compression stocking, or hip pain would not deter the nurse from completing the exam.

Cognitive Level: Application

Nursing Process: Evaluation

NCLEX: Physiological Integrity

## Chapter 41

1. An Emergency Department nurse has provided discharge teaching for home care to a young adult male experiencing a sprain from playing softball. Based of the following statements, which indicates further teaching is necessary?

1. "I should put a heating pad on my leg as soon as I get home."
2. "I should avoid weight bearing on this leg for a couple days."
3. "I should make sure to keep the ace bandage on my leg."
4. "I should prop this leg up when I'm sitting in a chair."

Answer: 1

Rationale: The acronym RICE (rest, ice, compression, elevation) is a recommended therapy for treating soft tissue trauma. The interventions allow the injured muscle, ligament, or tendon to heal (rest), cause vasoconstriction and reduce pain (ice), decrease edema formation (compression), and reduce edema and pain (elevation). These therapies should be used 24–48 hours.

Cognitive Level: Application

Nursing Process: Implementation

NCLEX: Physiologic Integrity: Basic Care and Comfort

2. Put the following stages of bone healing in the correct sequence in which they occur.

1. Fibrocartilaginous callus formation
2. Bone injury
3. Bone remodeling
4. Bony callus formation

Answer: 2, 1, 4, 3

Rationale: Following fracture, torn blood vessels within and near the bone bleed, forming a hematoma and an intense inflammatory response. Next, granulation tissue replaces the hematoma, and fibrocartilaginous callus formation provides a base for bone growth. The

third stage, bony callus formation, continues for up to three months. The last stage, bone remodeling, involves osteoclasts reabsorbing callus as it is replaced by mature bone.

Cognitive Level: Comprehension

Nursing Process: Evaluation

NCLEX: Physiologic Integrity: Physiological Adaptation

3. The nurse is concerned about the possibility of compartment syndrome for a client wearing a long leg cast. In preparation for the physician to perform the necessary treatment, the nurse would gather what supplies or equipment?

1. Extra pillows, to elevate the casted extremity above the heart
2. A Doppler, to aid in assessing the strength of peripheral pulses
3. Ace bandages, to wrap around the bi-valved cast
4. A percussion hammer, to physically assess reflexes for damage

Answer: 3

Rationale: Compartment syndrome occurs when excess pressure in a limited space constricts the structures within a compartment, reducing circulation to muscles and nerves. With increased edema, this event threatens the viability of the client's limb and increases the risk of sepsis. Treatment can include removing the cast entirely or bi-valving it (splitting it apart with a cast cutter) and securing the two sides with ace wraps, tape, or Velcro straps. If the pressure is internal, a fasciotomy might be necessary. Elevating the leg above the heart would compromise circulation. A Doppler could be used to assess pulses, and could a percussion hammer to check reflexes, but these are not therapeutic treatments for compartment syndrome.

Cognitive Level: Analysis

Nursing Process: Planning

NCLEX: Physiologic Integrity: Reduction of Risk Potential

4. An elderly woman was admitted to the orthopedic unit following a fall that resulted in a fractured left hip, and is placed in Buck's traction. Which of the following is an appropriate nursing action?

1. Providing pin site care every shift as ordered by the MD
2. Placing an abduction pillow between her legs for alignment
3. Having another person hold the weights when pulling her up in bed
4. Turning her to the unaffected side every two hours

Answer: 3

Rationale: Buck's traction is used preoperatively to control muscle spasms, immobilize a fractured hip, and maintain alignment of an extremity. Often, clients will "scoot" down toward the end of the bed, and the weights are resting on the floor. To avoid injury and added pain, one person holds the weights while the others use a lift sheet to reposition the client. Buck's traction is skin traction; no skeletal pins are used. An abduction pillow is used postoperatively, and a client cannot be turned with this type of therapy.

Cognitive Level: Application

Nursing Process: Implementation

NCLEX: Physiological Integrity: Basic Care and Comfort

5. Choose the position the nurse should promote the first several days postoperatively for the client with an above-the-knee amputation.

1. Sims' position as tolerated
2. Prone for one hour, several times a day
3. High Fowler's position
4. Sitting in a chair while awake

Answer: 2

Rationale: A complication following above-the-knee amputation is developing a contracture of the joint above the amputation. Lying prone will prevent abnormal flexion and fixation of the extremity. High Fowler's position and prolonged sitting can lead to hip contracture. Sims' position likely would be uncomfortable for the client.

Cognitive Level: Application

Nursing Process: Implementation

NCLEX: Physiological Integrity: Reduction of Risk Potential

6. The nurse is aware that which of the following occupations could put a client at risk for carpal tunnel syndrome? Select all that apply.

1. Farmer
2. Police officer
3. Barber
4. Computer technician
5. Carpet installer
6. Baker

Answer: 3; 4; 5; 6

Rationale: Carpal tunnel syndrome develops from repetitive use of the hand(s) or extremities as a result of twisting and turning the wrist, pronating and supinating the

forearm, kneeling, or raising arms over the head. Normal activities for a farmer or police officer would not place these occupations at risk

Cognitive Level: Analysis

Nursing Process: Evaluation

NCLEX: Health Promotion and Maintenance

7. A patient with a compound fracture has been admitted to the E.D., and is scheduled for immediate surgery. Which of the following nursing diagnoses would be most appropriate in the immediate postoperative period?

1. Transfer Ability, Impaired
2. Post-Trauma Syndrome, Risk for
3. Infection, Risk for
4. Falls, Risk for

Answer: 3

Rationale: All responses are potential diagnoses postoperative, but risk for infection is the priority. The client with an open, compound fracture has multiple bone breaks penetrating through the skin, and must be assessed and cared for vigilantly for signs of infection.

Cognitive Level: Analysis

Nursing Process: Nursing Diagnosis

NCLEX: Physiological Integrity: Reduction of Risk Potential

8. The nurse should observe for signs that indicate compromised circulation in a client with a long leg cast, including:

1. Swelling of the toes.
2. Drainage on the cast.
3. Increased temperature.
4. Foul odor detected.

Answer: 1

Rationale: Constriction of circulation decreases venous return and increases pressure within vessels. Fluid then shifts into the interstitial space, causing edema. Foul odor, drainage, and increased temperature would indicate potential infection.

Cognitive Level: Analysis

Nursing Process: Assessment

NCLEX: Physiological Integrity: Reduction of Risk Potential

9. The nurse recognizes that the contractures that develop most frequently after fracture of the hip are:

1. Internal rotation with abduction.
2. External rotation with abduction.
3. Flexion and adduction of the hip with flexion of the knee.
4. Hyperextension of the knee joint with foot drop deformity.

Answer: 3

Rationale: This type of contracture frequently occurs when the client lies in bed with knees bent and thighs not abducted. Internal or external rotation with abduction does not reflect types of contractures. Foot drop is a problem for all clients confined to bed; hyperextension of the knee is not normally possible.

Cognitive Level: Application

Nursing Process: Evaluation

NCLEX: Physiological Integrity: Reduction of Risk Potential

10. The nurse cannot palpate a client's pedal pulse following an ORIF procedure for a fractured tibia. Which action is the priority?

1. Notify the surgeon of the problem.
2. Check the lower extremity for pallor.
3. Use a Doppler to find the pedal pulse.
4. Assess the client's pain rating.

Answer: 3

Rationale: To assess if circulation is present when the pulse isn't palpable, the nurse next should use a Doppler. Notifying the surgeon should occur once all assessment data are collected; this can include the presence of pallor and pain.

Cognitive Level: Analysis

Nursing Process: Implementation

NCLEX: Physiological Integrity: Reduction of Risk Potential

## CHAPTER 42

1. A 30-year-old female client reporting to the clinic for a sport physical is told by the physician she is demonstrating signs consistent with the early onset of osteoporosis. The client asks how she could be at risk for this disease, since she is so active. Which of the following responses by the nurse is most correct?
- a. "You might have placed underlying stress on your skeleton from your frequent exercise."
  - b. "You are at an age when your estrogen levels have begun to decline drastically, thus increasing your risk for the development of osteoporosis."
  - c. "Do your bones feel weak?"
  - d. "Your dietary practices might be partially responsible."

Answer: d

Rationale: There is an increasing incidence of osteoporosis in female athletes as a result of intense dieting. Exercise is beneficial in the prevention of osteoporosis. It does not increase the likelihood of osteoporosis. The client is seeking information. She is not requiring an assessment at this time.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. The client diagnosed with osteoporosis has been prescribed calcitonin. The client reports experiencing nausea and vomiting. What initial action is indicated by the nurse?
- a. Hold the prescribed dosage.
  - b. Call the physician.
  - c. Monitor and record the frequency and amount of emesis.
  - d. Increase the amount of vitamin D in the diet.

Answer: c

Rationale: Calcitonin is associated with nausea and vomiting. These manifestations will subside. The nurse will need to record the event. Holding the dose is not indicated. The physician does not require immediate notification. Although vitamin D intake should be increased in the diet when calcitonin is prescribed, it does not address the question asked.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiologic Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Analysis

3. Sodium fluoride rinse has been prescribed to the client. When preparing to administer the medication, what nursing implications will need to be implemented? Select all that apply.

- a. Administer the medication immediately upon arising.
- b. Administer the medication with milk.
- c. Administer the medication after meals.
- d. Monitor fluoride levels annually.
- e. Avoid intake for 30 minutes after use.

Answers: c; e

Rationale: Sodium fluoride can be administered via tablets and mouth rinse. The medication is best administered after meals. Intake must be avoided for 30 minutes after administration. Milk products should be avoided. Fluoride levels are indicated every three months.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiologic Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

4. A 88-year-old female client having a history of osteoporosis has been admitted to the long-term care facility. She has a history of falls and dementia. Which of the following interventions will best aid in the prevention of injuries?

- a. The use of wrist restraints
- b. Using furniture as obstacles to keep the client in the bed
- c. Keeping the bed in a low position
- d. Keeping a nightlight on in the room

Answer: c

Rationale: Keeping the bed in a low position will reduce the incidence of injury should the client attempt to get up. The use of restraints could increase the incidence of injury. Using the furniture as an obstacle could cause injury if the client is able to get up. A nightlight is useful but is not the best means to prevent injury.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Safety and Infection Control

COGNITIVE LEVEL: Analysis

5. The client with gout reports the presence of small “lumps” on his ear and big toe. After being advised the lumps are accumulations of uric acid, the client becomes worried these deposits can become lodged in his blood, resulting in a blood clot. Which of the following explanations by the nurse will be most accurate?

- a. “These will not become problematic if you remain on the prescribed medications.”
- b. “Unfortunately, this is a common complication associated with gout.”
- c. “You will need to talk with the physician during your next visit.”
- d. “These accumulations are more common in areas of the body having lower temperatures, and are not in danger of causing clot development.”

Answer: d

Rationale: The deposits are known as tophi. They result from uric acid crystal buildup. They occur most often in locations with lower body temperature readings. They will not cause a clot. Medications prescribed to manage gout will reduce the amount of uric acid production or assist with its metabolism. The client will need correct information concerning the tophi. Advising the client to wait until a future visit to discuss the concern is not appropriate, as the client is seeking information at the present time.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

6. When providing care to the client with an exacerbation of gout, resulting in foot pain, which of the following interventions will aid in promoting comfort?

- a. Wrap the extremity in an ace bandage.
- b. Encourage liberal fluid intake.
- c. Provide range-of-motion exercises to the involved area to promote flexibility.
- d. Elevate the extremity using a cradle.

Answer: d

Rationale: The pain in the affected extremity will be lessened with elevation. Elevation will reduce inflammation. Wrapping the extremity and range of motion could increase the pain being experienced. Fluid intake is encouraged, but will not directly reduce the client's discomfort.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

7. The client with osteoarthritis reports achieving pain relief when using an over-the-counter ointment on the affected areas. When assessing the client's knowledge of safe administration practices, which of the following principles should the nurse plan to include in the teaching?

- a. Apply heat to the affected area after applying ointment.
- b. Use caution when using a heating pad and ointment together.
- c. Limit the use of ointment to 3–4 times per day.
- d. Initial skin irritation is common, and will subside within a few weeks of initiating treatment.

Answer: c

Rationale: Over-the-counter preparations should be used only 3–4 times per day. Heat use and these preparations should not be combined. If skin irritation is noted, the medication should be discontinued.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

8. A client is scheduled to undergo a hip replacement to manage osteoarthritis. A review of the client's history reflects overall health. When providing education concerning the procedure, the client asks if she should be concerned about complications. What information should be included concerning the occurrence of complications?

- a. "Complications are variable."
- b. "You may ask your physician about complications before the procedure is initiated."
- c. "You are healthy, and should have an uneventful recovery."

- d. "Complications can happen with any surgical procedure, and we will discuss their potential."

Answer: d

Rationale: Complications can result from any surgery. The client should be aware of the most common problems. Advising the client they are "variable" does not meet the question posed to the nurse. Waiting until just before the surgery is too late to begin discussing complications. The client's overall health does impact the incidence of complications, but it does not negate their occurrence.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential

COGNITIVE LEVEL: Analysis

9. The day after surgery to replace a hip joint, the client states he is not ready to ambulate, and will consider it tomorrow. Which of the following actions by the nurse is indicated first?

- a. Ask the client why he is resistant to ambulating at this time.
- b. Contact the physician.
- c. Call nursing assistants to assist with ambulation anyway.
- d. Document the client's refusal.

Answer: a

Rationale: Determining the reason the client is declining to participate is beneficial in the client's care. It is premature to contact the physician. Forcing the client to get out of bed would constitute a crime. Documentation of the exchange is needed, but should be done once the reason for the refusal is known.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Analysis

10. A client with a history of osteoarthritis reports discomfort unrelieved by the medications. Which of the following nonpharmacological interventions might assist the client in managing the discomfort? Select all that apply.

- a. Suggest the use of ice to the painful joints.
- b. Encourage rest of the painful joints.
- c. Discuss the use of relaxation techniques.
- d. Encourage distraction techniques.

- e. Advise the client to perform range-of-motion exercises to reduce the cramping sensation.

Answers: b; c; d

Rationale: Rest, relaxation, and distraction are nonpharmacological methods to reduce pain associated with osteoarthritis. Ice and range-of-motion exercises might increase the client's discomfort.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Basic Care and Comfort

COGNITIVE LEVEL: Application

## Chapter 43

1. A nurse working in a long-term care facility cares for a client with Parkinson's disease. When giving L-dopa, which of the following statements made to the client's family shows the nurse's understanding of the client's medication?
  - a) "This medicine increases the ability to have clearer thoughts."
  - b) "We need to give this medicine to help movement become smoother."
  - c) "We need to make sure that there are no seizures."
  - d) "This pill will help with pain control."

Answer: b

Rationale: Dopamine (an amine) is involved in emotions and moods and in regulating motor control. Parkinson's disease results from destruction of dopamine-secreting neurons. A decrease in acetylcholine-secreting neurons is seen in Alzheimer's disease and myasthenia gravis. Amino acids have an inhibitory influence, and drugs containing these are used to treat seizure disorders. Neuropeptides are widely distributed in the CNS, and are involved in pain transmission pathways.

Assessment

Physiological Integrity

Application

Learning Outcome 1

2. A client's family asks the nurse "What does damage to Broca's area mean?" just after the physician leaves the client's room. The best response by the nurse is:

- a) "The way you communicate will have to change."
- b) "You'll have to speak very loudly when you talk."
- c) "Make sure there are no obstacles in the room, because sight will be a problem."
- d) "Perhaps you would like to learn how to provide range-of-motion exercises."

Answer: a

Rationale: Broca's area in the cerebrum regulates verbal expression—the ability to say words. Wernicke's area, also part of the cerebrum, is the comprehension area of the brain, responsible for understanding of spoken words. The visual center is located in the occipital lobe, and the somatic area in the postcentral gyrus registers body sensations such as temperature, touch, pressure, and pain.

Assessment

Physiological Integrity

Application

Learning Outcome 1

3. A parasympathetic response that the nurse can assess would include: (Select all that apply.)

1. Decrease in heart rate.
2. Increase in heart rate.
3. Dilation of coronary vessels.
4. Hyperactive bowel sounds.
5. Hypoactive bowel sounds.

Answer: 1; 4

Rationale: The parasympathetic responses include a decrease in heart rate and strength of heartbeat; increased peristalsis; and a dilation of the coronary vessels, although the nurse will not be able to assess this. The other options are effects of the sympathetic nervous system.

Assessment

Physiological Integrity

Application

Learning Outcome 1

4. When taking a health history of an elderly client, which statement by the nurse would best focus on function of the central nervous system?

- a) "Do you get dizzy when moving from a sitting to standing position?"
- b) "Do you have difficulty adjusting to a change in temperature?"
- c) "Can you describe your sleep pattern?"
- d) "Have you had any weight loss?"

Answer: b

Rationale: Temperature regulation is located in the brainstem, which is part of the CNS. Although there is a potential for altered balance and increase in postural hypotension

from a change in the CNS in the elderly client, this assessment finding is mainly regulated by the autonomic nervous system. Sleep patterns are regulated by the reticular formation, and weight loss can be affected by the sensory division of the nervous system.

Assessment

Physiological Integrity

Application

Learning Outcome 2

5. A client states that he has been hearing noises. The nurse should:

- a) Make sure the client is referred to a psychiatrist.
- b) Document that the client has a mental illness.
- c) Ask the client if he has any visual disturbances.
- d) Explain to the client that this is not unusual.

Answer: c

Rationale: Information about perception difficulties such as visual and/or auditory disturbances is an important part of the health history of the nervous system. The nervous system controls cognition and sensory function, which include vision and auditory changes. Making a referral to a psychiatrist would not be the appropriate next step, and it is not within the scope of nursing practice for the nurse to document mental illness. Hearing and vision changes are not usual assessment findings, and should be investigated.

Assessment

Physiological/Psychosocial Integrity

Application

Learning Outcome 2

6. An ED nurse receives a report that an incoming client has a Glasgow Coma Scale (GCS) score of 8. The nurse should be prepared to:
- a) Treat the client's pain.
  - b) Assess airway, breathing, and circulation.
  - c) Get a complete history from the client.
  - d) Triage with the other ED clients.

Answer: b

Rationale: The GCS (Glasgow Coma Scale) is a standardized system for assessment of consciousness. A score of 15 indicates full alertness, and a score of 8 or less is usually indicative of coma—the lowest possible score is 3. A comatose client receives high priority, and the nurse will utilize the ABCs of care in this case.

Implementation

Physiological Integrity

Application

Learning Outcome 3

7. In reviewing a client's chart, the nurse notices that the client has had damage to the trigeminal nerve (CN V). Before bringing in the meal tray, the nurse should:
- a) Tell the client what food is on the tray.
  - b) Assess the client's ability to swallow.
  - c) Make sure to speak loudly and with eye contact.
  - d) Assist the client in identifying where items are on the tray.

Answer: b

Rationale: The corneal reflex test evaluates the trigeminal nerve (CN V) as well as CN VII. The olfactory nerve (CN 1) controls the client's sense of smell. Gag reflex is controlled by CN IX, and auditory function is controlled by the acoustic nerve (CN VIII).

Implementation

Physiological Integrity

Application

Learning Outcome 3

8. The nurse tells the client "Stick out your tongue" and notices the client's tongue deviates to the right side. How should the nurse document the findings?

- a) Abnormal hypoglossal nerve response
- b) Findings consistent with first cranial nerve damage
- c) Sluggish oculomotor response
- d) Absent Homans' sign

Answer: a

Cranial nerve XII (hypoglossal) is tested by having the client stick her tongue out. An abnormal finding is that the tongue deviates to either side. Cranial nerve I is the olfactory nerve, and is assessed by having the client smell; cranial nerve III is the oculomotor nerve, and along with the trochlear and abducens nerves helps the eye move. Homans' sign is a check for thrombophlebitis in the calves.

Assessment

Physiological Integrity

Application

Learning Outcome 3

9. The nurse asks the client to stand with his feet together and eyes closed. The client sways, and the nurse reaches to steady the client to prevent a fall. The nurse documents this as:
- a) A normal finding.
  - b) Abnormal graphesthesia.
  - c) Positive Romberg's test.
  - d) Clonus.

Answer: c

Romberg's test is an assessment of the position sense of the lower extremities. Normal findings include the client's being able to stand with good balance, feet together and eyes closed. An abnormal finding (a positive Romberg's) is identified when the client has good balance with his eyes open, but sways or falls when his eyes are closed. Graphesthesia is the ability to feel writing on the skin. Clonus is a continued contraction of the muscle when stimulus is applied.

Assessment

Physiological Integrity

Application

Learning Outcome 3

10. A client has dysphagia. The nurse should:
- a) Bring a paper and pencil into the room for communication.
  - b) Turn the radio off when speaking to the client.
  - c) Provide foods that are easy to swallow.
  - d) Bring the client a walker.

Answer: c

Rationale: Dysphagia is difficulty swallowing. The client should have foods that are easy to swallow and require minimal chewing. Assessment of the client's gag reflex before any food or drink is given is critical. Aphasia is difficulty with language function. Dysphonia is change in the tone of the voice, and ataxia is lack of coordination and movement.

Implementation

Physiological Integrity

Application

Learning Outcome 4

## **Chapter 44**

1. The priority nursing intervention for the client with increasing ICP (intracranial pressure) is:

- a) Controlling pain.
- b) Monitoring for nausea and vomiting.
- c) Ensuring adequate oxygenation.
- d) Maintaining a calm environment.

Answer: c

Rationale: Ensuring adequate oxygenation to support brain function is the most important step in management of ICP. Although pain control, a calm environment, and vomiting (a sign of increased ICP) would be important, they are secondary to airway.

Implementation

Physiological Integrity

Application

Learning Outcome 1

2. A client with increased intracranial pressure is being repositioned. Of the following, which are appropriate? Select all that apply.

1. Clients with ICP should remain in a stationary position.
2. Slow, gentle movements with repositioning
3. The client should be returned to supine position.
4. Repositioning every hour
5. Head of bed elevated

Answer: 2; 5

Rationale: Clients with ICP should be repositioned slowly and with gentle movements, because rapid changes can cause the pressure to increase. Position changes should be done less frequently for clients with ICP because turning, skin care, and passive ROM exercises can elicit posturing, which also causes increased ICP. The head of the bed

should be elevated. The degree depends on the reaction of the client to the position; 30 degrees is usually appropriate, but this can vary by the client.

Implementation

Physiological Integrity

Application

Learning Outcome 1

3. The client has a history of headaches. In order to differentiate between tension-type headaches and migraines, the nurse should ask which of the following?

- a) "Do you feel cold or hot before your headache?"
- b) "Do your headaches occur for weeks or months at a time?"
- c) "Which treatments seem to help your headaches when they do occur?"
- d) "Do you take a lot of ibuprofen?"

Answer: a

Rationale: Migraines can be preceded by an aura—a sensation of light or warmth. Cluster headaches occur repeatedly, for weeks to months at a time. Analgesic rebound headaches can occur as a result of overuse of certain medications, including ibuprofen. Asking which treatments help does not differentiate between the types of headaches.

Assessment

Physiological Integrity

Application

Learning Outcome 1

4. A child presents to the unit with a history of petit mal seizures. After one such episode, the nurse correctly documents which of the following? "The client:

- a) "Became unconscious, and all four extremities were jerking uncontrollably for two minutes."
- b) "Was sitting very still, and stared off into space for a period of two minutes."
- c) "Repeatedly moved from the chair to the bed while touching her arms for a length of two minutes."
- d) "Pulled her arms in toward her body and flexed her hands over her chest. This lasted two minutes."

Answer: b

Rationale: Absence (petit mal) seizures are characterized by sudden, brief cessation of all motor activity accompanied by a blank stare and unresponsiveness. These seizures are more common in children than in adults. Jerking of extremities and periods of non-purposeful movements describe grand mal and generalized seizure activity. Decerebrate posturing is a sign of increased ICP.

Assessment

Physiological Integrity

Application

Learning Outcome 1

5. A football player is discharged from the Emergency Department after being diagnosed with a closed head injury. Client teaching regarding complications should include monitoring for:

- a) Stiff neck after several weeks.
- b) Leakage of CSF immediately after discharge.
- c) Changes in mental status for 2 to 3 days after the injury.
- d) Increase in anxiety or difficulty sleeping.

Answer: c

Rationale: Death from head trauma can occur immediately, within two hours or up to three weeks after the injury, and clients should notify their healthcare provider immediately if they notice changes in symptoms. They should avoid alcohol. A stiff neck is indicative of bacterial meningitis. Leakage of CSF is caused from a skull fracture. Complications from a head injury include drowsiness and difficulty arousing.

Implementation

Physiological Integrity

Application

Learning Outcome 1

6. A client has been diagnosed with a malignant brain tumor. When asked about metastasis, the best response by the nurse is:

- a) "You should ask your physician about this."
- b) "Brain tumors usually stay in the central nervous system."
- c) "The most likely organs will be the liver and GI system."
- d) "You need to think positively about your future."

Answer: b

Rationale: Malignant brain tumors rarely metastasize outside CNS. The most common primary sites include breast, kidney, lung, and GI tract. Although diagnosing the disease falls under the physician's scope of practice, educating the client about the disease process is part of the nurse's role. Avoiding the question with clichés is never a good response.

Implementation

Physiological/Psychosocial Integrity

Application

Learning Outcome 1

7. A client is being monitored for increased ICP. Using the Monro-Kellie hypothesis as a basis for explanation, the nurse makes which comment to the client's family?

- a) "The pressure in the brain is increasing because the brain is swelling."
- b) "Increasing brain pressure decreases the amount of blood flow to the brain itself."
- c) "Because there is more pressure in the brain, the blood flow is also increasing."
- d) "There is nothing that can be done."

Answer: b

Rationale: The Monro-Kellie hypothesis states that a dynamic equilibrium exists among the three components (brain, cerebrospinal fluid, and blood) of the skull. A change in the volume of any component results in a decrease in the remaining components to maintain normal intracranial pressures.

Assessment

Physiological Integrity

Application

Learning Outcome 2

8. A client with ICP is going to be evaluated by a neurosurgeon. The nurse identifies which of the following as priority results to be present on the chart for review? Select all that apply.

1. MRI result
2. Complete blood count of the cerebrospinal fluid
3. Arterial blood gases

4. Bronchoscopy results
5. Serum osmolality

Answer: 1; ,3; 5

Rationale: Diagnosis of increased ICP is made on the basis of observation and neurologic assessment; even subtle changes can be clinically significant. Testing can include CT scan or MRI, serum osmolality, and ABGs. Lumbar puncture is not performed.

Assessment

Physiological Integrity

Application

Learning Outcome 2

9. A client with altered consciousness is brought to the Emergency Department. The client is lethargic, and has decreased respirations and slow motor movements. Upon physical examination, the nurse finds several narcotic analgesic patches on the client's torso. The next intervention would include:

- a). Infusion of a hypotonic IV solution.
- b) Administration of naloxone.
- c) Removal of the patches.
- d) ICP monitoring.

Answer: c

Rationale: Removing the patches would be the first thing the nurse would do. Narcotic patches deliver medication systemically. The next step would be to administer naloxone—a narcotic reversal agent. A hypertonic IV solution is often given to treat disturbances in consciousness, and monitoring for ICP would be premature at this point.

Implementation

Physiological Integrity

Application

Learning Outcome 4

11. A client with a brain abscess is admitted for acute care. Along with an antibiotic, the nurse can expect to administer which of the following?

- a) Morphine
- b) Decadron
- c) Valium
- d) Ativan

Answer: b

Rationale: Decadron is a steroid, and is often used in conjunction with antibiotics to decrease the inflammatory response. Morphine, Valium, and Ativan are all depressants and should be used cautiously or not at all, as they can mask early manifestations in those who might be at risk of deteriorating LOC.

Implementation

Physiological Integrity

Application

Learning Outcome 5

## Chapter 45

1. A client was diagnosed with a left cerebral hemorrhage. To meet the needs of the client and family, the nurse will include teaching in the following areas: (Select all that apply.)

1. How to use a sign board
2. Transfer techniques
3. Information about impulse control
4. Time adjustment to complete activities

Answer: 1; 2; 4

Rationale: The left cerebral hemisphere is responsible for the language center, calculation skills, and thinking/reasoning abilities. Reading and speaking could be compromised if there is left-sided brain damage. The client also might display over-cautious behavior and might be slow to respond or complete activities. Transfer techniques would apply regardless of the side involved. Impulse control problems can arise with right-sided involvement.

Implementation

Physiological Integrity

Application

Learning Outcome 2

2. A client has the nursing diagnosis: *Swallowing, Impaired*, and complains of frequent heartburn. The nurse should:

- a). Assist the client in maintaining a sitting position for 30 minutes after the meal.
- b). Teach the client the “chin tuck” technique when swallowing.
- c). Check the client’s mouth for pocketing of food.
- d). Assist the client to a 90-degree sitting position, or as high as tolerated, during meals.

Answer: a

Rationale: Keeping the client upright for a time after the meal will help prevent food from being regurgitated back into the esophagus. The position of the client during the meals as well as teaching the “chin tuck” technique will assist with the swallowing mechanism, but will not help with regurgitation. Pocketing food does not cause regurgitation.

Implementation

Physiological Integrity

Application

Learning Outcome 2

3. A nurse is teaching a wellness class, and is covering the warning signs of stroke. A client asks “What’s the most important thing for me to remember?” The nurse states:

- a) “Know your family history.”
- b) “Keep a list of your medications.”
- c) “Be alert for sudden weakness or numbness.”
- d) “Call 911 if you notice a gradual onset of paralysis or confusion.”

Answer: c

Rationale: Warning signs of stroke include sudden weakness, paralysis, loss of speech, confusion, dizziness, unsteadiness, loss of balance—the key word is *sudden*. Family history and past medical history can be indicators for risk, but they are not warning signs of stroke. Gradual onset of symptoms is not indicative of a stroke.

Implementation

Physiological Integrity

Application

Learning Outcome 1

45.4. A client with a spinal cord injury at the T1 level complains of a severe headache and an “anxious feeling.” The nurse initially should:

- a) Try to calm the client and make the environment soothing.
- b) Assess for a full bladder.
- c) Notify the physician.
- d) Prepare the client for diagnostic radiography.

Answer: b

Rationale: Autonomic dysreflexia occurs in clients with injury at level T6 or higher, and is a life-threatening situation that will require immediate intervention or the client will

die. The most common cause is an overextended bladder or bowel. Symptoms include hypertension, headache, diaphoresis, bradycardia, visual changes, anxiety, and nausea. A calm, soothing environment is fine, though not what the client needs in this case. The nurse should recognize this as an emergency and proceed accordingly. Once the assessment has been completed, the findings will need to be communicated to the physician.

Assessment

Physiological Integrity

Analysis

Learning Outcome 2

45.5. A client hospitalized with a known AV malformation begins to complain of a headache, and becomes disorientated. The nurse should:

- a) Recommend to the family that they start to look for a long-term care facility.
- b) Prepare to give aspirin or a “clot buster.”
- c) Ready the client for surgery.
- d) Document the changes and monitor closely.

Answer: c

Rationale: An AV malformation is a cluster of vessels, usually located in the midline cerebral artery, that, if ruptured, becomes a surgical emergency to cut the blood flow to the vessels or the client will bleed out into the brain. Symptoms of rupture include headache; change in level of consciousness; nausea and vomiting; neurological deficits—symptoms that mimic any brain bleed. Giving medication to affect coagulation will only make the bleeding worse. Recommending long-term care and merely documenting the changes are not appropriate interventions for a medical emergency.

Implementation

Physiological Integrity

Application

Learning Outcome 2

45.6. A nurse at a family gathering witnesses an adult relative drop her plate, become disoriented, and have noticeable changes in her speech. Nursing actions include the following. Organize them in order of priority, starting with the top priority.

1. Call 911.
2. Call ahead to the hospital.
3. Assist the client to a safe position.
4. Comfort the client's spouse.
5. Assess the client's respiratory effort.

Answer: 3, 5, 1, 2, 4

Rationale: Pre-hospital management includes making sure the client is free from further injury, assessment of ABCs, followed by the goals of stroke care, which are rapid recognition and reaction to stroke warning signs, rapid emergency medical services dispatch, rapid EMS system transport and hospital prenotification, and rapid diagnosis and treatment in the hospital.

Implementation

Physiological Integrity

Application

Learning Outcome 3

45.7. A school nurse is called after a student falls down a flight of stairs. The student is breathing, but unconsciousness. After the ambulance is called, the nurse should:

- a) Protect the client's neck and head from any movement.
- b) Place the client on his side to prevent aspiration.
- c) Open the airway using the head tilt maneuver.
- d) Try to rouse the client by gently shaking his shoulders.

Answer: c

Rationale: Guidelines for emergency care are avoiding flexing, extending, or rotating the neck; immobilization of the neck; securing the head; maintaining the client in the supine position; and transferring from the stretcher with backboard in place to the hospital bed. This client is unconscious, and the nurse must protect the neck from any (or any further) damage. If the client vomits, the nurse should utilize the log-roll technique to turn the client while keeping the head, neck, and spine in alignment. The airway should be opened using the jaw thrust maneuver. Rousing the client by shaking could cause damage to the spinal cord.

Implementation

Physiological Integrity

Application

Learning Outcome 3

46-8. A hospitalized client with a C7 cord injury begins to yell "I can't feel my legs anymore." The nurse should:

- a) Remind the client of her injury and try to comfort her.
- b) Call the physician and get an order for radiologic evaluation.
- c) Prepare the client for surgery, as her condition is worsening.
- d) Explain to the client that this could be a common, temporary problem.

Answer: d

Rationale: Spinal shock is a condition almost half the people with acute spinal injury experience. It is characterized by a temporary loss of reflex function below level of injury, and includes the following symptomatology: flaccid paralysis of skeletal muscles, loss of sensation below the injury, and possibly bowel and bladder dysfunction and loss of ability to perspire below the injury level. In this case, the nurse should explain to the client what is happening.

Implementation

Physiological Integrity

Application

Learning Outcome 4

45.9. A post-stroke client is going home on oral Coumadin (warfarin). During discharge teaching, which statement by the client would reflect an understanding of the effects of this medication?

- a) "I will stop taking this medicine if I notice any bruising."
- b) "I will not eat spinach while I'm taking this medicine."
- c) "It will be OK for me to eat anything, as long as it is low-fat."
- d) "I'll check my blood pressure frequently while taking this medication."

Answer: b

Rationale: Warfarin is a vitamin K antagonist. Green, leafy vegetables contain vitamin K, and will therefore interfere with the therapeutic effects of the drug. Bruising is a common side effect, and the drug should not be stopped unless by prescriber order. Low-fat foods do not interfere with warfarin therapy, which is not prescribed to affect the blood pressure.

Evaluation

Physiological Integrity

Application

Learning Outcome 5

45.10. A client with a spinal cord injury was given IV Decadron (dexamethasone) after arriving in the Emergency Department. The client also has a history of hypoglycemia. During the hospital stay, the nurse would expect to see:

- a) Increased episodes of hypoglycemia.
- b) Possible episodes of hyperglycemia.
- c) No change in the client's glycemic parameters.
- d) Both hyper- and hypoglycemic episodes.

Answer: b

Rationale: A common side effect of corticosteroids is hyperglycemia. Stress as well as the medication could cause this person to have periods of elevated blood sugars.

Evaluation

Physiological Integrity

Application

Learning Outcome 5

## Chapter 46

1. A client's spouse states "I've noticed that my spouse doesn't sleep well anymore and sometimes can't find the right words when we're visiting." The nurse should correctly respond:

- a) "Does anyone in your family have Alzheimer's disease?"
- b) "How long have you noticed these changes?"
- c) "These are common changes associated with age."
- d) "Do you think your spouse is depressed?"

Answer: b

Rationale: Although depression is underdiagnosed in the elderly client, and delirium closely resembles signs and characteristics of dementia, every effort must be made to get a clear history before an accurate diagnosis can be made. Family history is important to note, but a diagnosis of Alzheimer's disease is made by eliminating all physiological factors first.

Assessment

Physiological Integrity

Application

Learning Outcome 2

2. A client is hospitalized with Guillain-Barré syndrome and the nursing diagnosis *Spontaneous Ventilation, Impaired* has been identified. In planning care for this client, the nurse will prioritize the following interventions, with 1 being the most critical and 4 the least:

- 1) Careful airway suctioning to prevent infection
- 2) Client education regarding residual problems
- 3) Monitor arterial blood gases to identify changes.
- 4) Maintain hydration and caloric intake.

Answer: 1, 3, 4, 2

Rationale: Respiratory failure and infection are serious complications for the client hospitalized with Guillain-Barré syndrome. Remember ABCs—patent airway is the first concern, followed by close assessment of the arterial blood gases. Nutrition would come next, and although it is important to educate the client during all cares of his hospitalization, this is not a priority intervention compared to the others.

Implementation

Physiological Integrity

Application

Learning Outcome 2

3. A client comes to the clinic with complaints of blurred vision and muscle spasms that come and go, which have been occurring over the past several months. The client is scheduled for an MRI and lumbar puncture with examination of the CSF. A critical piece of the client history for the nurse to note is that:

- a) The client is from Canada.
- b) The client has a family history of epilepsy.
- c) The client has been depressed.

- d) The client's father had Parkinson's disease.

Answer: a

Rationale: High rates of multiple sclerosis occur in regions of northern Europe, the U.S., and Canada. The diagnostic studies to make a diagnosis of MS include examination of the CSF and an MRI to identify increase in immunoglobulin G as well as sclerotic plaque lesions on the spinal cord. Family history of epilepsy and Parkinson's disease and depression are important items of the client's history, but do not support a diagnosis of MS.

Assessment

Physiological Integrity

Application

Learning Outcome 1

4. A nurse working in a fertility clinic reviews the health history of a client whose father had Huntington's disease. What statement by the nurse would best address this client's risk factors?

- a) "Have you ever been tested for this disease?"
- b) "What do you know about testing for this disease?"
- c) "Are you sure you want to have children?"
- d) "Your child has a 50% chance of getting this disease."

Answer: b

Rationale: Children of a person with Huntington's disease have a 50% chance of inheriting it. The gene has been identified, and now a person can be tested to see if he has inherited it from a parent. Sensitive issues such as genetic predisposition, counseling, and risk must be handled tactfully, and it would be important to begin the history with

questions about the client's knowledge level. Assessing that initially can then lead to more in-depth questioning of the client.

#### Assessment

#### Physiological/Psychosocial Integrity

#### Application

#### Learning Outcome 1

5. A home health nurse visits a client with stage 2 Alzheimer's disease who lives at home with a spouse. In order to meet the needs of the spouse, the nurse suggests:

- a) Making arrangements for the client to visit the local senior citizen's center in the afternoon.
- b) Providing the client a list of daily activities to complete.
- c) Finding respite care to come into the home several days a week.
- d) Finding placement in a long-term care facility.

Answer: c

Rationale: Stage 2 clients generally are more confused, can demonstrate repetitive behavior, are less able to make simple decisions and to adapt to environmental changes, and are often unable to carry out activities of daily living. The spouse needs opportunities to have breaks from the demands of the client's care. Since the stage 2 client does not adapt well to changes in her environment, it would be best to have someone come into the home, rather than to have the client go out. An outing or a list of activities would be better suited for the client in stage 1. Recommending placement in long-term care might be premature, and is not up to the nurse.

#### Implementation

#### Psychosocial Integrity

Application

Learning Outcome 2

6. A client with stage 2 Alzheimer's disease has lost 5 pounds over the past month. The best nursing intervention would be:

- a) Recommend referral to a nutritionist.
- b) Make sure the client is put on a mechanical soft diet.
- c) Give the client food choices he can select.
- d) Provide quick snacks throughout the day.

Answer: d

Rationale: For the client with stage 2 Alzheimer's disease, nutrition and hydration problems arise, simply because the client is not able to complete activities of daily living. Increased confusion, frustration, and wandering occurs during this stage. Providing the client with opportunities to have snacks throughout the day, and giving foods that are easy to eat "on the go," like fruit slices, protein shakes, or finger foods such as sandwiches and cookies, are ways to offset the nutritional deficits that occur simply because the client is not interested in sitting down at the table for a meal. A nutritionist could be involved at some point, and there might not be a problem with the client's teeth or chewing/swallowing mechanisms. Because of altered mental status, the client might or might not be able to state what food choices he prefers.

Implementation

Physiological Integrity

Application

Learning Outcome 2

7. A client complains of periods of confusion and forgetfulness at times, and reports clear thought process at most times of the day. The symptoms have been gradually worsening. The best response by the nurse is:

- a) "You probably have nothing to worry about, it's most likely stress-related."
- b) "Everybody has a few problems with memory as they get older."
- c) "Have you started any new medications since the symptoms began?"
- d) "You should probably have an MRI of your brain."

Answer: c

Rationale: The diagnosis of Alzheimer's disease requires the documented presence of dementia, onset between 40 and 90 years, no loss of consciousness, and absence of systemic or brain disorders that could cause mental changes. Side effects of medication should also be ruled out as a possible cause of the symptoms. A nurse should never discount the client's concerns and memory loss with confusion, and forgetfulness is not part of the normal aging process. The nurse needs to explore further before an expensive diagnostic study is considered. It would be beyond the scope of practice for the nurse to recommend this testing.

Assessment

Physiological Integrity

Application

Learning Outcome 3

8. A client states "My doctor said sometimes I would have an on/off problem with this medication—what does that mean?" The best response by the nurse is:

- a) "There will be times when you are depressed (off) and when you are happy (on)."
- b) "You will have to take breaks from this medicine by stopping (off) and starting it (on) again, so you don't build up a tolerance to it."

- c) "The on times will be when your symptoms are under control, the off times are when you will have increased problems with symptom management."
- d) "I'm not a pharmacist, so I shouldn't be answering this question."

Answer: c

Rationale: Clients taking Parkinson's drugs can experience episodes of hypomobility (off), when the dopamine/acetylcholine are imbalanced, and periods of symptom management when these two neurotransmitters are in better balance – the on time. On/off phenomenon has nothing to do with depressive episodes, and the medication for Parkinson's should not be started and stopped. A nurse should be able to answer questions about the client's medications, or at least attempt to find the answer if it is not known.

Implementation

Physiological Integrity

Application

Learning Outcome 4

9. A client with myasthenia gravis is taking pyridostigmine (Mestinon). Teaching about this medication should include immediately reporting:

- a) Increased weakness.
- b) Problems with increased drooling.
- c) Orthostatic hypotension.
- d) Headache.

Answer: a

Rationale: Overdose or underdosing of anticholinesterase drugs can lead to a myasthenic or cholinergic crisis. The goal of pharmacological therapy is to increase muscle tone; weakness after taking the medication should be reported as soon as possible to offset a

medical emergency. Increased drooling, lowering of blood pressure, and headache are all common side effects of pyridostigmine (Mestinon).

Implementation

Physiological Integrity

Application

Learning Outcome 4

10. A client with stage 2 Alzheimer's disease becomes very agitated in the evenings.

Appropriate nursing interventions would include:

- a) Use of anti-anxiety medications or tranquilizers.
- b) Moving the client to an area of activity to provide distraction.
- c) Playing soft music in the client's room.
- d) Recommending the client be moved to a more secure environment.

Answer: c

Rationale: Music therapy, massage, art therapy, sound, and dance are all alternative therapies that have been helpful in the treatment of Alzheimer's disease. Stage 2 with increased agitation in the evenings is part of the "sundowner's" phenomenon, and, although common, can be frustrating to the client as well as her caregivers. A quiet environment with less stimulation is often helpful. Though the use of anti-anxiety agents and tranquilizers might be helpful, this is not a true nursing intervention. If the client is not a danger to herself or others, there would be no indication that a more secure environment would be the best intervention.

Implementation

Psychosocial Integrity

Application

Learning Outcome 4

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## **Chapter 47**

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1. When the nurse was assessing a client for neurological changes from a head trauma, which eye assessments are included? Select all that apply.

1. Ptosis
2. Extraocular movements
3. Accommodation
4. Color of iris
5. Nystagmus

Answer: 1; 2; 3; 5

Ptosis refers to drooping lid placement. If cranial nerve damage has occurred, the lids will have a lack of tone to keep it open or incomplete closure of the lid when trying to close it. Extraocular control of movement of the eyeball to follow objects and coordination (synchronization) of both eyes to move as one reflect a cranial nerve dysfunction.

Accommodation is the bending of the light through all of the structures of the anterior and posterior chamber of the eye to clearly focus on one point on the retina. This includes light adjustments and alignment through both the vitreous and aqueous humor before “converging” on the single point on the retina. Cranial nerve functioning will alter the clarity of the image being projected on the retina. Nystagmus is the involuntary rhythmic movement of the eyes that occurs with cranial nerve changes and some medications. The color of the iris does not reflect any neurological changes or deficits in cranial nerves.

Bloom's: Application

Nursing Process: Assessment

Client Need: Physiological Integrity: Physiological Adaptation

2. When teaching a community health class about eye safety, which statement by one of the participants would reflect a need for additional teaching?

1. “I will wear goggles whenever I work around equipment such as lawnmowers, saws, and trimmers.”
2. “When I play sports, I should wear protective eyewear to minimize risks of eye injury.”
3. “When working with chemicals, if a splash occurs, I should first call 911 and then go to the emergency facility.”
4. “When working or playing in the outdoors, I should wear shades that have UV protection even if the day is cloudy.”

Answer: 3

If a chemical splash occurs, the first action should be to thoroughly rinse the eyes separately, so as not to cross-contaminate the opposite eye. Then call 911 and allow transport to emergency facility at that point. The neutralizing or diluting of chemicals will

minimize the risk and severity of damage to the eyes if done immediately (prior to calling 911). Therefore, additional teaching is needed to improve understanding of the need for an intervention prior to calling 911 under this circumstance. “*I will wear goggles whenever I work around equipment such as lawnmowers, saws, and trimmers*” is correct. Goggles will minimize the exposure risk from flying objects that might be thrown into the eye by equipment. “*When I play sports, I should wear protective eyewear to minimize risks of eye injury*” is correct. Protective eyewear will become a barrier for objects and direct contact with the eye during sports events. “*When working or playing in the outdoors, I should wear shades that have UV protection even if the day is cloudy*” is correct. UV protection is needed anytime the participants are in the sun, whether sunny or cloudy. The UV rays are harmful, and can damage the eyes even when clouds are present.

Bloom's: Application

Nursing Process: Evaluation

Client Need: Safe, Effective Care Management: Safety and Infection Control

3. The client was complaining of dizziness and disequilibrium with head movements. The nurse understands which nursing diagnosis would be the top priority based upon these findings?
  1. Fluid Balance, Deficit
  2. Adjustment Impairment
  3. Coping, Ineffective
  4. Falls, Risk for

Answer: 4

Rationale: Dizziness and disequilibrium are caused by changes within the vestibule and semicircular canals of the inner ear, which give the sensation of starting, stopping, and position of the head in relationship to gravitational pull. The dizziness and disequilibrium create a risk for potential injury from falling from loss of balance. Therefore, this is the top priority for this client. Not enough information is given in the stem to say if the symptoms of dizziness and disequilibrium are a fluid imbalance. *Adjustment Impairment* is defined as a disability requiring a change in lifestyle, characterized by inadequate support system, impaired cognition, sensory overload assault to self-esteem, altered loss of control or incomplete grieving. Therefore, this NANDA does not apply to the physical symptoms of dizziness and disequilibrium. *Coping, Ineffective* is defined as an inability or incomplete ability to deal with stressors and/or to apply strategies to deal with stress or a perceived threat. Dizziness and disequilibrium are physical symptoms, not characteristic of psychosocial adaptation measures.

Bloom's: Analysis

Nursing Process: Planning

Client Need: Physiological Integrity: Reduction of Risk Potential

4. When the nurse is planning the health history questions to ask a client about possible hearing changes that might have occurred due to frequent sinus infections, which question would be appropriate? Select all that apply.
1. "Do you have any pain in your ears?"
  2. "Have you ever had drainage from your ears?"
  3. "Does anyone in your family have congenital deafness?"
  4. "Have you noticed a change in your hearing, such as muffling of sounds?"

Answer: 1; 2; 4

"*Do you have any pain in your ears?*" is appropriate to the situation presented. Ear pain can be caused by pressure buildup by fluid and/or purulent matter in the sinus cavities as it spreads up through the eustachian tube into the middle ear. Pressure builds up and can lead to rupture of the tympanic membrane, or secretions can create scar tissue, both of which can diminish hearing. "*Have you ever had drainage from your ears?*" is appropriate. Drainage from the ears indicates a rupture in the tympanic membrane. Therefore, a rupture could create a change in hearing. "*Have you noticed a change in your hearing, such as muffling of sounds?*" should be asked. Asking for subjective description of client's perception of hearing changes is appropriate to try to identify and describe any changes that might have occurred with the frequent sinus infections. "*Does anyone in your family have congenital deafness?*" does not address the client's current status; it is asking about the family's history. If the client had congenital deafness, a change in hearing would not be present. The question does not relate to the current situation of sinus infections impacting current hearing status. Thus, this question should not be asked.

Bloom's: Application

Nursing Process: Planning

Client Need: Physiological Integrity: Physiological Adaptation

5. When the nurse is assessing for a possible conductive hearing loss, which assessment would be the first one to perform?
1. Inspection of the external ear
  2. Weber test
  3. Rinne test
  4. Tympanogram

Answer: 1

Visual inspection of the external ear will give information about possible obstructions from cerumen, drainage, redness, swelling, or objects present in the external canal. Visual inspection can also give you the condition of the tympanic membrane—intactness (or rupture), swelling, redness, and scarring. Pain also might be identified when using the otoscope to visualize the structures in the external canal. Therefore, the first nursing action (inspection) will guide the choice of next assessments that need to be made. A

Weber test is done to identify equality of sound hear in both ears. This would be the next step in the assessment process. Normally, sound is heard equally in both ears. A Rinne test is done to identify the difference between bone and air conduction of sound by each ear. This is the third step. Normally, sound can be heard twice as long by air conduction as by bone conduction. Tympanograms are done to measure the pressure of the middle ear by evaluating the tympanic membrane's response to waves of pressure. Normal pressure is a 100 daPa (a very small amount). Abnormal findings can be caused by fluid in the middle ear, perforated tympanic membrane, impacted cerumen, or a tumor in the middle ear. This test would be done last, only if other symptoms were noted or indicated by the nurse's findings.

Bloom's: Application

Nursing Process: Assessment

Client Need: Safe, Effective Care Management: Management of Care

6. The nurse suspects that a bone-conductive hearing loss is present in the client. Which diagnostic would best differentiate between bone conduction loss and air conduction loss?
1. Rinne test
  2. Weber test
  3. Assessment of balance and body position
  4. Palpation of mastoid process

Answer: 1

A Rinne test is a comparison of sound by air in contrast to bone conduction. Bone conduction is greater than air conduction in the ear with conductive loss. Therefore, this test would be helpful to identifying a conductive loss. A Weber test will identify a hearing loss by lateralization (increase in sound) to the ear with a conductive hearing loss. Thus this test would be helpful to identify a difference between left and right ear changes that might be related to a conductive hearing loss. Balance and body position changes would reflect a disturbance in the inner ear and possible nerve damage. If balance and body position are affected, this information does not differentiate between a conductive hearing loss, a nerve loss, and a combination of both types of losses. Since other factors might be present, assessing balance and perception of body position will not identify the potential source of the hearing problem. Therefore, this assessment would be the least helpful in the assessment process to identify the source for a conduction hearing loss. Palpation of the mastoid process would tell you if pain or swelling is present.

Tenderness, swelling, or nodules can indicate inflammation of the external auditory canal and mastoid sinuses. Mastoiditis can lead to fluid or scarring within the middle ear, which could interfere with sound conduction from the external to the inner ear. Therefore, this assessment would be helpful to identify a source for conduction hearing loss.

Bloom's: Analysis

Nursing Process: Evaluation

Client Need: Health Promotion and Maintenance

7. When planning home management for a client who recently lost vision after eye trauma, which of the following would be most appropriate to evaluate the emotional status of the client?

1. "Do you feel depressed about your vision loss?"
2. "Tell me how your change in vision has affected how you feel about yourself."
3. "Have you made arrangements for someone to help you around the house?"
4. "You know, a lot of people do very well with little help once they get home."

Answer: 2

By asking what the client's feelings about the loss or the perceived effect of the loss, the nurse can explore the current mental state of the client without any preconceived idea of the needs of the client. This is an open-ended question that requires more than a "yes or no" response that would elicit information specifically for this client. "*Do you feel depressed about your vision loss?*" is a simple "yes/no"-response question that does not elicit input about feelings or personal concerns about the client's emotional state. In grieving, denial is the first stage of loss. The client might not be ready to admit to feelings. This is a non-therapeutic approach that does not gather client information about current emotional status. In asking "Have you made arrangements for someone to help you around the house?" the nurse has assumed that assistance will be needed, and does not focus upon the feelings or emotional state of the client. Also, the question doesn't address any possible coping strategies that might be needed to deal with the loss. Therefore, the nurse has changed the topic away from the emotional state of the client to home management. Generalizing about other people's feelings does not help the client to identify and verbalize the client's own feelings about the loss or her emotional state. Therefore, this is a non-therapeutic statement or a communication block that should be avoided.

Bloom's: Application

Nursing Process: Planning

Client Need: Psychosocial Integrity

8. When explaining a tonometer test results of 28 mm Hg to a client, the nurse would use which explanation to be most accurate? The tonometer measures the pressure in the:

1. Posterior chamber of your eye, which is too low and requires medication to increase the pressure to prevent blindness from retinal damage.
2. Inner ear, to evaluate the semicircular canals functions related to nerve damage, and 28 mm Hg is "within the normal range."

3. Pressure in the middle ear that builds up with Mastoiditis, and 28 mm Hg is very high, and needs to be treated with surgical insertion of tubes to drain the fluid behind the tympanic membrane.

4. Anterior chamber of the eye that builds up from overproduction or decreased drainage of the aqueous humor, and could lead to possible retinal changes due to above-normal pressures, like yours, if not treated.

Answer: 4

The tonometer is a non-invasive tool to measure the anterior pressure that can build up with glaucoma from overproduction of aqueous humor or decreased drainage from blockage of the canal of Schlemm. Either condition can be treated with surgery or drug management. A measurement of 28 mm Hg is above the normal range of 12–15 mm Hg or 15–20 mm Hg. A tonometer measures the pressure in the anterior, not the posterior, chamber of the eye. Medication can be used to reduce the pressures in the anterior chamber; posterior fluid (vitreous humor) is not replaced. A tonometer measures eye pressures, and it has nothing to do with the semicircular canal functions in the inner ear. A tympanogram measures the pressure behind the tympanic membrane. A tonometer measures eye pressures and has nothing to do with ear pressure. A tympanogram measures pressure on the tympanic membrane, and can be increased by pressure from fluids with mastoiditis.

**\*\*(See Note to author below about conflicting data)**

Bloom's: Analysis

Nursing Process: Evaluating

Client Need: Physiological Integrity: Physiological Adaptation

**\*\*\*\*NOTE TEXT contradicts itself for two different norms are given on page 5 of chapter 47 and page 39 of chapter 48.... Please clarify which range is desired for consistency in text readings.**

9. When performing the caloric test, nystagmus develops in the left eye while irrigating the right ear. The nurse evaluates the client further for which condition that contributes to the results of the caloric test?

1. Alcohol, CNS depression, or barbiturate use
2. Increased anterior pressure in the left eye
3. Nothing further, since nerves are intact in the inner ear
4. Increased pressure from brain lesions

Answer: 3

Rationale: Nystagmus (repeated abnormal movements of the eyes) is a normal response to ear irrigation in the opposite eye. The response of nystagmus in the opposite eye of the ear irrigation reflects the crossover of innervation within the brain, which reflect the intact vestibular system within the inner ear. Alcohol, CNS depression, or barbiturate use will alter the results, and nystagmus will be diminished or absent. Anterior eye pressure

(within the eyeball) does not alter nystagmus, which is related to neuromuscular stimulation to the outside of the eyeball. If brain lesions are present, the nystagmus will not occur.

Bloom's: Application

Nursing Process: Evaluation

Client Need: Health Promotion and Maintenance

10. When assessing a 75-year-old client, which findings would require immediate action by the nurse? A statement about:

1. Floaters being present at times.
2. Additional light and "reading glasses" being needed more often.
3. The development of a white circle around colored part of eye.
4. Frequent falls from tripping over items in the floor.

Answer: 4

Excessive falling down can represent changes in vision that are current and enough to alter the field of vision. Macular degeneration, depth perception changes, and adaptation to changes in light represent a need for immediate and additional assessments. If macular degeneration is severe, full vision could be lost. Early intervention is needed to preserve what vision is left. Floaters are often seen in older clients, and are related to debris or condensation when the vitreous body pulls away from the retina. Unless excessive, with vision greatly impaired suddenly, this is not an urgent problem. Near vision accommodation is gradually lost as elasticity is decreased and presbyopia (a common problem in older clients) develops with the aging process. This is not an urgent problem. White circles around the colored part of the eye (arcus senilis) are caused by lipid deposits, through a gradual process that does not require immediate care.

Bloom's: Application

Nursing Process: Evaluation

Client Need: Health Promotion and Maintenance

## Chapter 48

1. A young female who has a 2-year-old and a new baby has just lost all vision in one eye following a vehicle trauma. The client asks what she will do, since she has no help when she goes home. The nurse would choose which nursing diagnoses when planning care? Select all that apply.

1. Post-Trauma Syndrome
2. Grieving, Actual/Anticipatory
3. Family Processes, Interrupted

4. Self-Esteem, Situational Low
5. Injury, Risk for

Answer: 2; 3; 4; 5

Actual grieving relates to the state in which the individual reacts to an actual or perceived loss, including verbalization of distress related to the loss (eye). Anticipatory loss relates to the intellectual and emotional responses and behaviors by which the individual works through the process of modifying her self-concept based upon the perception of potential losses. This is expressed by sorrow, anger, or resolution of grief prior to the actual reality of the loss. Both of these are noted when the client recognizes that help will be needed due to a future role change, or the need for some physical assistance based upon her actual vision change. *Family Processes, Interrupted* is defined as a change in family relationships and/or functioning and demonstrated by changes in assigned tasks, resources available, and satisfaction with family. The client realizes that parenting and caring for the children will be altered and adaptations will be needed, which will impact on the client's relationship with her children. *Self-Esteem, Situational Low* applies to this client since it is defined as the development of negative perception of self-worth in response to the current situation, with examples related to body image disturbance, functional impairment, and loss (vision). The client expresses concern about her ability to care for the children adequately after the vision loss. Therefore, her self-perception has changed as a result of the vision loss. The risk for injury for this client is based upon actual vision changes that alter depth perception, visual field, and risk for falls/trauma as she interacts with the environmental conditions. Post-trauma syndrome relates to a sustained maladaptive response to a traumatic, overwhelming event that results in flashbacks, panic, anger, and avoidance. The client does not give those symptoms when discussing this current vision loss and the lack of help at home. The client might be at risk for this NANDA at a later date, but it is not a current issue to be included in the plan of care.

Bloom's: Analysis

Nursing Process: Evaluation

Client Need: Psychosocial Integrity

2. Upon admission when orienting a client who has been blind since birth to the hospital room, which activity by the nurse would be appropriate? Select all that apply.

1. Orient the client both verbally and physically to the layout of the room.
2. Describe everything in detail about how the equipment works.
3. Tell the client you will leave the light on 24 hours a day.
4. Place signs to remind staff to not move equipment without telling the client.

Answer: 1; 2; 4

Orienting the client both verbally and physically should be done to allow the client to understand where items are and what is present in the room. Therefore, this action is appropriate to the situation for a totally blind client. Describing in detail what equipment is present and how to use everything that the client will use will allow independence and

safety (such as using the call bell). Therefore, this action is appropriate to the totally blind client's orientation to the room. Posting a sign as a reminder to leave equipment (chairs, tables, etc.) in the same location will minimize the risk of injury when the client is up in the room. Staff from all departments might not be familiar with the client's special needs, and a simple reminder will allow all staff to contribute to the client's well-being. Therefore, this action is appropriate for the nurse during the orientation process. Telling the client that a light will be on will not increase safety for a client that has no vision. In some cases, even though the client is blind, this action will alter the sleeping pattern of the client. Therefore, this action is not recommended for any client, especially not for a totally blind one.

Bloom's: Application

Nursing Process: Intervention

Client Need: Safe, Effective Care Environment: Safety and Infection Control

3. Which instructions would be appropriate for the nurse to give to a client with acute conjunctivitis from *Staphylococcus*? Select all that apply.

1. You should wash your hands before cleansing the eye and giving eyedrops.
2. You can rub your eyes with a clean, soft cloth for itching.
3. You can soak your lids with warm saline to soften crusts and exudates.
4. You should not share towels, make-up, or contact lens with anyone else.

Answer: 1; 3; 4

Prevention of cross-contamination by handwashing (hand hygiene) will minimize the risk of bringing in other organisms to an already infected eye. This action should be encouraged at all times, but especially when there already is an infection present. Soaking the lids with sterile saline will soften the crusts from exudates that accompany the *Staphylococcus* infection. Therefore, this action will assist in the management. This action is appropriate, and should be included in the instructions. Sharing supplies, such as towels, make-up, or contacts, is never a good idea due to potential for cross-contamination from person to person. But during an actual infection, instructions should include discouragement of using the same equipment after the infection is cleared.

Towels need to be washed in hot water. Make-up and contacts should be discarded and not reused. Therefore, this action should be included in instructions. The action of rubbing one's eyes can traumatize the eyes further, and should not be encouraged.

Soaking or rinsing the eyes with sterile saline or moisturizing solutions will assist in the process. Rubbing also brings the risk of cross-contamination from other sources, including the other eye if only one eye is involved. This action is inappropriate, and should not be included in care.

Bloom's: Application

Nursing Process: Intervention

Client Need: Health Promotion and Maintenance

4. Following a severe corneal ulcer, the client had keratoplasty (corneal transplant). What nursing care should be included in the plan of care? The client should: (Select all that apply.)

1. Wear an eye-shield the first 24 hours and then at night until several weeks postoperatively as directed by healthcare provider.
2. Be instructed to avoid lifting, sneezing, coughing or bending over at the waist.
3. Report any change, such as increased pain, drainage, bleeding, floaters, and cloudiness noted.
4. Be instructed on how to administer eyedrops and ointments in a sterile manner.
5. Be educated on the need for mydriatics during the postoperative period.

Answer: 1; 2; 3; 4

An eye-shield is needed to remind the client not to touch or bump the eye until complete healing of the corneal transplant has occurred. During the night, the eye is protected to avoid possible scratching or trauma while asleep. Lifting, sneezing, coughing, or bending will increase intraocular pressure, and should be avoided while the corneal transplant is healing. Any change (pain, drainage, bleeding, floaters, or cloudiness) should be reported immediately, since a complication might have developed (rupture of suture, infection, internal tears, etc.). The use of a sterile technique is needed for eye medication after surgery to prevent introduction of bacteria or trauma from touching the eye. Mydriatics will dilate the pupil of the eye and increase intraocular pressures. Therefore, they are not given postoperatively following a corneal transplant because they will minimize the blood flow and healing of the eye repair. Mydriatics are used in the preoperative phase to visualize the internal structures. Postoperatively, the medications that are given include antibiotics, corticosteroids, and sterile moisturizing solutions if needed.

Bloom's: Application

Nursing Process: Planning

Client Need: Physiological Integrity: Reduction of Risk Potential

5. Before teaching about home management for clients with open-angled glaucoma, which order would be questioned by the nurse?

1. Timolol (Timoptic), beta-adrenergic blocker, for a 60-year-old with congestive heart failure (CHF)
2. Dorzolamide (Trusopt), a carbonic anhydrase inhibitor, for a client with asthma and chronic obstructive pulmonary disease (COPD)
3. Acetazolamide (Diamox) for a 20-year-old male
4. Brimonidine (Alphagan), an adrenergic agonist, for a healthy 40-year-old

Answer: 1

Timolol (Timoptic) is a selected beta-adrenergic blocker that will reduce the intraocular pressure by decreasing production of aqueous humor. Its systemic effects might limit its use for clients with asthma, chronic obstructive pulmonary disease (COPD), heart block,

and congestive heart failure (CHF). Therefore, the nurse should question the use of this med with a client with CHF. Dorzolamide (Trusopt) lowers intraocular pressure, and is often an adjunctive therapy that removes fluids through kidney filtration. It is a carbonic anhydrase inhibitor that is contraindicated in closed-angle glaucoma, renal disease, and allergy to sulfa, but is indicated for open-angled glaucoma. This order is appropriate for this client, and should not be questioned. Acetazolamide (Alphagan) is also a carbonic anhydrase inhibitor that is used as an adjunctive therapy to remove fluids through kidney filtration. A healthy 20-year-old would have no contraindications unless allergic to sulfa drugs. This would not be questioned by the nurse. Brimonidine (Alphagan) is based on an epinephrine, sympathomimetic drug action to dilate the pupil and reduce the production of aqueous humor in clients with open-angled glaucoma. This drug is appropriate to give if no hypertension or cardiac disease is present, such as in a healthy 40-year-old.

Bloom's: Analysis

Nursing Process: Evaluation

Client Need: Physiological Integrity: Pharmacological and Parenteral Therapies

6. In a client with human immunodeficiency virus (HIV), the nurse should assess for which complications that might be present? Select all that apply.

1. Retinitis pigmentosa with retinal atrophy
2. Kaposi neoplasms of the external surfaces of the eyelid
3. Cotton-wool spots around the optic nerve
4. Exudative macular degeneration
5. Cytomegalovirus (CMV) retinitis

Answer: 2; 3; 5

Kaposi neoplasms are opportunistic neoplasms from suppressed immune responses of HIV. They appear as red, brown, or purple blotches that can enlarge as they develop. Cotton-wool spots around the optic nerve indicate noninfectious ophthalmic lesion in HIV clients. Cytomegalovirus (CMV) retinitis is an overgrowth of virus that can develop from immune suppression in HIV clients. Although it often develops first in only one eye, bilateral contamination usually occurs and leads to major vision damage. Retinitis pigmentosa is an inherited disorder that is either a dominant or recessive trait which might be associated with X-linked traits and not associated with immune deficiencies such as HIV. Exudative macular degeneration is not associated with HIV, but is related to aging, smoking, race, and possibly genetic factors

.

Bloom's: Analysis

Nursing Process: Assessing

Client Need: Physiological Integrity: Physiological Adaptation

7. Following myringotomy for acute otitis media, which topic would be appropriate for teaching about home management by the nurse?

1. Ear irrigations should be placed on the wall of the external canal, and not on the tympanic membrane.
2. Air travel and sudden barometric shifts will not affect the surgical procedure.
3. Sterile cotton-tipped swabs can be used to clean the ear drainage.
4. Shampooing and swimming are not restricted after a couple of weeks.

Answer: 2

Air travel and sudden barometric shifts should not affect the client to create a pressure buildup, since the tubes are in place and pressure equalization between the middle ear and the atmosphere can occur through the myringotomy tubes. Prior to the placement of the tubes, pressure in the middle ear would cause a severe increase in pain from the barometric shift with air travel. If pain does occur, this would indicate the tubes have been misplaced, and are no longer functioning. No ear irrigations should be given during the postoperative periods for a myringotomy (tubes inserted into the tympanic membrane). No water should be allowed to enter the external ear, since the fluid could enter the middle ear through the tubes and contaminate the middle ear. Even sterile swabs are not to be placed in the external canal after the myringotomy, because of the potential of dislodging the tubes, as well as the potential for contamination into the middle ear. Therefore, nothing should be inserted into the ear following surgery. A loosely placed sterile cotton ball can be placed in the external opening of the ear, not in the external canal or near the tympanic membrane. The cotton ball can collect any secretions that drain out, but it should not be packed deeply into the ear canal. Shampooing, swimming, submerging in water, and getting water in the ear are contraindicated for several months (not weeks) due to the risk of water contamination into the middle ear.

Bloom's: Application

Nursing Process: Planning

Client Need: Safe, Effective Care Environment: Safety and Infection Control

8. The client with otosclerosis would be expected to have which potential finding by the nurse during assessment?
1. Rinne test results that bone conduction is equal or greater than air conduction
  2. Severe vertigo is present when questioned.
  3. Purulent drainage is observed or reported with cyanosis of the tympanic membrane.
  4. Diminished hearing is noted in the lower tones, such as a man's speaking voice.

Answer: 1

A Rinne test differentiates between bone and air conduction. In otosclerosis, there is greater bone conduction than air conduction, due to the calcification and fixation of the malleus, incus, and stapes bones (bony ossicles) of the middle ear. Also, talking on the phone is retained longer than direct communication with people, since it represents bone conduction rather than air conduction of people speaking. Severe vertigo is the hallmark

symptom of inner ear disturbances, not the middle ear stapes fixation associated with otosclerosis. Purulent drainage with cyanosis of the tympanic membrane represents an acute or chronic middle ear infection that has caused a rupture of the tympanic membrane. Infection is not related to otosclerosis, which is often inherited. Diminished hearing begins in the upper tones or higher pitches that are lost first. Speaking in lower tones like a man's deeper pitch is more easily heard by a client with otosclerosis.

Bloom's: Application

Nursing Process: Evaluation

Client Need: Physiological Integrity: Physiological Adaptation

9. A client with severe symptoms of tinnitus, vertigo, sensorineural hearing deficit, nausea, and vomiting would have which nursing diagnosis as a first priority?
1. Nutrition, Imbalanced, Less than Body Requirements
  2. Trauma, Risk for
  3. Disturbed Sleep Patterns
  4. Sensory Perception, Disturbed: hearing

Answer: 2

Rationale: The symptoms listed are for labyrinthitis or Ménière's disease which disturbs all balance and coordination of motor skills related to gravitational pulls. Therefore, this is a disturbance of the inner ear. "Trauma Risk for" is the top priority. With imbalance and altered sensory input/perception, the risk for falls is very high. Actions to prevent injury from falls and/or other trauma should be the highest priority in management of care. "Nutrition, Imbalanced, Less than Body Requirements" is not the top priority, although this is relative to the symptoms present. It is a serious NANDA that should be third in the listing. Until nausea and vomiting are controlled, fluids need to be given by alternate methods, such as IV. The symptoms of vertigo and tinnitus do alter the ability to rest and sleep effectively. This is significant, but should not be the first priority, and therefore would be ranked fourth in the grouping. Long-term sleep deficits can lead to major psychological disorders that do need to be assessed further, but safety is a more immediate problem for this client. "Sensory Perception, Disturbed: hearing" is accurate for client that has tinnitus, vertigo, nausea, etc.; therefore, careful attention must be paid during the communication process to make sure that information is exchanged clearly and completely to avoid confusion or additional problems. However, the first priority is safety related to falls. This might be the second priority.

Bloom's: Analysis

Nursing Process: Planning

Client Need: Safe, Effective Care Environment: Management of Care

10. A client with a nursing diagnosis of *Communication: Impaired, Verbal related to hearing deficit* would expect which action in the plan of care? Select all that apply.

1. Speak face-to-face, but do not overarticulate your words.
2. Offer alternative methods of communication, such as paper and pencil.
3. Speak loudly and in a higher pitch for easier understanding of words.
4. Restate in exactly the same words if not understood the first time.
5. Do not use facial and hand gestures that are distracting while talking.

Answer: 1; 2

Many clients with hearing deficits can read lips to some extent to assist in the communication process. Facing away from the client will not alert the client to the need to communicate. Offering alternative methods of communication can allow for independence and clarity of communication if the client wants to use another method. By offering, the nurse allows the client to maintain self-esteem and input to one's management. Do not speak louder, but in a deeper tone for better understanding, since higher pitch is lost first with most hearing problems. Do not use the same words, since the consonants or vowels are not being understood. Try alternative words or methods of communication to get the point across. Repeating the same words is frustrating for both persons. Facial gestures and hand gestures (non-verbal cues) will contribute to understanding of a communication exchange. Therefore, they are not distracting but helpful to get one's point across.

Bloom's: Application

Nursing Process: Intervention

Client Need: Psychosocial Integrity

## **Chapter 49**

1. A client is scheduled to undergo a prostate biopsy. When providing education concerning postoperative care related to the procedure, which of the following should be included?
  - a. Avoid strenuous activity for 24 hours.
  - b. There may be discomfort for 24–48 hours after the procedure.
  - c. The client can immediately return to his preprocedure activity level.
  - d. The names of sexual contacts must be collected.

Answer: b

Rationale: The client might experience discomfort for 1–2 days after the procedure. Strenuous activity is avoided only for about 4 hours. Since the client must restrict activity for a short period after the procedure, the client cannot immediately return to his previous activity level. Names of sexual contacts will have no bearing on the prostate biopsy.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

2. A male client reports to the clinic with an open area on his penis. Which of the following questions will be most important to include in the data collection?

- a. "Have you had sexual intercourse recently?"

- b. "Do you think you have a disease?"
- c. "Are you promiscuous?"
- d. "When did you initially notice this open area?"

Answer: d

Rationale: It will be of importance to record the onset of the open area. The remaining questions are closed, and will not elicit much information. Asking the client about promiscuity is judgmental. Determining the date of the last episode of sexual intercourse might be indicated later if a disease is diagnosed.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

3. While providing care to the parents of a baby boy who has the chromosomal makeup of XXY, which of the following should be included in the teaching plan?

- a. The boy will have an enlarged penis and scrotum.
- b. The boy will be at increased risk for the development of testicular cancer.
- c. The child will be sterile.
- d. The child might have altered development of secondary sex characteristics.

Answer: d

Rationale. Individuals having the XXY chromosomal makeup might have an alteration in the development of secondary sexual characteristics. This is a result of the genetic mutations in the sex-determining region Y gene. An enlarged penis and scrotum would not be present in the XXY male. There is no research to support the increased development of testicular cancer or the incidence of infertility.

4. The nurse is obtaining a health history on a client complaining of recent-onset impotence. During the interview, which of the following questions will be most beneficial in identifying a potential cause of the manifestation?

- a. "Does this occur often?"
- b. "How does your partner feel about this problem?"
- c. "For what diseases and disorders have you been treated?"
- d. "Are you on any medications?"

Answer: c

Rationale: A client's health history can provide clues to the underlying cause of impotence. Open-ended questions will elicit the most information. Determining the frequency of impotence is important, but a closed question will limit the amount of information obtained. The client's partner is important, but is not the primary focus of this question. The client should be asked to list any medications being taken. Again, presenting a closed question will provide limited information.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

5. A female client has reported to the clinic for an initial gynecological examination. The client reports feeling nervous. When beginning the interview, which of the following questions would be most appropriate?

- a. "How many sexual partners have you had?"
- b. "Are you OK?"
- c. "How often are you intimate with your partner?"
- d. "What concerns do you have about today's examination?"

Answer: d

Rationale: The client is nervous. Efforts should be made to put the client at ease. Initial questions should be general and less invasive. As the interview progresses, questions can become increasingly sensitive as the situation warrants. The number of sexual partners and frequency of intercourse are private matters, and asking about them might yield important information later in the interview. The client's behavior indicates she is nervous, and asking if she is OK does nothing to manage the situation.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Psychosocial Integrity

CLIENT NEEDS SUBCATEGORY: Coping and Adaptation

COGNITIVE LEVEL: Analysis

6. A client is approximately 4 weeks pregnant. The client reports noting a scant amount of vaginal bleeding. The examination reveals the cervix is closed. Based upon your

knowledge, which of the following hormones do you anticipate will be lower than expected for the client?

- a. Progesterone
- b. Estrogen
- c. Prostaglandin
- d. Luteinizing hormone

Answer: a

Rationale: The progesterone levels elevate during early pregnancy. These rising levels aid in supporting maintenance of the endometrial layer. If the levels fall, breakthrough bleeding will result. Estrogen is elevated during pregnancy, but is not directly related to the bleeding being experienced by this client. Prostaglandins and luteinizing hormone aid in the release of the mature follicle from the ovary.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

7. A client is scheduled for a mammogram. Which of the following might adversely impact the testing?

- a. The use of deodorant
- b. The use of facial makeup
- c. The administration of medications used to increase bleeding times
- d. Eating breakfast the morning of the test

Answer: a

Rationale: Cosmetic products used in the test area could impact the examination. Facial makeup will not influence the test. A mammogram is a noninvasive test. Medications and dietary intake will not impact the test.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

8. When providing education to a client concerning breast self-examinations, the client asks what days are best to perform the examination. What information should be included in the response given to the client?

- a. It does not matter what day the examination is performed.
- b. It is best to perform the examination on the first day of the menstrual period.
- c. It is best to perform the examination in the days just prior to the menstrual period.
- d. The examination is best performed after the menstrual period.

Answer: d

Rationale: The body's hormones can influence the consistency and sensation of the breast tissue. The estrogen and progesterone levels are low after the menstrual cycle. The breast might be tender and swollen during and just prior to the menstrual period.

NURSING PROCESS STEP: Intervention

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

9. When obtaining the health history of a 60-year-old female, the client reports noting small red lesions on her vulva. Based upon your knowledge, which of these diagnoses is most likely correct?

- a. Herpes simplex
- b. Primary syphilis
- c. Secondary syphilis
- d. Vulvar carcinoma

Answer: d

Rationale: The client's reports are most indicative of vulvar cancer. Herpes simplex presents with painful lesions. Primary syphilis manifests as firm, painless ulcers. Secondary syphilis does not present with vulvar lesions.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

10. The nurse is teaching a client how to perform a testicular self-examination. What information should be provided to the client?

- a. Any painful lump should be reported.
- b. Tenderness of the scrotal sac contents should be reported.
- c. Most men have one testicle that is significantly larger than the other.
- d. It is best to do the examination upon arising on the designated day.

Answer: a

Rationale: Any lump, painful or painless, warrants reporting to the physician. The scrotal sac contents routinely are somewhat tender. Testicles that are found to differ significantly in size should be reported to the physician. The time of day does not influence the examination's findings.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

## CHAPTER 51

1. A 41-year-old client has reported to the clinic with clinical manifestations consistent with menopause. The client states that her menstrual periods have become irregular, with the last period occurring approximately four months ago. What information should be provided to the client concerning the use of contraceptives?

- a. Contraceptives should continue to be utilized.
- b. Contraceptives are no longer needed.
- c. Contraceptives will only be needed in the months after menstruation is experienced.
- d. Contraceptive use will only be needed for another two months.

Answer: a

Rationale: It takes approximately one year of menstrual cycle cessation in order for a woman to be considered in menopause. It is still possible for the woman to become pregnant during this period of time.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. The client who has been experiencing the clinical manifestations associated with menopause voices an interest in using alternative and complementary therapies to manage them. What initial response by the nurse is indicated?

- a. "Those seldom work."
- b. "Many women report success with these measures."
- c. "What types of therapies are of interest to you?"
- d. "Have you discussed this with the physician?"

Answer: c

Rationale: Alternative and complementary therapies are used by many women to manage the manifestations associated with menopause. The nurse has a responsibility to collect data from the client. The nurse will need to determine which types of therapies are of interest to the client. The success of these remedies varies by user. It is inappropriate for the nurse to meet the client's request with negativity. Clients using alternative therapies are asked to report them to their physicians. This is not, however, the initial step for this scenario.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

3. During the teaching session for a client who recently had a hysterectomy, the client states that she is nervous about taking the estrogen replacement therapy prescribed by her physician. She states that she is worried about developing breast cancer later in life. Which of the statements by the nurses will be most appropriate?

- a. "The risk of breast cancer is somewhat increased for women with a family history who opt to take estrogen replacement therapy."
- b. "The risk of breast cancer is not increased for women who have had a hysterectomy and take estrogen replacement medications."
- c. "Perhaps you should consider an estrogen–progestin combination therapy."
- d. "Taking estrogen replacement is not required after a hysterectomy."

Answer: b

Rationale: The risk for the development of breast cancer is not greater for women who take estrogen replacement therapy after undergoing a hysterectomy. Progestin therapies are not used for women who are in surgical menopause. Further, it is inappropriate for the nurse to make suggestions of a prescriptive nature, as it violates the scope of practice. While it is not mandatory for the client to take estrogen replacement therapy after surgery, the nurse should clarify and correct misconceptions of the client.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Pharmacological and Parenteral Therapies

COGNITIVE LEVEL: Application

4. A 30-year-old woman reports increasing difficulty during the days preceding the onset of her menstrual cycle. Which of the following might assist in the management of her condition? Select all that apply.

- a. Increase dietary sugar intake to promote energy.
- b. Increase intake of simple carbohydrates.
- c. Reduce caffeine.
- d. Utilize guided imagery.

Answers: c; d

Rationale: A reduction in caffeine intake is indicated to reduce irritability. Guided imagery can be used to reduce stress and promote relaxation. Dietary intake can be modified to aid in the management of premenstrual syndrome. Simple carbohydrates and sugars are reduced.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

5. A client who has been experiencing premenstrual syndrome reports to the clinic with a diet diary she has kept over the past several weeks. Which of the following findings should be reviewed with the client, with a recommendation made for dietary modification?

- a. Daily intake of caffeine-free soda
- b. Daily intake of low-fat yogurt
- c. Foods rich in magnesium
- d. Daily intake of white bread

Answer: d

Rationale: Dietary intake of simple carbohydrates should be reduced. White bread should be traded for whole-wheat bread if possible. Dietary adjustments of reduced caffeine and increased calcium and magnesium are beneficial in the management of premenstrual syndrome.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Analysis

6. A woman is scheduled to undergo a laparoscopic procedure. Which of the following statements by the client indicates the need for further education?

- a. "I can expect to go home a few hours after the procedure."
- b. "I might experience some abdominal pain after the procedure."
- c. "There might be some vaginal bleeding after the procedure."
- d. "Shoulder pain should be reported, as it might signal a complication."

Answer: d

Rationale: The presence of shoulder pain is anticipated after laparoscopic procedures. The discomfort is a result of the air injected into the abdominal cavity to promote visualization during the procedure.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

7. A 13-year-old female reports to the school nurse with concerns about her menstrual cycle. The client states that she has not yet started her period, and asks if this is normal. Which of the following should be included in the nurse's response?

- a. The client should be referred to a gynecologist for a pelvic examination.
- b. The client should have started her period by now.
- c. It is not abnormal for the client to have not yet started her period.
- d. The client should be tested for hormonal imbalances.

Answer: c

Rationale: The average age of onset for menarche is 12.8 years. The absence of menarche at the age of 13 is not a reason for concern. It is premature for the client to be examined or have testing for a hormonal imbalance.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Growth and Development Through the Life span

COGNITIVE LEVEL: Application

8. The nurse is collecting data during a routine clinic visit. The client reports she has experienced bleeding between her menstrual periods. What initial action by the nurse is most appropriate?

- a. Determine the timing of the bleeding episodes.
- b. Determine the amount of the bleeding episodes.
- c. Assess for the presence of sexually transmitted infections.
- d. Review the length of the client's normal menstrual cycles.

Answer: a

Rationale: Bleeding between menstrual cycles could have several causes. Bleeding can be a result of midcycle ovulation, and normal. It is most important to identify the timing of the bleeding to determine the underlying cause. Assessment of the amount of bleeding is next in importance. There is no indication the client has sexually transmitted infections. The length of the client's menstrual cycle is a part of the data collection process, but is not of the greatest importance.

NURSING PROCESS STEP: Assessment

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Analysis

9. A client has been experiencing anovulatory dysfunctional uterine bleeding. The client is 25 years of age, and is concerned about maintaining her fertility. Based upon your knowledge, which management technique likely would be employed first?

- a. Oral contraceptives
- b. Progestin therapy
- c. Therapeutic D and C
- d. Endometrial ablation

Answer: a

Rationale: Oral contraceptives can be used to regulate uterine bleeding in women when the bleeding is anovulatory. Progestin therapy can be used to treat ovulatory uterine bleeding. The therapeutic D and C would not be an initial therapy for condition. Endometrial ablation would destroy the client's fertility.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

10. A client is preparing to be discharged to home after a hysterectomy. Which of the following statements by the client indicates the teaching session has been successful?

- a. "I will need to report temperature greater than 101 degrees."
- b. "I might experience vaginal bleeding for about one week."
- c. "I will need to report any hot flashes, as they indicate my hormone replacement therapy is not effective."
- d. "I will still need to see my physician for gynecological examinations."

Answer: d

Rationale: The client who has had a hysterectomy still will need to have gynecological examinations. The client should be advised to seek medical advice if a temperature greater than 100°F is encountered. Vaginal bleeding after hysterectomy can last up to four weeks. The client who has a hysterectomy with the loss of the ovaries will immediately begin surgical menopause. The loss of estrogen is immediate. The hormone replacement therapy will take time to begin to manage the clinical manifestations associated with menopause.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risk Potential

COGNITIVE LEVEL: Application

## **Chapter 52**

1. A client recently diagnosed with herpes simplex II asks how to best manage the lesions. What information should be given to the client?
  - a. The use of soap should be restricted.
  - b. It is safe to use a solution of 50% rubbing alcohol and 50% water to clean the lesions.
  - c. Wearing nylon panties will reduce discomfort.
  - d. Gentle soap and water can be used to clean the lesions.

Answer: d

Rationale: The lesions need to be kept clean and dry. It is safe to use mild soap and water. Rubbing alcohol would cause burning of the lesions, and should not be used. Nylon panties will promote moisture and reduce ventilation to the perineal area.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

2. A client recently treated for pelvic inflammatory disease asks how she can best prevent a recurrence of the disease. What information should be provided to the client?

- a. The physician will prescribe prophylactic antibiotic therapy.
- b. The use of condoms will be beneficial.
- c. Annual gynecological examinations should be scheduled.
- d. Douching after intercourse will assist in removing potential pathogens from the genital area.

Answer: b

Rationale: Condoms provide a barrier from the introduction of pathogens to the woman's body. Prophylactic antibiotics are not used to manage pelvic inflammatory disease. Annual gynecological examinations are recommended, but will not prevent the spread of the disease. Douching can actually increase the incidence of pelvic inflammatory disease. Douching will force fluids higher into the woman's vagina and cervical area.

NURSING PROCESS STEP: Planning

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

3. A client treated for pelvic inflammatory disease is preparing for discharge. During the teaching session, the use of tampons is discussed. Which of the following statements by the client indicate the understanding of the content provided? Select all that apply.

- a. "I will be able to wear tampons."
- b. "The use of tampons is forever prohibited."

- c. "Tampons must be changed at least every four hours."
- d. "I should wear pads at night."

Answers: a; c; d

Rationale: The use of tampons is allowed. Clients using tampons must remember to change them regularly. Wearing pads at night will ensure the tampons are not left in too long while the client sleeps.

NURSING PROCESS STEP: Evaluation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Reduction of Risks Potential

COGNITIVE LEVEL: Application

4. A pregnant client reports to the clinic and learns she has tested positive for herpes simplex. The nurse develops a plan of care. Which of the following nursing diagnoses has the highest priority?

- a. Injury, Risk for related to the disease process
- b. Knowledge, Deficient related to the diagnosis
- c. Anxiety related to the diagnosis
- d. Family Processes, Interrupted related to the effects of the diagnosis on her relationship with her partner

Answer: a

Rationale: All of the presented nursing diagnoses are of importance to the client. The client's greatest risk is related to the potential for complications from the herpes simplex. Once the risk of injury is addressed, the diagnosis of next greatest importance involves the knowledge deficit. Anxiety and interrupted family processes can be managed after the client's risk for injury and knowledge deficit are managed.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Management of Care

COGNITIVE LEVEL: Analysis

5. A client has been diagnosed with latent syphilis. During the counseling session, the client asks about transmitting the disease to his spouse. What information should be provided to the client?

- a. "You will need to abstain from sexual relations until treatment is completed."
- b. "You will need to wear a condom."
- c. "At this late stage, the disease is contained to only you."
- d. "At this stage of the disease, transmission is by contact with blood."

Answer: d

Rationale: During latent syphilis, the disease is transmitted by exposure to contaminated blood. Sexual contact will not transmit the disease.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Safe, Effective Care Environment

CLIENT NEEDS SUBCATEGORY: Safety and Infection Control

COGNITIVE LEVEL: Analysis

6. During a gynecological examination and testing, a female client is diagnosed with a Chlamydial infection. The client denies any symptoms of the disease, and asks when she contracted the disease. What information should be provided to the client?

- a. The client has most likely had the infection for about 1–3 weeks.
- b. The infection has been in her body for less than 1 month, since no symptoms are present.
- c. The infection might have been in her body for an indefinite period of time.
- d. Symptoms typically begin a few months after the infection enters the body.

Answer: c

Rationale: The infection can be asymptomatic in the woman's body for months or years before symptoms are produced. The incubation period for the disease is 1–3 weeks.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

7. The nurse is planning to teach a course about sexually transmitted infections. What information concerning genital warts should be included?

- a. Handwashing will aid in the reducing the spread of genital warts.

- b. Genital warts will result in cervical cancer for the majority of women who get them.
- c. Women who have certain types of genital warts should be vaccinated against other types.
- d. The risk for the development of penile cancer is high in men diagnosed with genital warts.

Answer: a

Rationale: Handwashing is the first line of defense for the body against disease. A select number of disease strains are implicated in causing cervical cancer. The vaccine against the virus is limited to those individuals who do not have the disease. The rate of penile cancer is not overly high in men who have been diagnosed with genital warts.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

8. A client asks which method of contraception will provide the greatest protection against sexually transmitted infections. What method can the nurse recommend?

- a. Oral contraceptives
- b. Male condoms
- c. Sponges
- d. Spermicides

Answer: b

Rationale: The condom will provide a barrier against pathogens. Oral contraceptives contain hormones, and will not impact resistance to sexually transmitted infections. Sponges and spermicides contain chemicals to kill sperm. These chemicals alone do not provide protection from disease.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

COGNITIVE LEVEL: Application

9. A client reports to the clinic with a painless, ulcerated area on her labia. Based upon your knowledge, what diagnosis do you anticipate?

- a. Herpes simplex II
- b. Syphilis
- c. Condylomata acuminata
- d. Gonorrhea

Answer: b

Rationale: Painless ulcerations are indicative of syphilis. Herpes simplex II infection will present with a painful ulceration. Condylomata acuminata appear as fleshy growths in which the skin is intact. Gonorrhea infections manifest with dysuria or discharge.

NURSING PROCESS STEP: Diagnosis

CLIENT NEEDS CATEGORY: Physiological Integrity

CLIENT NEEDS SUBCATEGORY: Physiological Adaptation

COGNITIVE LEVEL: Application

10. A client with herpes simplex II is concerned about sexual relations. What information should be provided to the client?

- a. The infection can be transmitted only when the lesions present.
- b. The infection can be prevented with condom use.
- c. Sexual relations must be avoided during the prodromal period and for at least 10 days after the lesions are healed.
- d. Sexual activity is permissible once the lesions have dried out.

Answer: c

Rationale: The herpes simplex virus can be transmitted during the prodromal period and for approximately 10 days after the lesions have healed. During these periods, sexual activity should be avoided. During the prodromal period, lesions are not present, but it is believed the virus is shed, making transmission possible. Condom use is beneficial in protection against the disease, but it is not 100%. Viral shedding is limited after the lesions have healed, but this is not the only period of potential transmission.

NURSING PROCESS STEP: Implementation

CLIENT NEEDS CATEGORY: Health Promotion and Maintenance

CLIENT NEEDS SUBCATEGORY: Prevention and/or Early Detection of Health Problems

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COGNITIVE LEVEL: Analysis