1. Following discharge teaching, a male client with duodenal ulcer tells the nurse the he will drink plenty of dairy products, such as milk, to help coat and protect his ulcer. What is the best follow-up action by the nurse?
    - Review with the client the need to avoid foods that are rich in milk and cream

2. A male client with hypertension, who received new antihypertensive prescriptions at his last visit returns to the clinic two weeks later to evaluate his blood pressure (BP). His BP is 158/106 and he admits that he has not been taking the prescribed medication because the drugs make him "feel bad". In explaining the need for hypertension control, the nurse should stress that an elevated BP places the client at risk for which pathophysiological condition?
    - Stroke secondary to hemorrhage

3. The nurse observes an unlicensed assistive personnel (UAP) positioning a newly admitted client who has a seizure disorder. The client is supine and the UAP is placing soft pillows along the side rails. What action should the nurse implement?
    - Instruct the UAP to obtain soft blankets to secure to the side rails instead of pillows.

4. An adolescent with major depressive disorder has been taking duloxetine (Cymbalta) for the past 12 days. Which assessment finding requires immediate follow-up?
    - Describes life without purpose

5. A 60-year-old female client with a positive family history of ovarian cancer has developed an abdominal mass and is being evaluated for possible ovarian cancer. Her Papanicolau (Pap) smear results are negative. What information should the nurse include in the client's teaching plan?
    - Further evaluation involving surgery may be needed

6. A client who recently underwear a tracheostomy is being prepared for discharge to home. Which instructions is most important for the nurse to include in the discharge plan?
    - Teach tracheal suctioning techniques
7. In assessing an adult client with a partial rebreather mask, the nurse notes that the oxygen reservoir bag does not deflate completely during inspiration and the client's respiratory rate is 14 breaths / minute. What action should the nurse implement?
    - Document the assessment data
    - Rational: reservoir bag should not deflate completely during inspiration and the client's respiratory rate is within normal limits.
8. During shift report, the central electrocardiogram (EKG) monitoring system alarms. Which client alarm should the nurse investigate firs?
    - Respiratory apnea of 30 seconds
9. During a home visit, the nurse observed an elderly client with diabetes slip and fall. What action should the nurse take first?
    - Check the client for lacerations or fractures
10. At 0600 while admitting a woman for a schedule repeat cesarean section (C-Section), the client tells the nurse that she drank a cup a coffee at 0400 because she wanted to avoid

getting a headache. Which action should the nurse take first?

- Inform the anesthesia care provider

11. After placing a stethoscope as seen in the picture, the nurse auscultates S1 and S2 heart sounds. To determine if an S3 heart sound is present, what action should the nurse take first?
    - Listen with the bell at the same location
12. A 66-year-old woman is retiring and will no longer have a health insurance through her place of employment. Which agency should the client be referred to by the employee health nurse for health insurance needs?
    - Medicare

13. A client who is taking an oral dose of a tetracycline complains of gastrointestinal upset. What snack should the nurse instruct the client to take with the tetracycline?
    - Toasted wheat bread and jelly

14. Following a lumbar puncture, a client voices several complaints. What complaint indicated to the nurse that the client is experiencing a complication?
    - **"I have a headache that gets worse when I sit up"**
    - "I am having pain in my lower back when I move my legs"
    - "My throat hurts when I swallow"
    - "I feel sick to my stomach and am going to throw up"

15. An elderly client seems confused and reports the onset of nausea, dysuria, and urgency with incontinence. Which action should the nurse implement?
    - Obtain a clean catch mid-stream specimen

16. The nurse is assisting the mother of a child with phenylketonuria (PKU) to select foods that are in keeping with the child's dietary restrictions. Which foods are contraindicated for this child?
    - Foods sweetened with aspartame

17. Before preparing a client for the first surgical case of the day, a part-time scrub nurse asks the circulating nurse if a 3 minute surgical hand scrub is adequate preparation for this client. Which response should the circulating nurse provide?
    - Direct the nurse to continue the surgical hand scrub for a 5 minute duration
18. Which breakfast selection indicates that the client understands the nurse's instructions about the dietary management of osteoporosis?
    - Bagel with jelly and skim milk

19. The charge nurse of a critical care unit is informed at the beginning of the shift that less than the optimal number of registered nurses will be working that shift. In planning assignments, which client should receive the most care hours by a registered nurse (RN)?
    - An 82-year-old client with Alzheimer's disease newly-fractures femur who has a Foley catheter and soft wrist restrains applied

20. A mother brings her 6-year-old child, who has just stepped on a rusty nail, to the pediatrician's office. Upon inspection, the nurse notes that the nail went through the shoe and pierced the bottom of the child's foot. Which action should the nurse implement first?
    - **Cleanse the foot with soap and water and apply an antibiotic ointment**
    - Provide teaching about the need for a tetanus booster within the next 72 hours.
    - have the mother check the child's temperature q4h for the next 24 hours
    - transfer the child to the emergency department to receive a gamma globulin injection
21. The mother of an adolescent tells the clinic nurse, "My son has athlete's foot, I have been applying triple antibiotic ointment for two days, but there has been no improvement." What instruction should the nurse provide?
    - Stop using the ointment and encourage complete drying of the feet and wearing clean socks.
22. A 26-year-old female client is admitted to the hospital for treatment of a simple goiter, and levothyroxine sodium (Synthroid) is prescribed. Which symptoms indicate to the nurse that the prescribed dosage is too high for this client? The client experiences
    - Bradycardia and constipation
    - Lethargy and lack of appetite
    - Muscle cramping and dry, flushed skin
    - **Palpitations and shortness of breath**
23. A client with a history of heart failure presents to the clinic with a nausea, vomiting, yellow vision and palpitations. Which finding is most important for the nurse to assess to the client?
    - Obtain a list of medications taken for cardiac history
24. The healthcare provider prescribes an IV solution of isoproterenol (Isuprel) 1 mg in 250 ml of D_5W at 300 mcg/hour. The nurse should program the infusion pump to deliver how many ml/hour? (Enter numeric value only.)
    - 75
    - Rationale: Convert mg to mcg and use the formula D/H x Q. 300 mcg/hour / 1,000 mcg x 250 ml = 3/1 x 25 = 75 ml/hour
25. The pathophysiological mechanism are responsible for ascites related to liver failure? (Select all that apply)
    - Fluid shifts from intravascular to interstitial area due to decreased serum protein
    - Increased hydrostatic pressure in portal circulation increases fluid shifts into abdomen
    - Increased circulating aldosterone levels that increase sodium and water retention
26. The nurse is auscultating a client's heart sounds. Which description should the nurse use to document this sound? (Please listen to the audio first to select the option that applies)
    - Murmur
    - Rationale: A murmur is auscultated as a swishing sound that is associated with the blood turbulence created by the heart or valvular defect.

27. The healthcare provider prescribes celtazidime (Fortax) 35 mg every 8 hours IM for an infant. The 500 mg vial is labeled with the instruction to add 5.3 ml diluent to provide a concentration of 100 mg/ml. How many ml should the nurse administered for each dose? (Enter numeric value only. If rounding is required, round to the nearest tenth)
    - 0.4
    - rationale: 35mg/100mg x 1 = 0.35 = 0.4 ml
28. The nurse notes that a client has been receiving hydromorphone (Dilaudid) every six hours for four days. What assessment is most important for the nurse to complete?
    - **Auscultate the client's bowel sounds**
    - Observe for edema around the ankles
    - Measure the client's capillary glucose level
    - Count the apical and radial pulses simultaneously
    - Rationale: hydromorphone is a potent opioid analgesic that slows peristalsis and frequently causes constipation, so it is most important to Auscultate the client's bowel sounds

29. A female client is admitted with end stage pulmonary disease is alert, oriented, and complaining of shortness of breath. The client tells the nurse that she wants "no heroic measures" taken if she stops breathing, and she asks the nurse to document this in her medical record. What action should the nurse implement?
    - Ask the client to discuss "do not resuscitate" with her healthcare provider
30. A client is receiving a full strength continuous enteral tube feeding at 50 ml/hour and has developed diarrhea. The client has a new prescription to change the feeding to half strength. What intervention should the nurse implement?
    - Add equal amounts of water and feeding to a feeding bag and infuse at 50ml/hour
31. A female client reports that her hair is becoming coarse and breaking off, that the outer part of her eyebrows have disappeared, and that her eyes are all puffy. Which follow-up question is best for the nurse to ask?
    - Have you noticed any changes in your fingernails?
    - Rationale: The pattern of reported manifestations is suggestive of hypothyroidism
32. After a third hospitalization 6 months ago, a client is admitted to the hospital with ascites and malnutrition. The client is drowsy but responding to verbal stimuli and reports recently spitting up blood. What assessment finding warrants immediate intervention by the nurse?
    - **Capillary refill of 8 seconds**
    - bruises on arms and legs
    - round and tight abdomen
    - pitting edema in lower legs
33. After the nurse witnesses a preoperative client sign the surgical consent form, the nurse signs the form as a witness. What are the legal implications of the nurse's signature on the client's surgical consent form? (Select all that apply)
    - The client voluntarily grants permission for the procedure to be done
    - The client is competent to sign the consent without impairment of judgment

- The client understands the risks and benefits associated with the procedure

34. Following surgery, a male client with antisocial personality disorder frequently requests that a specific nurse be assigned to his care and is belligerent when another nurse is assigned. What action should the charge nurse implement?
    - Advise the client that assignments are not based on clients requests
35. A client with cervical cancer is hospitalized for insertion of a sealed internal cervical radiation implant. While providing care, the nurse finds the radiation implant in the bed. What action should the nurse take?
    - Place the implant in a lead container using long-handled forceps
36. The client with which type of wound is most likely to need immediate intervention by the nurse?
    - **Laceration**
    - Abrasion
    - Contusion
    - Ulceration
    - Rationale: A laceration is a wound that is produced by the tearing of soft body tissue. This type of wound is often irregular and jagged. A laceration wound is often contaminated with bacteria and debris from whatever object caused the cut.

37. The nurse is planning care for a client admitted with a diagnosis of pheochromocytoma.
Which intervention has the highest priority for inclusion in this client's plan of care?
    - Monitor blood pressure frequently
    - Rationale: A pheochromocytoma is a rare, catecholamine-secreting tumor that may precipitate life-threatening hypertension. The tumor is malignant in 10% of cases but may be cured completely by surgical removal. Although pheochromocytoma has classically been associated with 3 syndromes—von Hippel-Lindau (VHL) syndrome, multiple endocrine neoplasia type 2 (MEN 2), and neurofibromatosis type 1 (NF1)—there are now 10 genes that have been identified as sites of mutations leading to pheochromocytoma.
38. When caring for a client who has acute respiratory distress syndrome (ARDS), the nurse elevates the head of the bed 30 degrees. What is the reason for this intervention?
    - **To reduce abdominal pressure on the diaphragm**
    - to promote retraction of the intercostal accessory muscle of respiration
    - to promote bronchodilation and effective airway clearance
    - to decrease pressure on the medullary center which stimulates breathing
    - Rationale: a semi-sitting position is the best position for matching ventilation and perfusion and for decreasing abdominal pressure on the diaphragm, so that the client can maximize breathing.
39. When assessing a mildly obese 35-year-old female client, the nurse is unable to locate the gallbladder when palpating below the liver margin at the lateral border of the rectus abdominal muscle. What is the most likely explanation for failure to locate the gallbladder by palpation?
    - The client is too obese
    - Palpating in the wrong abdominal quadrant
    - Deeper palpation technique is needed

- **The gallbladder is normal**
- Rationale: a normal healthy gallbladder is not palpable

40. A woman with an anxiety disorder calls her obstetrician's office and tells the nurse of increased anxiety since the normal vaginal delivery of her son three weeks ago. Since she is breastfeeding, she stopped taking her antianxiety medications, but thinks she may need to start taking them again because of her increased anxiety. What response is best for the nurse to provide this woman?
    - describe the transmission of drugs to the infant through breast milk
    - encourage her to use stress relieving alternatives, such as deep breathing exercises
    - **Inform her that some antianxiety medications are safe to take while breastfeeding**
    - Explain that anxiety is a normal response for the mother of a 3-week-old.
    - Rationale: there are several antianxiety medications that are not contraindicated for breastfeeding mothers.
41. An older male client with a history of type 1 diabetes has not felt well the past few days and arrives at the clinic with abdominal cramping and vomiting. He is lethargic, moderately, confused, and cannot remember when he took his last dose of insulin or ate
    last. What action should the nurse implement first?
    - **Start an intravenous (IV) infusion of normal saline**
    - obtain a serum potassium level
    - administer the client's usual dose of insulin
    - assess pupillary response to light
    - Rationale: the nurse should first start an intravenous infusion of normal saline to replace the fluids and electrolytes because the client has been vomiting, and it is unclear when he last ate or took insulin. The symptoms of confusion, lethargy, vomiting, and abdominal cramping are all suggestive of hyperglycemia, which also contributes to diuresis and fluid electrolyte imbalance.
42. A client who received multiple antihypertensive medications experiences syncope due to a drop in blood pressure to 70/40. What is the rationale for the nurse's decision to hold the client's scheduled antihypertensive medication?
    - increased urinary clearance of the multiple medications has produced diuresis and lowered the blood pressure
    - the antagonistic interaction among the various blood pressure medications has reduced their effectiveness
    - **The additive effect of multiple medications has caused the blood pressure to drop too low**
    - the synergistic effect of the multiple medications has resulted in drug toxicity and resulting hypotension
43. Which client is at the greatest risk for developing delirium?
    - **An adult client who cannot sleep due to constant pain.**
    - an older client who attempted 1 month ago
    - a young adult who takes antipsychotic medications twice a day
    - a middle-aged woman who uses a tank for supplemental oxygen
44. Which intervention should the nurse include in a long-term plan of care for a client with

Chronic Obstructive Pulmonary Disease (COPD)?

- **Reduce risks factors for infection**
- Administer high flow oxygen during sleep
- Limit fluid intake to reduce secretions
- Use diaphragmatic breathing to achieve better exhalation

45. Which location should the nurse choose as the best for beginning a screening program for hypothyroidism?
    - **A business and professional women's group.**
    - An African-American senior citizens center
    - A daycare center in a Hispanic neighborhood
    - An after-school center for Native-American teens
46. A female client has been taking a high dose of prednisone, a corticosteroid, for several months. After stopping the medication abruptly, the client reports feeling "very tired". Which nursing intervention is most important for the nurse to implement?
    - **Measure vital signs**
    - Auscultate breath sounds
    - Palpate the abdomen
    - Observe the skin for bruising
47. A male client reports the onset of numbness and tingling in his fingers and around his mouth. Which lab is important for the nurse to review before contacting the health care provider?
    - capillary glucose
    - urine specific gravity
    - **Serum calcium**
    - white blood cell count
48. What explanation is best for the nurse to provide a client who asks the purpose of using the log-rolling technique for turning?
    - working together can decrease the risk for back injury
    - **The technique is intended to maintain straight spinal alignment.**
    - Using two or three people increases client safety.
    - turning instead of pulling reduces the likelihood of skin damage
49. A client receiving chemotherapy has severe neutropenia. Which snack is best for the nurse to recommend to the client?
    - Baked apples topped with dried raisins
50. Which action should the school nurse take first when conducting a screening for scoliosis?
    - Inspect for symmetrical shoulder height.
51. An unlicensed assistive personnel (UAP) assigned to obtain client vital signs reports to the charge nurse that a client has a weak pulse with a rate of 44 beat/ minutes. What action should the charge nurse implement?
    - Assign a practical nurse (LPN) to determine if an apical radial deficit is present
52. After a sudden loss of consciousness, a female client is taken to the ED and initial assessment indicate that her blood glucose level is critically low. Once her glucose level
    is stabilized, the client reports that was recently diagnosed with anorexia nervosa and is being treated at an outpatient clinic. Which intervention is more important to include in

this client's discharge plan?

- Encourage a low-carbohydrate and high-protein diet

53. A client with a peripherally inserted central catheter (PICC) line has a fever. What client assessment is most important for the nurse to perform?
    - Observe the antecubital fossa for inflammation.
54. The nurse administers an antibiotic to a client with respiratory tract infection. To evaluate the medication's effectiveness, which laboratory values should the nurse monitor? Select all that apply
    - White blood cell (WBC) count
    - Sputum culture and sensitivity
55. A client is admitted to isolation with the diagnosis of active tuberculosis. Which infection control measures should the nurse implement?
    - **Negative pressure environment**
    - contact precautions
    - droplet precautions
    - protective environment
56. A school nurse is called to the soccer field because a child has a nose bleed (epistaxis). In what position should the nurse place the child?
    - Sitting up and leaning forward
57. A young adult who is hit with a baseball bat on the temporal area of the left skull is conscious when admitted to the ED and is transferred to the Neurological Unit to be monitored for signs of closed head injury. Which assessment finding is indicative of a
developing epidural hematoma?
    - Altered consciousness within the first 24 hours after injury.
58. A female client with breast cancer who completed her first chemotherapy treatment today at an out-patient center is preparing for discharge. Which behavior indicates that the
client understands her care needs
    - Rented movies and borrowed books to use while passing time at home
59. Which instruction should the nurse provide a pregnant client who is complaining of heartburn?
    - Eat small meal throughout the day to avoid a full stomach.
60. A client is admitted to the intensive care unit with diabetes insipidus due to a pituitary gland tumor. Which potential complication should the nurse monitor closely?
    - **Hypokalemia**
    - Ketonuria.
    - Peripheral edema
    - Elevated blood pressure
    - Rational: pituitary tumors that suppress antidiuretic hormone (ADH) result in diabetes insipidus, which causes massive polyuria and serum electrolyte imbalances, including hypokalemia, which can lead to lethal arrhythmias.
61. A female client reports she has not had a bowel movement for 3 days, but now is defecating frequent small amount of liquid stool. Which action should the nurse implement?
    - Digitally check the client for a fecal impaction
62. After changing to a new brand of laundry detergent, an adult male reports that he has a

fine itchy rash. Which assessment finding warrants immediate intervention by the nurse?

- Bilateral Wheezing.

63. The nurse should teach the parents of a 6 year-old recently diagnosed with asthma that the symptom of acute episode of asthma are due to which physiological response?
    - Inflammation of the mucous membrane & bronchospasm
64. A 10 year old who has terminal brain cancer asks the nurse, "What will happen to my body when I die?" How should the nurse respond?
    - "The heart will stop beating & you will stop breathing."
65. The nurse is assessing a 3-month-old infant who had a pylorotomy yesterday. This child should be medicated for pain based on which findings? Select all that apply:
    - **Restlessness**
    - **Clenched Fist**
    - **Increased pulse rate**
    - **Increased respiratory rate.**
    - Increased temperature
    - Peripheral pallor of the skin
66. The nurse is preparing to administer an oral antibiotic to a client with unilateral weakness, ptosis, mouth drooping and, aspiration pneumonia. What is the priority nursing assessment that should be done before administering this medication?
    - Determine which side of the body is weak.
67. The nurse who is working on a surgical unit receives change of shift report on a group of clients for the upcoming shift. A client with which condition requires the most immediate attention by the nurse?
    - Gunshot wound three hours ago with dark drainage of 2 cm noted on the dressing.
    - Mastectomy 2 days ago with 50 ml bloody drainage noted in the Jackson-pratt drain.
    - Collapsed lung after a fall 8h ago with 100 ml blood in the chest tube collection container
    - **Abdominal-perineal resection 2 days ago with no drainage on dressing who has fever and chills.**
    - Rationale: the client with an abdominal- perineal resection is at risk for peritonitis and needs to be immediately assessed for other signs and symptoms for sepsis.
68. The nurse is caring for a client who had gastric bypass surgery yesterday. Which intervention is most important for the nurse to implement during the first 24 postoperative hours?
    - Measure hourly urinary output.
    - Rationale: a serious early complications of gastric bypass surgery is an anastomoses leak, often resulting in death.
69. When preparing to discharge a male client who has been hospitalized for an adrenal crisis, the client expresses concern about having another crisis. He tells the nurse that he wants to stay in the hospital a few more days. Which intervention should the nurse implement?
    - Schedule an appointment for an out-patient psychosocial assessment.
70. An adult female client tells the nurse that though she is afraid her abusive boyfriend might one day kill her, she keeps hoping that he will change. What action should the

nurse take first?

- Explore client's readiness to discuss the situation.

71. In caring for a client with Cushing syndrome, which serum laboratory value is most important for the nurse to monitor?
    - Lactate
    - **Glucose**
    - Hemoglobin
    - Creatinine
72. Azithromycin is prescribed for an adolescent female who has lower lobe pneumonia and recurrent chlamydia. What information is most important for the nurse to provide to this client?
    - Use two forms of contraception while taking this drug.
73. A client in the emergency center demonstrates rapid speech, flight of ideas, and reports sleeping only three hours during the past 48h. Based on these finding, it is most important for the nurse to review the laboratory value for which medication?
    - Divalproex.
    - Rationale: divalproex is the first line of treatment for bipolar disorder BPD because it has a high therapeutic index, few side effects, and a rapid onset in controlling symptoms and preventing recurrent episodes of mania and depression. The serum value of divalproex should be determined since the client is exhibiting symptoms of mania, which may indicate non-compliance with the medication regimen.
74. A male client who is admitted to the mental health unit for treatment of bipolar disorder has a slightly slurred speech pattern and an unsteady gait. Which assessment finding is most important for the nurse to report to the healthcare provider?
    - Serum lithium level of 1.6 mEq/L or mmol/l (SI)
    - Rationale: The therapeutic level of Serum lithium is 0.8 to 1.5 mEq/L or mmol/l (SI). Slurred speech and ataxia are sign of lithium toxicity.
75. A client was admitted to the cardiac observation unit 2 hours ago complaining of chest pain. On admission, the client's EKG showed bradycardia, ST depression, but no ventricular ectopy. The client suddenly reports a sharp increase in pain, telling the nurse, "I feel like an elephant just stepped on my chest" The EKG now shows Q waves and ST segment elevations in the anterior leads. What intervention should the nurse perform?
    - Administer prescribed morphine sulfate IV and provide oxygen at 2 L/min per nasal cannula.
76. The nurse is developing a teaching program for the community. What population characteristic is most influential when choosing strategies for implementing a teaching plan?
    - Literacy level
77. A client is being discharged with a prescription for warfarin (Coumadin). What instruction should the nurse provide this client regarding diet?
    - Eat approximated the same amount of leafy green vegetables daily so the amount of vitamin K consumed is consistent.
78. A client who had a small bowel resection acquired methicillin resistant staphylococcus aureus (MRSA) while hospitalized. He treated and released, but is readmitted today

because of diarrhea and dehydration. It is most important for the nurse to implement which intervention.

- Maintain contact transmission precaution

79. A postoperative female client has a prescription for morphine sulfate 10 mg IV q3 hours for pain. One dose of morphine was administered when the client was admitted to the post anesthesia care unit (PACU) and 3 hours later, the client is again complaining of pain. Her current respiratory rate is 8 breaths/minute. What action should the nurse take?
    - Administer Naxolone IV
80. Which intervention is most important for the nurse to include in the plan of care for an older woman with osteoporosis?
    - Place the client on fall precautions
81. Based on the information provided in this client's medical record during labor, which should the nurse implement? (Click on each chart tab for additional information. Please be sure to scroll to the bottom right corner of each tab to view all information contained in the client's medical record.)
    - Continue to monitor the progress of labor.
82. An unlicensed assistive personnel UAP leaves the unit without notifying the staff. In what order should the unit manager implement this intervention to address the UAPs behavior? (Place the action in order from first on top to last on bottom.)
    1. Note date and time of the behavior.
    2. Discuss the issue privately with the UAP.
    3. Plan for scheduled break times.
    4. Evaluate the UAP for signs of improvement.
83. A client with intestinal obstructions has a nasogastric tube to low intermittent suction and is receiving an IV of lactated ringer's at 100 ml/H. which finding is most important for the nurse to report to the healthcare provider?
    - Serum potassium level of 3.1 mEq/L or mmol/L (SI)
    - Rationale: **The normal potassium level** in the blood is 3.5-5.0 milliEquivalents per liter (mEq/L).
84. Which type of Leukocyte is involved with allergic responses and the destruction of parasitic worms?
    - Neutrophils
    - Lymphocytes
    - **Eosinophils**
    - Monocytes
    - Rationale: Eosinophils are involved in allergic responses and destruction of parasitic worms.
85. The healthcare provider prescribes the antibiotic cephradine 500mg PO every 6 hours for a client with a postoperative wound infection. Which foods should the nurse encourage this client to eat?
    - Yogurt and/or buttermilk.
86. Several months after a foot injury, and adult woman is diagnosed with neuropathic pain.

The client describes the pain as severe and burning and is unable to put weight on her foot. She asks the nurse when the pain will “finally go away.” How should the nurse respond?

- Assist the client in developing a goal of managing the pain

87. One day following an open reduction and internal fixation of a compound fracture of the leg, a male client complains of “a tingly sensation” in his left foot. The nurse determines the client’s left pedal pulses are diminished. Based on these finding, what is the client’s greatest risk?
    - Neurovascular and circulation compromise related to compartment syndrome.
88. The nurse is completing a head to be assessment for a client admitted for observation after falling out of a tree. Which finding warrants immediate intervention by the nurse?
    - Clear fluid leaking from the nose.
89. A client with multiple sclerosis (MS) has decreased motor function after taking a hot bath (Uhthoff’s sign). Which pathophysiological mechanism supports this response?
    - Temporary vasodilation
90. While assessing a radial artery catheter, the client complains of numbness and pain distal to the insertion site. What interventions should the nurse implement?
    - Promptly remove the arterial catheter from the radial artery.
91. A client is admitted with an epidural hematoma that resulted from a skateboarding accident. To differentiate the vascular source of the intracranial bleeding, which finding should the nurse monitor?
    - Rapid onset of decreased level of consciousness.
92. The nurse finds a client at 33 weeks gestation in cardiac arrest. What adaptation to cardiopulmonary resuscitation (CPR) should the nurse implement?
    - Position a firm wedge to support pelvis and thorax at 30 degree tilt.
93. When preparing a client for discharge from the hospital following a cystectomy and a urinary diversion to treat bladder cancer, which instruction is most important for the
nurse to include in the client’s discharge teaching plan?
    - Report any signs of cloudy urine output.
94. For the past 24 hours, an antidiarrheal agent, diphenoxylate, has been administered to a bedridden, older client with infectious gastroenteritis. Which finding requires the nurse to
take further action?
    - Tented skin turgor.
95. After repositioning an immobile client, the nurse observes an area of hyperemia. To assess for blanching, what action should the nurse take?
    - Apply light pressure over the area.
96. The nurse enters a client’s room and observes the client’s wrist restraint secured as seen in the picture. What action should the nurse take?
    - Reposition the restraint tie onto the bedframe.
97. A female client with acute respiratory distress syndrome (ARDS) is chemically paralyzed and sedated while she is on as assist-control ventilator using 50% FIO2. Which assessment finding warrants immediate intervention by the nurse?
    - Diminished left lower lobe sounds

- Rationale: Diminished lobe sounds indicate collapsed alveoli or tension pneumothorax, which required immediate chest tube insertion to re-inflate the lung.

98. The development of atherosclerosis is a process of sequential events. Arrange the pathophysiological events in orders of occurrence. (Place the first event on top and the last on the bottom)
    1. Arterial endothelium injury causes inflammation
    2. Macrophages consume low density lipoprotein (LDL), creating foam cells
    3. Foam cells release growth factors for smooth muscle cells
    4. Smooth muscle grows over fatty streaks creating fibrous plaques
    5. Vessel narrowing results in ischemia
99. Following a motor vehicle collision, an adult female with a ruptured spleen and a blood pressure of 70/44, had an emergency splenectomy. Twelve hours after the surgery, her urine output is 25 ml/hour for the last two hours. What pathophysiological reason
supports the nurse's decision to report this finding to the healthcare provider?
    - Oliguria signals tubular necrosis related to hypoperfusion
100. A nurse-manager is preparing the curricula for a class for charge nurses. A staffing formula based on what data ensures quality client care and is most cost-effective?
    - Skills of staff and client acuity
101. When performing postural drainage on a client with Chronic Obstructive Pulmonary Disease (COPD), which approach should the nurse use?
    - Explain that the client may be placed in five positions
102. A client presents in the emergency room with right-sided facial asymmetry. The nurse asks the client to perform a series of movements that require use of the facial muscles. What symptoms suggest that the client has most likely experience a Bell's palsy rather than a stroke?
    - Inability to close the affected eye, raise brow, or smile
103. The nurse is teaching a client how to perform colostomy irrigations. When observing the client's return demonstration, which action indicated that the client understood the teaching?
    - Keeps the irrigating container less than 18 inches above the stoma
104. The nurse should teach the client to observe which precaution while taking dronedarone?
    - Avoid grapefruits and its juice
105. A client who sustained a head injury following an automobile collision is admitted to the hospital. The nurse include the client's risk for developing increased
intracranial pressure (ICP) in the plan of care. Which signs indicate to the nurse that ICP has increased?
    - Increased Glasgow coma scale score.
    - Nuchal rigidity and papilledema.
    - **Confusion and papilledema**
    - Periorbital ecchymosis.
    - Rationale: papilledema is always an indicator of increased ICP, and confusion is usually the first sign of increased ICP. Other options do not necessarily reflect

increased ICP.

106. The nurse is caring for a client receiving continuous IV fluids through a single lumen central venous catheter (CVC). Based on the CVC care bundle, which action should be completed daily to reduce the risk for infection?

- Confirm the necessity for continued use of the CVC.

107. During an annual physical examination, an older woman's fasting blood sugar (FBS) is determined to be 140 mg/dl or 7.8 mmol/L (SI). Which additional finding obtained during a follow-up visit 2 weeks later is most indicative that the client has diabetes mellitus (DM)?

- Repeated fasting blood sugar (FBS) is 132 mg/dl or 7.4 mmol/L (SI).

108. A new mother tells the nurse that she is unsure if she will be able to transition into parenthood. What action should the nurse take?

- Determine if she can ask for support from family, friend, or the baby's father.

109. A client who was admitted yesterday with severe dehydration is complaining of pain a 24 gauge IV with normal saline is infusing at a rate of 150 ml/hour. Which intervention should the nurse implement first?

- Stop the normal saline infusion.

110. An elderly female is admitted because of a change in her level of sensorium. During the evening shift, the client attempts to get out bed and falls, breaking her left hip. Buck's skin traction is applied to the left leg while waiting for surgery. Which intervention is most important for the nurse to include in this client's plan care?

- Ensure proper alignment of the leg in traction.

111. An Unna boot is applied to a client with a venous stasis ulcer. One week later, when the Unna boot is removed during a follow-up appointment, the nurse observes that the ulcer site contains bright red tissue. What action should the nurse take in response to this finding?

- Document the ongoing wound healing.

112. At the end of a preoperative teaching session on pain management techniques, a client starts to cry and states, "I just know I can't handle all the pain." What is the priority nursing diagnosis for this client?

- Anxiety

113. The nurse note a visible prolapse of the umbilical cord after a client experiences spontaneous rupture of the membranes during labor. What intervention should the nurse implement immediately?

- Elevate the presenting part off the cord.

114. A client who had a right hip replacement 3 day ago is pale has diminished breath sound over the left lower lung fields, a temperature of 100.2 F, and an oxygen saturation rate of 90%. The client is scheduled to be transferred to a skilled nursing facility (SNF) tomorrow for rehabilitative critical pathway. Based on the client's symptoms, what recommendation should the nurse give the healthcare provider?

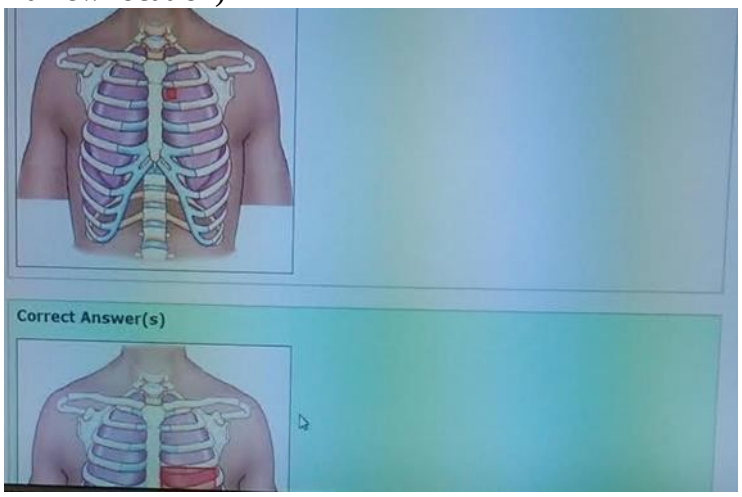
- Reassess readiness for SNF transfer.

115. A client who is newly diagnosed with type 2 diabetes mellitus (DM) receives a prescription for metformin (Glucophage) 500 mg PO twice daily. What information should the nurse include in this client's teaching plan? (Select all that apply.)

- Recognize signs and symptoms of hypoglycemia.
- Report persist polyuria to the healthcare provider.

- Take Glucophage with the morning and evening meal.

116. The nurse is developing an educational program for older clients who are being discharged with new antihypertensive medications. The nurse should ensure that the educational materials include which characteristics? Select all that apply
    - Written at a twelfth grade reading level
    - **Contains a list with definitions of unfamiliar terms**
    - **Uses common words with few Syllables**
    - Printed using a 12 point type font
    - **Uses pictures to help illustrate complex ideas**
    - Rationale: During the aging process older clients often experience sensory or cognitive changes, such as decreased visual or hearing acuity, slower thought or reasoning processes, and shorter attention span. Materials for this age group should include at least of terms, such as a medical terminology that incline may not know and use common words that expresses information clearly and simply. Simple, attractive pictures help hold the learner's attention. The reading level of material should be at the 4th to 5th grade level. Materials should be printed using large font (18-point or higher), not the standard 12-point font.

117. During the admission assessment, the nurse auscultates heart sounds for a client with no history of cardiovascular disease. Where should the nurse listen when assessing the client's point of maximal impulse (PMI) (Click the chosen location. To change, click on a new location)
    - 

118. An older male adult resident of long-term care facility is hospitalized for a cardiac catheterization that occurred yesterday. Since the procedure was conducted, the client has become increasingly disoriented. The night shift nurse reports that he attempted to remove the sandbag from his femoral artery multiple times during the night. What actions should the nurse take? (Select all that apply.)
    - Notify the healthcare provider of the client's change in mental status.
    - Include q2 hour's reorientation in the client's plan of care.

119. An older male comes to the clinic with a family member. When the nurse attempts to take the client's health history, he does not respond to questions in a clear

manner. What action should the nurse implement first?

- Assess the surroundings for noise and distractions.

120. The nurse caring for a client with acute renal fluid (ARF) has noted that the client has voided 800 ml of urine in 4 hours. Based on this assessment, what should the nurse anticipate that client will need?

- Large amounts of fluid and electrolyte replacement.

121. Which intervention should the nurse include in the plan of care for a child with tetanus?

- Minimize the amount of stimuli in the room

122. Suicide precautions are initiated for a child admitted to the mental health unit following an intentional narcotic overdose. After a visitor leaves, the nurse finds a package of cigarettes in the client's room. Which intervention is most important for the
nurse to implement?

- Remove cigarettes for the client's room

123. A family member of a frail elderly adult asks the nurse about eligibility requirements for hospice care. What information should the nurse provide? (Select all that apply.)

- A client must be willing to accept palliative care, not curative care.
- The healthcare provider must project that the client has 6 months or less to live.

124. A client with atrial fibrillation receives a new prescription for dabigatran. What instruction should the nurse include in this client's teaching plan?

- Avoid use of nonsteroidal ant-inflammatory drugs (NSAID).

125. A nurse with 10 years experience working in the emergency room is reassigned to the perinatal unit to work an 8 hour shift. Which client is best to assign to this nurse?

- A mother with an infected episiotomy

126. An infant who is admitted for surgical repair of a ventricular septal defect (VSD) is irritable and diaphoretic with jugular vein distention. Which prescription should the nurse administer first?

- Digoxin.

127. The nursing staff on a medical unit includes a registered nurse (RN), practical nurse (PN), and an unlicensed assistive personnel (UAP). Which task should the charge
nurse assign to the RN?

- Supervise a newly hired graduate nurse during an admission assessment.

128. While teaching a young male adult to use an inhaler for his newly diagnosed asthma, the client stares into the distance and appears to be concentrating on something other than the lesson the nurse is presenting. What action should the nurse take?

- Ask the client what he is thinking about at his time.

129. After several hours of non-productive coughing, a client presents to the emergency room complaining of chest tightness and shortness of breath. History includes
end stage chronic obstructive pulmonary disease (COPD) and diabetes mellitus. While completing the pulmonary assessment, the nurse hears wheezing and poor air movement bilaterally. Which actions should the nurse implement? (Select all that apply.)

- Administer PRN nebulizer treatment.
- Obtain 12 lead electrocardiogram.
- Monitor continuous oxygen saturation.

130. The nurse caring for a 3-month-old boy one day after a pylorotomy notices that

the infant is restless, is exhibiting facial grimaces, and is drawing his knees to his chest. What action should the nurse take?

- Administer a prescribed analgesia for pain.

131. A 4-year-old with acute lymphocytic leukemia (ALL) is receiving a chemotherapy (CT) protocol that includes methotrexate (Mexate, Trexal, MIX), an antimetabolite. Which information should the nurse provide the parents about caring for
their child?

- Use sunblock or protective clothing when outdoors.

132. Two days after admission a male client remembers that he is allergic to eggs, and informs the nurse of the allergy. Which actions should the nurse implement? (Select all that apply)

- Notify the food services department of the allergy.
- Enter the allergy information in the client's record.
- Add egg allergy to the client's allergy arm band.

133. The rapid response team's detects return of spontaneous circulation (ROSC) after 2 min of continuous chest compressions. The client has a weak, fast pulse and no respiratory effort, so the healthcare provider performs a successful oral, intubation. What
action should the nurse implement?

- Perform bilateral chest auscultation.

134. After administering an antipyretic medication. Which intervention should the nurse implement?

- Encouraging liberal fluid intake

135. A client with hyperthyroidism is being treated with radioactive iodine (I-131). Which explanation should be included in preparing this client for this treatment?

- Describe radioactive iodine as a tasteless, colorless medication administered by the healthcare provider

136. After a colon resection for colon cancer, a male client is moaning while being transferred to the Postanesthesia Care Unit (PACU). Which intervention should the nurse implement first?

- Determine client's pulse, blood pressure, and respirations

137. The nurse is caring for a group of clients with the help of a licensed practical nurse (LPN) and an experienced unlicensed assistive personnel (UAP). Which procedures can the nurse delegate to the UAP? (Select all that apply)

- Take postoperative vital signs for a client who has an epidual following knee arthroplasty
- Collect a sputum specimen for a client with a fever of unknown origin
- Ambulate a client who had a femoral-popliteal bypass graft yesterday

138. A male client with cirrhosis has ascites and reports feeling short of breath. The client is in semi Fowler position with his arms at his side. What action should the nurse implement?

- Raise the head of the bed to a Fowler's position and support his arms with a pillow

139. A client with a history of chronic pain requests a nonopioid analgesic. The client is alert but has difficulty describing the exact nature and location of the pain to the nurse. Which action should the nurse implement next?

- Administer the analgesic as requested

- Rationale: Chronic pain may be difficult to describe but should be treated with analgesics as indicated.

140. A client with a chronic health problem has difficulty ambulating short distance due to generalized weakness, but is able to bear weight on both legs. To assist with ambulation and provide the greatest stability, what assistive device is best for this client?

- Crutches with 2 point gait.
- Crutches with 3 point gait.
- **Crutches with 4 point gait.**
- A quad cane

141. The nurse uses the parkland formula (4ml x kg x total body surface area = 24 hours fluid replacement) to calculate the 24-hours IV fluid replacement for a client with
40% burns who weighs 76kg. How many ml should the client receive? (Enter numeric value only.)

- Answer: 12160
- Rationale: 4ml x 67kg x 40 (bsa) =12,160 ml

142. A client with leukemia undergoes a bone marrow biopsy. The client's laboratory values indicate the client has thrombocytopenia. Based on this data, which nursing assessment is most important following the procedure?

- **Observe aspiration site.**
- Assess body temperature
- Monitor skin elasticity
- Measure urinary output

143. An 18-year-old female client is seen at the health department for treatment of condylomata acuminate (perineal warts) caused by the human papillomavirus (HPV). Which intervention should the nurse implement?

- Reinforce the importance of annual papanicolaou (Pap) smears.

144. A client admitted to the psychiatric unit diagnosed with major depression wants to sleep during the day, refuses to take a bath, and refuses to eat. Which nursing intervention should the nurse implement first?

- Establish a structured routine for the client to follow.

145. A client with history of bilateral adrenalectomy is admitted with a week, irregular pulse, and hypotension. Which assessment finding warrants immediate intervention by the nurse?

- Ventricular arrhythmias.

- Rationale: adrenal crisis, a potential complication of bilateral adrenalectomy, results in the loss of mineralocorticoids and sodium excretions that is characterized by hyponatremia, hyperkalemia, dehydration, and hypotension. Ventricular arrhythmias are life threatening and required immediate intervention to correct critical potassium levels.

146. The mother of a 7-month-old brings the infant to the clinic because the skin in the diaper area is excoriated and red, but there are no blisters or bleeding. The mother reports no evidence of watery stools. Which nursing intervention should the nurse implement?

- Instruct the mother to change the child's diaper more often.

147. A resident of a long-term care facility, who has moderate dementia, is having difficulty eating in the dining room. The client becomes frustrated when dropping utensils on the floor and then refuses to eat. What action should the nurse implement?

- Encourage the client to eat finger foods.

148. A client is receiving mesalamine 800 mg PO TID. Which assessment is most important for the nurse to perform to assess the effectiveness of the medication?

- Bowel patterns
- Rationale: the client should be assessed for a change in bowel patterns to evaluate the effectiveness of this medication because Mesalamine is used to treat ulcerative colitis (a condition which causes swelling and sores in the lining of the colon [large intestine] and rectum) and also to maintain improvement of ulcerative colitis symptoms. Mesalamine is in a class of medications called anti-inflammatory agents. It works by stopping the body from producing a certain substance that
  may cause inflammation.

149. While in the medical records department, the nurse observes several old medical records with names visible in waste container. What action should the nurse implement?

- Contact the medical records department supervisor.

150. A 16-year-old adolescent with meningococcal meningitis is receiving a continuous IV infusion of penicillin G, which is prescribed as 20 million units in a total volume of 2 liters of normal saline every 24 hr. The pharmacy delivers 10 million units/ liters of normal saline. How many ml/hr should the nurse program the infusion pump? (Enter numeric value only. If rounding is required, round to the nearest whole number.)

- Answer 83
- Rationale: 1000 ml-----12hr.
- Xml ---------1hr.

- 1000/12 = 83.33 = 83.

151. While visiting a female client who has heart failure (HF) and osteoarthritis, the home health nurse determines that the client is having more difficulty getting in and out of the bed than she did previously. Which action should the nurse implement first?

- Submit a referral for an evaluation by a physical therapist.

152. A client has an intravenous fluid infusing in the right forearm. To determine the client's distal pulse rate most accurately, which action should the nurse implement?

- Palpate at the radial pulse site with the pads of two or three fingers.

153. A child is admitted to the pediatric unit diagnosed with sickle cell crisis. When the nurse walks into the room, the unlicensed assistive personnel (UAP) is encouraging the child to stay in bed in the supine position. Which action should the nurse implement?

- Reposition the client with the head of the bed elevated.

154. A preschool-aged boy is admitted to the pediatric unit following successful resuscitation from a near-drowning incident. While providing care to child, the nurse begins talking with his preadolescent brother who rescued the child from the swimming pool and initiated resuscitation. The nurse notices the older boy becomes withdrawn when asked about what happened. What action should the nurse take?

- Ask the older brother how he felt during the incident.

155. After six days on a mechanical ventilator, a male client is extubated and place on 40% oxygen via face mask. He is awake and cooperative, but complaining of a severe sore throat. While sipping water to swallow a medication, the client begins coughing, as if strangled. What intervention is most important for the nurse to implement?

- Hold oral intake until swallow evaluation is done.

156. The nurse is interacting with a female client who is diagnosed with postpartum depression. Which finding should the nurse document as an objective signs of depression? (Select all that apply)

- Interacts with a flat affect.
- Avoids eye contact.
- Has a disheveled appearance.

157. A client in the postanesthesia care unit (PACU) has an eight (8) on the Aldrete postanesthesia scoring system. What intervention should nurse implement?

- Transfer the client to the surgical floor.

158. In caring for the body of a client who just died, which tasks can be delegate to the unlicensed assistive personnel (UAP)? (Select all that apply.)

- Place personal religious artifacts on the body.
- Attach identifying name tags to the body.
- Follow cultural beliefs in preparing the body.

159. An adult male reports the last time he received penicillin he developed a severe maculopapular rash all over his chest. What information should the nurse provide the client about future antibiotic prescriptions?

- Be alert for possible cross-sensitivity to cephalosporin agents.

160. A client with a prescription for "do not resuscitate" (DNR) begins to manifest signs of impending death. After notifying the family of the client's status, what priority action should the nurse implement?

- The client's need for pain medication should be determined.

161. A client with cirrhosis of the liver is admitted with complications related to end stage liver disease. Which intervention should the nurse implement? (Select all that apply.)

- **Monitor abdominal girth.**
- Increase oral fluid intake to 1500 ml daily.
- **Report serum albumin and globulin levels.**
- Provide diet low in phosphorous.
- **Note signs of swelling and edema.**
- Rational: monitoring for increasing abdominal girth and generalized tissue edema and swelling are focused assessments that provide data about the progression of disease related complications. In advanced cirrhosis, liver function failure results in low serum albumin and serum protein levels, which caused third spacing that results in generalized fluid retention and ascites. Other options are not indicated in end stage liver disease.

162. During discharge teaching, the nurse discusses the parameters for weight monitoring with a client who was recently diagnosed with heart failure (HF). Which information is most important for the client to acknowledge?

- Report weight gain of 2 pounds (0.9kg) in 24 hours

163. Which problem, noted in the client's history, is important for the nurse to be aware of prior to administration of a newly prescribed selective serotonin reuptake inhibitor (SSRI)?

- **Aural migraine headaches.**

164. When implementing a disaster intervention plan, which intervention should the nurse implement first?

- Initiate the discharge of stable clients from hospital units

- **Identify a command center where activities are coordinated**
- Assess community safety needs impacted by the disaster
- Instruct all essential off-duty personnel to report to the facility

165. The nurse is evaluating a client's symptoms, and formulates the nursing diagnosis, "high risk for injury due to possible urinary tract infection." Which symptoms indicate the need for this diagnosis?

- **Fever and dysuria.**

166. A client is admitted with metastatic carcinoma of the liver, ascites, and bilateral 4+ pitting edema of both lower extremities. When the client complains that the antiembolic stocking are too constricting, which intervention should the nurse implement?

- **Maintain both lower extremities elevated on pillows.**

167. A client with muscular dystrophy is concerned about becoming totally dependent and is reluctant to call the nurse to assist with activities of daily living (ADLs). To achieve maximum mobility and independence, which intervention is most important for the nurse to include in the client's plan of care?

- **Teach family proper range of motion exercises.**

168. The nurse is teaching a postmenopausal client about osteoporosis prevention. The client reports that she smokes 2 packs of cigarettes a day and takes 750 mg calcium supplements daily. What information should the nurse include when teaching this client about osteoporosis prevention?

- **Postmenopausal women need an intake of at least 1,500 mg of calcium daily.**

169. When evaluating a client's rectal bleeding, which findings should the nurse document?

- **Color characteristics of each stool.**

170. The nurse is auscultating a client's lung sounds. Which description should the nurse use to document this sound?

- **High pitched or fine crackles.**
- Rhonchi
- High pitched wheeze

- Stridor

171. An adult male is admitted to the emergency department after falling from a ladder. While waiting to have a computed tomography (CT) scan, he requests something for a severe headache. When the nurse offers him a prescribed does of acetaminophen, he asks for something stronger. Which intervention should the nurse implement?

- **Explain the reason for using only non-narcotics.**

172. The nurse is managing the care of a client with Cushing's syndrome. Which interventions should the nurse delegate to the unlicensed assistive personnel (UAP)? (Select all that apply)

- **Weigh the client and report any weight gain.**
- **Report any client complaint of pain or discomfort.**
- **Note and report the client's food and liquid intake during meals and snacks.**

173. Ten years after a female client was diagnosed with multiple sclerosis (MS), she is admitted to a community palliative care unit. Which intervention is most important for the nurse to include in the client's plan of care?

- **Medicate as needed for pain and anxiety.**

174. An increased number of elderly persons are electing to undergo a new surgical procedure which cures glaucoma. What effect is the nurse likely to note as a result of this increases in glaucoma surgeries?

- **Decrease prevalence of glaucoma in the population.**

175. The nurse is caring for a client who is entering the second stage of labor. Which action should the nurse implement first?

- **Convey to the client that birth is imminent.**

176. To evaluate the effectiveness of male client's new prescription for ezetimibe, which action should the clinic nurse implement?

- **Remind the client to keep his appointments to have his cholesterol level checked.**

177. Diagnostic studies indicate that the elderly client has decreased bone density. In providing client teaching, which area of instruction is most important for the nurse to include?

178. Fall prevention measures.

179. A young adult client is admitted to the emergency room following a motor vehicle collision. The client's head hit the dashboard. Admission assessment include: Blood

pressure 85/45 mm Hg, temperature 98.6 F, pulse 124 beat/minute and respirations 22 breath/minute. Based on these data, the nurse formulates the first portion of nursing diagnosis as " Risk of injury" What term best expresses the "related to" portion of nursing diagnosis?

- Infection
- Increase intracranial pressure
- **Shock**
- Head Injury.

180. An older male client with history of diabetes mellitus, chronic gout, and osteoarthritis comes to the clinic with a bag of medication bottles. Which intervention should the nurse implement first?

- **Identify pills in the bag.**

181. A male client who was diagnosed with viral hepatitis A 4 weeks ago returns to the clinic complaining of weakness and fatigue. Which finding is most important for the nurse to report to the healthcare provider?

- **New onset of purple skin lesions.**

182. In assessing a client twelve hours following transurethral resection of the prostate (TURP), the nurse observes that the urinary drainage tubing contains a large amount of clear pale pink urine and the continuous bladder irrigation is infusing slowly. What action should the nurse implement?

- **Ensure that no dependent loops are present in the tubing.**

183. The healthcare provider prescribes the antibiotic Cefdinir (cephalosporin) 300mg PO every 12 h for a client with postoperative wound infections. Which feeds should the nurse encourage this client to eat?

- **Yogurt and/or buttermilk.**
- Avocados and cheese
- Green leafy vegetables
- Fresh fruits

184. The charge nurse is making assignment on a psychiatric unit for a practical nurse (PN) and newly license register nurse (RN). Which client should be assigned to the RN?

- An adult female who has been depress for the past several month and denies suicidal ideations.

- A middle-age male who is in depressive phase on bipolar disease and is receiving
  Lithium.

- **A young male with schizophrenia who said voices is telling him to kill his psychiatric.**

- An elderly male who tell the staff and other client that he is superman and he can fly.

- Rationale: The RN should deal with the client with command hallucinations and these can be very dangerous if the client's acts on the commands, especially if the command is a homicidal in nature. Other client present low safety risk.

185. A client at 30 week gestation is admitted due to preterm labor. A prescription of terbutaline sulfate 8.35 mg is gives subcutaneously. Based on which finding should the nurse withhold the next dose of this drug?

- **Maternal pulse rate of 162 beats per min**

186. In assessing an older female client with complication associated with chronic obstructive pulmonary disease (COPD), the nurse notices a change in the client's appearance. Her face appears tense and she begs the nurse not to leave her alone. Her pulse rate is 100, and respirations are 26 per min. What is the primary nursing diagnosis?

- **Anxiety related to fear of suffocation.**

187. A client with a cervical spinal cord injury (SCI) has Crutchfield tongs and skeletal traction applied as a method of closed reduction. Which intervention is most important
for the nurse to include in the client's a plan of care?

- **Provide daily care of tong insertion sites using saline and antibiotic ointment**

188. A client arrives on the surgical floor after major abdominal surgery.
What intervention should the nurse perform first?

- **Determine the client's vital sign.**

189. A client is admitted to the emergency department with a respiratory rate of 34 breaths per minute and high pitched wheezing on inspiration and expiration, the medical diagnosis is severe exacerbation of asthma. Which assessment finding, obtained 10 min after the admission assessment, should the nurse report immediately to the emergency department healthcare provider?

190. No wheezing upon auscultation of the chest.

191. The nurse is planning a class for a group of clients with diabetes mellitus about blood glucose monitoring. In teaching the class as a whole, the nurse should emphasize the need to check glucose levels in which situation?

- **During acute illness**

192. A 350-bed acute care hospital declares an internal disaster because the emergency generators malfunctioned during a city-wide power failure. The UAPs working on a general medical unit ask the charge nurse what they should do first. What instruction should the charge nurse provide to these UAPs?

- **Tell all their assigned clients to stay in their rooms.**

193. The nurse is auscultating is auscultating a client's heart sounds. Which description should the nurse use to document this sound? (Please listen to the audio file to select the option that applies.)

- **Murmur**
- s1 s2
- pericardial friction rub
- s1 s2 s3

194. The healthcare provider changes a client's medication prescription from IV to PO administration and double the dose. The nurse notes in the drug guide that the prescribed medication, when given orally, has a high first-pass effect and reduce bioavailability. What action should the nurse implement?

- **Administer the medication via the oral route as prescribed**

195. A client refuses to ambulate, reporting abdominal discomfort and bloating caused by "too much gas buildup" the client's abdomen is distended. Which prescribed PRN medication should the nurse administer?

- **Simethicone (Mylicon)**

196. The public nurse health received funding to initiate primary prevention program in the community. Which program the best fits the nurse's proposal?

- Case management and screening for clients with HIV.
- Regional relocation center for earthquake victims
- **Vitamin supplements for high-risk pregnant women.**
- Lead screening for children in low-income housing.
- Rational: Primary prevention activities focus on health promotions and disease preventions, so vitamin for high-risk pregnant women provide adequate vitamin and mineral for fetal developmental.

197. When assessing and adult male who presents as the community health clinic with a history of hypertension, the nurse note that he has 2+ pitting edema in both ankles. He

also has a history of gastroesophageal reflex disease (GERD) and depression. Which intervention is the most important for the nurse to implement?

- Arrange to transport the client to the hospital
- Instruct the client to keep a food journal, including portions size.
- **R eview t he cli ent's us e of over t he co u nter (OTC) m ed ications .**
- Reinforce the importance of keeping the feet elevated.
- Rationale: Sodium is used in several types of OTC medications. Including antacids, which the client may be using to treat his GERD. Further evaluation is need it to determine the need for hospitalization (A) A food journal (B) may help over, but dietary modifications are needed now since edema is present. (C) May relieve dependent edema, but not treat the underlying etiology.

198. An older client is admitted to the intensive care unit with severe abdominal pain, abdominal distention, and absent bowel sound. The client has a history of smoking 2 packs of cigarettes daily for 50 years and is currently restless and confused. Vital signs are: temperature 96`F, heart rate 122 beats/minute, respiratory rate 36 breaths/minute, mean arterial pressure(MAP) 64 mmHg and central venous pressure (CVP) 7 mmHg. Serum laboratory findings include: hemoglobin 6.5 grams/dl, platelets 6o, 000, and white blood cell count (WBC) 3,000/mm3. Based on these findings this client is at greatest risk for which pathophysiological condition?

- **Multiple organ dysfunction syndrome (MODS)**
- Disseminated intravascular coagulation (DIC)
- Chronic obstructive disease.
- Acquired immunodeficiency syndrome (AIDS)
- Rational: MODS are a progressive dysfunction of two or more major organs that requires medical intervention to maintain homeostasis. This client has evidence of several organ systems that require intervention, such as blood pressure, hemoglobin, WBC, and respiratory rate. DIC may develop as a result of MODS. The other options are not correct.

199. A man expresses concern to the nurse about the care his mother is receiving while hospitalized. He believes that her care is not based on any ethical standards and ask what type of care he should expect from a public hospital. What action should the nurse take?

- **Provide the man and his mother with a copy of the Patient's Bill of Rights**

200. A client experiencing withdrawal from the benzodiazepines alprazolam (Xanax)
is demonstrating severe agitation and tremors. What is the best initial nursing action?

- Administer naloxone (Narcan) per PNR protocol
- **Initiate seizure precautions**
- Obtain a serum drug screen
- Instruct the family about withdrawal symptoms.
- Rationale: Withdrawal of CNS depressants, such as Xanax, results in rebound over-excitation of the CNS. Since the client exhibiting tremors, the nurse should anticipate seizure activity and protect the client.

201. The nurse is caring for a client who is taking a macrolide to treat a bacterial infection. Which finding should the nurse report to the healthcare provider before administering the next dose?

- **Jaundice**
- Nausea
- Fever
- Fatigue

202. A client with Alzheimer's disease (AD) is receiving trazodone (Desyrel), a recently prescribed atypical antidepressant. The caregiver tells the home health nurse that the client's mood and sleep patterns are improved, but there is no change in cognitive ability. How should the nurse respond to this information?

- Explain that it may take several weeks for the medication to be effective
- **Confirm the desired effect of the medication has been achieved.**
- Notify the health care provider than a change may be needed.
- Evaluate when and how the medication is being administered to the client.
- Rationale: Trazodone o Desyrel, an atypical antidepressant, is prescribed for client with AD to improve mood and sleep.

203. A client with diabetic peripheral neuropathy has been taking pregabalin (Lyrica) for 4 days. Which finding indicates to the nurse that the medication is effective?

- **Reduced level of pain**
- Full volume of pedal pulses
- Granulating tissue in foot ulcer
- Improved visual acuity

204. A group of nurse-managers is asked to engage in a needs assessment for a piece of equipment that will be expensed to the organization's budget. Which question is most important to consider when analyzing the cost-benefit for this piece of equipment?

- **How many departments can use this equipment?**
- Will the equipment require annual repair?
- Is the cost of the equipment reasonable?
- Can the equipment be updated each year?

205. While receiving a male postoperative client's staples de nurse observe that the client's eyes are closed and his face and hands are clenched. The client states, "I just hate having staples removed". After acknowledgement the client's anxiety, what action should the nurse implement?

- Encourage the client to continue verbalize his anxiety
- **Attempt to distract the client with general conversation**
- Explain the procedure in detail while removing the staples
- Reassure the client that this is a simple nursing procedure.
- Rational: Distract is an effective strategy when a client experience anxiety during an uncomfortable procedure. (A & D) increase the client's anxiety.

206. A male client is admitted for the removal of an internal fixation that was inserted for the fracture ankle. During the admission history, he tells the nurse he recently received vancomycin (vancomycin) for a methicillin-resistant Staphylococcus aureus (MRSA) wound infection. Which action should the nurse take? (Select all that apply.)

- **Collect multiple site screening culture for MRSA**
- Call healthcare provider for a prescription for linezolid (Zyrovix)
- **Place the client on contact transmission precautions**
- Obtain sputum specimen for culture and sensitivity
- **Continue to monitor for client sign of infection.**
- Rationale: Until multi-site screening cultures come back negative (A), the client should be maintained on contact isolation(C) to minimize the risk for nosocomial infection. Linezolid (Zyvox), a broad spectrum anti-infectant, is not indicated, unless the client has an active skin structure infection cause by MRSA or multidrug- resistant strains (MDRSP) of Staphylococcus aureus. A sputum culture is not indicated9D) based on the client's history is a wound infection.

207. A vacuum-assistive closure (VAC) device is being use to provide wound care for a client who has stage III pressure ulcer on a below-the- knee (BKA) residual limb. Which intervention should the nurse implement to ensure maximum effectiveness of t he device?

- **Ensure the transparent dressing has no tears that might create vacuum leaks**

208. The nurse is developing the plan of care for a client with pneumonia and includes the nursing diagnosis of "Ineffective airway clearance related to thick pulmonary secretions." Which intervention is most important for the nurse to include in the client's plan of care?

- **Increase fluid intake to 3,000 ml/daily**

209. The nurse plans to collect a 24- hour urine specimen for a creatinine clearance test. Which instruction should the nurse provide to the adult male client?

- Clearance around the meatus, discard first portion of voiding, and collect the rest in a sterile bottle
- **Urinate at specific time, discard the urine, and collect all subsequent urine during the next 24 hours.**
- For the next 24 hours, notify the nurse when the bladder is full, and the nurse will collect catheterized specimens.
- Urinate immediately into a urinal, and the lab will collect specimen every 6 hours, for the next 24 hours.
- Rationale: Urinate at specific time, discard the urine, and collect all subsequent urine during the next 24 hours is the correct procedure for collecting 24-hour urine specimen. Discarding even one voided specimen invalidate the test.

210. The nurse is preparing to administer a histamine 2-receptor antagonist to a client with peptic ulcer disease. What is the primary purpose of this drug classification?

- **Decreases the amount of HCL secretion by the parietal cells in the stomach**

211. The healthcare provider prescribes acarbose (Precose), an alpha-glucosidase inhibitor, for a client with Type 2 diabetes mellitus. Which information provides the best indicator of the drug's effectiveness?

- **Hemoglobin A1C (HbA1C) reading less than 7%**

212. The nurse assesses a client with new onset diarrhea. It is most important for the nurse to question the client about recent use of which type of medication?

- **Antibiotics**
- Anticoagulants

- Antihypertensive
- Anticholinergics

213. A neonate with a congenital heart defect (CHD) is demonstrating symptoms of heart failure (HF). Which interventions should the nurse include in the infant's plan of care?

- **Give O2 at 6 L/nasal cannula for 3 repeated oximetry screens below 90%**
- Administer diuretics via secondary infusion in the morning only
- **Evaluate heart rate for effectiveness of cardio tonic medications**
- **Use high energy formula 30 calories/ounce at Q3 hours feeding via soft nipples**
- **Ensure Interrupted and frequent rest periods between procedures.**
- Rationale: Pulse oximetry screening supports prescribed level of O2. HR provides an evaluative criterion for cardiac medications, which reduce heart rate, increase strength contractions (inotropic effects) and consequently affect systemic circulation and tissue oxygenation. Breast milk or basic formula provide 20 calories/ounce, so frequent feedings with high energy formula. D minimize
  fatigue is necessary.

214. The nurse is caring for a 4-year-old male child who becomes unresponsive as his heart rate decreases to 40 beats/minute. His blood pressure is 88/70 mmHg, and his oxygen saturation is 70% while receiving 100% oxygen by non-rebreather face mask. In what sequence, from first to last, should the nurse implement these actions? (Place the first action on top and last action on the bottom.)

1. **Start chest compressions with assisted manual ventilations**
2. **Administer epinephrine 0.01 mg/kg intraosseous (IO)**
3. **Apply pads and prepare for transthoracic pacing**
4. **Review the possible underlying causes for bradycardia**

215. An elderly male client is admitted to the mental health unit with a sudden onset of global disorientation and is continuously conversing with his mother, who died 50 years ago. The nurse reviews the multiple prescriptions he is currently taking and assesses his urine specimen, which is cloudy, dark yellow, and has foul odor. These findings suggest that his client is experiencing which condition?

- **Delirium**
- Depression

- Dementia
- Psychotic episode

216. Following an esophagogastroduodenoscopy (EGD) a male client is drowsy and difficult to arouse, and his respiration are slow and shallow. Which action should the nurse implement? Select all that apply.

- **Prepare medication reversal agent**
- **Check oxygen saturation level**
- **Apply oxygen via nasal cannula**
- Initiate bag- valve mask ventilation.
- Begin cardiopulmonary resuscitation
- Rationale: Sedation, given during the procedure may need to be reverse if the client does not easily wake up. Oxygen saturation level should be asses, and oxygen applied to support respiratory effort and oxygenation. The client is still breathing so the bag- valve mask ventilation and CPR are not necessary.

217. The nurse is planning preoperative teaching plan of a 12-years old child who is scheduled for surgery. To help reduce the child anxiety, which action is the best for the nurse to implement?

- Give the child syringes or hospital mask to play it at home prior to hospitalization.
- Include the child in pay therapy with children who are hospitalized for similar surgery.
- **Provide a family tour of the preoperative unit one week before the surgery is scheduled.**
- Provide doll an equipment to re-enact feeling associated with painful procedures.
- Rationale: School age children gain satisfaction from exploring and manipulating their environment, thinking about objectives, situations and events, and making judgments based on what they reason. A tour of the unit allows the child to see the hospital environment and reinforce explanation and conceptual thinking.

218. Which intervention should the nurse implement during the administration of vesicant chemotherapeutic agent via an IV site in the client's arm?

- **Assess IV site frequently for signs of extravasation**

219. When development a teaching plan for a client newly diagnosed type 1 diabetes, the nurse should explain that an increase thirst is an early sing of diabetes ketoacidosis

(DKA), which action should the nurse instruct the client to implement if this sign of DKA occur?

- Resume normal physical activity
- Drink electrolyte fluid replacement
- **Give a dose of regular insulin per sliding scale**
- Measure urinary output over 24 hours.
- Rationale: As hyperglycemia persist, ketone body become a fuel source, and the client manifest early signs of DKA that include excessive thirst, frequent urination, headache, nausea and vomiting. Which result in dehydration and loss of electrolyte. The client should determine fingersticks glucose level and self-administer a dose of regular insulin per sliding scale.

220. The nurse is teaching a group of clients with rheumatoid arthritis about the need to modify daily activities. Which goal should the nurse emphasize?

- **Protect joint function**
- Improve circulation
- Control tremors
- Increase weight bearing

221. An adult client experiences a gasoline tank fire when riding a motorcycle and is admitted to the emergency department (ED) with full thickness burns to all surfaces of both lower extremities. What percentage of body surface area should the nurse document in the electronic medical record (EMR)?

- 9 %
- 18 %
- **36 %**
- 45 %
- Rational: according to the rule of nines, the anterior and posterior surfaces of one lower extremity is designated as 18 %of total body surface area (TBSA), so both extremities equals 36% TBSA, other options are incorrect.

222. A client with hyperthyroidism is receiving propranolol (Inderal). Which finding indicates that the medication is having the desired effect?

- Decrease in serum T4 levels
- Increase in blood pressure

- **Decrease in pulse**
- Goiter no longer palpable

223. An older male client with type 2 diabetes mellitus reports that has experiences legs pain when walking short distances, and that the pain is relieved by rest. Which client behavior indicates an understanding of healthcare teaching to promote more effective arterial circulation?

- Consistently applies TED hose before getting dressed in the morning.
- Frequently elevated legs thorough the day.
- Inspect the leg frequently for any irritation or skin breakdown
- **Completely stop cigarette/ cigar smoking.**
- Rationale: Stopping cigarette smoking helps to decrease vasoconstriction and improve arterial circulation to the extremity.

224. A community health nurse is concerned about the spread of communicable diseases among migrant farm workers in a rural community. What action should the nurse take to promote the success of a healthcare program designed to address this problem?

- **Establish trust with community leaders and respect cultural and family values**

225. The nurse performs a prescribed neurological check at the beginning of the shift on a client who was admitted to the hospital with a subarachnoid brain attack (stroke). The client's Glasgow Coma Scale (GCS) score is 9. What information is most important for the nurse to determine?

- **The client's previous GCS score**
- When the client's stroke symptoms started
- If the client is oriented to time
- The client's blood pressure and respiration rate
- Rationale: The normal GCS is 15, and it is most important for the nurse to determine if it abnormal score a sign of improvement or a deterioration in the client's condition

226. The charge nurse in a critical care unit is reviewing clients' conditions to determine who is stable enough to be transferred. Which client status report indicates readiness for transfer from the critical care unit to a medical unit?

- **Chronic liver failure with a hemoglobin of 10.1 and slight bilirubin elevation**

227. Based on principles of asepsis, the nurse should consider which circumstance to be sterile?

- One inch- border around the edge of the sterile field set up in the operating room
- A wrapped unopened, sterile 4x4 gauze placed on a damp table top.
- **An open sterile Foley catheter kit set up on a table at the nurse waist level**
- Sterile syringe is placed on sterile area as the nurse riches over the sterile field.
- Rationale: A sterile package at or above the waist level is considered sterile. The edge of sterile field is contaminated which include a 1-inch border (A). A sterile objects become contaminated by capillary action when sterile objects become in contact with a wet contaminated surface.

228. An unlicensed assistive personnel (UAP) reports that a client's right hand and fingers spasms when taking the blood pressure using the same arm. After confirming the presence of spams what action should the nurse take?

- Ask the UAP to take the blood pressure in the other arm
- Tell the UAP to use a different sphygmomanometer.
- **R eview t he cli ent's s er um calci um level**
- Administer PRN antianxiety medication.
- Rationale: Trousseau's sign is indicated by spasms in the distal portion of an extremity that is being used to measure blood pressure and is caused by hypocalcemia (normal level 9.0-10.5 mg/dl, so C should be implemented.

229. A 56-years-old man shares with the nurse that he is having difficulty making decision about terminating life support for his wife. What is the best initial action by the nurse?

- **Provide an opportunity for him to clarify his values related to the decision**
- Encourage him to share memories about his life with his wife and family
- Advise him to seek several opinions before making decision
- Offer to contact the hospital chaplain or social worker to offer support.
- Rationale: When a client is faced with a decisional conflict, the nurse should first provide opportunities for the client to clarify values important in the decision. The rest may also be beneficial once the client as clarified the values that are important to him in the decision-making process.

230. A client is being discharged home after being treated for heart failure (HF). What instruction should the nurse include in this client's discharge teaching plan?

- **Weigh every**
- Eat a high protein diet
- Perform range of motion exercises
- Limit fluid intake to 1,500 ml daily

231. A woman just learned that she was infected with Heliobacter pylori. Based on this finding, which health promotion practice should the nurse suggest?

- **Encourage screening for a peptic ulcer**

232. A client who recently underwear a tracheostomy is being prepared for discharge to home. Which instructions is most important for the nurse to include in the discharge plan?

- **Teach tracheal suctioning techniques**

233. A child with heart failure is receiving the diuretic furosemide (Lasix) and has serum potassium level 3.0 mEq/L. Which assessment is most important for the nurse to obtain?

- **Cardiac rhythm and heart rate.**
- Daily intake of foods rich in potassium.
- Hourly urinary output
- Thirst ad skin turgor.

234. The nurse note a depressed female client has been more withdrawn and non- communicative during the past two weeks. Which intervention is most important to include in the updated plan of care for this client?

- Encourage the client's family to visit more often
- Schedule a daily conference with the social worker
- Encourage the client to participate in group activities
- **Engage the client in a non-threatening conversation.**
- Rationale: Consistent attempts to draw the client into conversations which focus on non-threatening subjects can be an effective means of eliciting a response, thereby decreasing isolation behaviors. There is not sufficient data to support the effectiveness of A as an intervention for this client. Although B may be indicated, nursing interventions can also be used to treat this client. C is too threatening to this client.

235. A client with rheumatoid arthritis (RA) starts a new prescription of etanercept (Enbrel) subcutaneously once weekly. The nurse should emphasize the importance of reporting problem to the healthcare provider?

- Headache
- Joint stiffness
- **Persistent fever**
- Increase hunger and thirst
- Rationale: Enbrel decrease immune and inflammatory responses, increasing the client's risk of serious infection, so the client should be instructed to report a persistent fever, or other signs of infection to the healthcare provider.

236. The nurse is assessing an older adult with type 2 diabetes mellitus. Which assessment finding indicates that the client understands long- term control of diabetes?

- The fating blood sugar was 120 mg/dl this morning.
- Urine ketones have been negative for the past 6 months
- **The hemoglobin A1C was 6.5g/100 ml last week**
- No diabetic ketoacidosis has occurred in 6 months.
- Rationale: A hemoglobin A1C level reflects he average blood sugar the client had over the previous 2 to 3 month, and level of 6.5 g/100 ml suggest that the client understand long-term diabetes control. Normal value in a diabetic patient is up to
  6.5 g/100 ml.

237. An older male client is admitted with the medical diagnosis of possible cerebral vascular accident (CVA). He has facial paralysis and cannot move his left side. When entering the room, the nurse finds the client's wife tearful and trying unsuccessfully to give him a drink of water. What action should the nurse take?

- **Ask the wife to stop and assess the client's swallowing reflex**

238. A 13 years-old client with non-union of a comminuted fracture of the tibia is admitted with osteomyelitis. The healthcare provider collects home aspirate specimens for culture and sensitivity and applies a cast to the adolescent's lower leg. What action should the nurse implement next?

- Administer antiemetic agents
- Bivalve the cast for distal compromise
- Provide high- calorie, high-protein diet
- **Begin parenteral antibiotic therapy**

- Rationale: The standard of treatment for osteomyelitis is antibiotic therapy and immobilization. After bond and blood aspirate specimens are obtained for culture and sensitivity, the nurse should initiate parenteral antibiotics as prescribed.

239. The nurse is preparing a community education program on osteoporosis. Which instruction is helpful in preventing bone loss and promoting bone formation?

- **Recommend weigh bearing physical activity**

240. A client with a history of chronic pain requests a nonopioid analgesic. The client is alert but has difficulty describing the exact nature and location of the pain to the nurse. What action should the nurse implement next?

- **Administer the analgesic as requested**

241. A male client receives a thrombolytic medication following a myocardial infarction. When the client has a bowel movement, what action should the nurse implement?

- **Send stool sample to the lab for a guaiac test**
- Observe stool for a day-colored appearance.
- Obtain specimen for culture and sensitivity analysis
- Asses for fatty yellow streaks in the client's stool.
- Rationale: Thrombolytic drugs increase the tendency for bleeding. So guaiac (occult blood test) test of the stool should be evaluated to detect bleeding in the intestinal tract.

242. The mother of a child with cerebral palsy (CP) ask the nurse if her child's impaired movements will worsen as the child grows. Which response provides the best explanation?

- **Brain damage with CP is not progressive but does have a variable course**

243. During shift report, the central electrocardiogram (EKG) monitoring system alarms. Which client alarm should the nurse investigate first?

- **Respiratory apnea of 30 seconds**

244. In early septic shock states, what is the primary cause of hypotension?

- Peripheral vasoconstriction
- **Peripheral vasodilation**
- Cardiac failure
- A vagal response

- Rationale: Toxins released by bacteria in septic shock create massive peripheral vasodilation and increase microvascular permeability at the site of the bacterial invasion.

245. A client diagnosed with calcium kidney stones has a history of gout. A new prescription for aluminum hydroxide (Amphogel) is scheduled to begin at 0730. Which client medication should the nurse bring to the healthcare provider's attention?

- **Allopurinol (Zyloprim)**
- Aspirin, low dose
- Furosemide (lasix)
- Enalapril (vasote)

246. A male client's laboratory results include a platelet count of 105,000/ mm3 Based on this finding the nurse should include which action in the client's plan of care?

- Cluster care to conserve energy
- Initiate contact isolation
- **Encourage him to use an electric razor**
- Asses him for adventitious lung sounds
- Rationale: This client is at risk for bleeding based on his platelet count (normal 150,000 to 400,000/ mm3). Safe practices, such as using an electric razor for shaving, should be encouraged to reduce the risk of bleeding.

247. A client is admitted to the hospital after experiencing a brain attack, commonly referred to as a stroke or cerebral vascular accident (CVA). The nurse should request a referral for speech therapy if the client exhibits which finding?

- Abnormal responses for cranial nerves I and II
- **Persistent coughing while drinking**
- Unilateral facial drooping
- Inappropriate or exaggerated mood swings

248. At 1615, prior to ambulating a postoperative client for the first time, the nurse reviews the client's medical record. Based on date contained in the record, what action should the nurse take before assisting the client with ambulation:

- **Remove sequential compression devices.**
- Apply PRN oxygen per nasal cannula.

- Administer a PRN dose of an antipyretic.
- Reinforce the surgical wound dressing.
- Rationale: Sequential compression devices should be removed prior to ambulation and there is no indication that this action is contraindicated. The client's oxygen saturation levels have been within normal limits for the previous four hours, so supplemental oxygen is not warranted.

249. Which assessment finding for a client who is experiencing pontine myelinolysis should the nurse report to the healthcare provider?

- **Sudden dysphagia**
- Blurred visual field
- Gradual weakness
- Profuse diarrhea

250. A client is scheduled to receive an IW dose of ondansetron (Zofran) eight hours after receiving chemotherapy. The client has saline lock and is sleeping quietly without any restlessness. The nurse caring for the client is not certified in chemotherapy administration. What action should the nurse take?

- Ask a chemotherapy-certified nurse to administer the Zofran
- **Administer the Zofran after flushing the saline lock with saline**
- Hold the scheduled dose of Zofran until the client awakens
- Awaken the client to assess the need for administration of the Zofran.
- Rationale: Zofran is an antiemetic administered before and after chemotherapy to prevent vomiting. The nurse should administer the antiemetic using the accepter technique for IV administration via saline lock. Zofran is not a chemotherapy drug and does not need to be administered by a chemotherapy-certified nurse.

251. When providing diet teaching for a client with cholecystitis, which types of food choices the nurse recommend to the client?

- High protein
- **Low fat**
- Low sodium
- High carbohydrate.
- Rationale: A client with cholecystitis is at risk of gall stones that can be move into the biliary tract and cause pain or obstruction. Reducing dietary fat decrease

stimulation of the gall bladder, so bile can be expelled, along with possible stones, into the biliary tract and small intestine.

252. A client with a history of cirrhosis and alcoholism is admitted with severe dyspnea and ascites. Which assessment finding warrants immediate intervention by the nurse?

- Jaundice skin tone
- **Muffled heart sounds**
- Pitting peripheral edema
- Bilateral scleral edema
- Rationale: Muffled heart sounds may indicative fluid build-up in the pericardium and is life- threatening. The other one are signs of end stage liver disease related to alcoholism but are not immediately life- threatening.

253. When entering a client's room, the nurse discovers that the client is unresponsive and pulseless. The nurse initiate CPR and Calls for assistance. Which action should the nurse take next?

- Prepare to administer atropine 0.4 mg IVP
- Gather emergency tracheostomy equipment
- Prepare to administer lidocaine at 100 mg IVP
- **Place cardiac monitor leads on the client's chest.**
- Rationale: Before further interventions can be done, the client's heart rhythm must be determined. This can be done by connecting the client to the monitor. A or C are not a first line drug given for any of the life threatening, pulses dysrhythmias

254. A client with a history of dementia has become increasingly confused at night and is picking at an abdominal surgical dressing and the tape securing the intravenous (IV) line. The abdominal dressing is no longer occlusive, and the IV insertion site is pink. What intervention should the nurse implement?

- Replace the IV site with a smaller gauge.
- **Redress the abdominal incision**
- Leave the lights on in the room at night.
- Apply soft bilateral wrist restraints.
- Rationale: The abdominal incision should be redressed using aseptic-techniques. The IV site should be assessed to ensure that it has not been dislodged and a

dressing reapplied, if need it. Leaving the light on at night may interfere with the client's sleep and increase confusion. Restraints are not indicated and should only be used as a last resort to keep client from self-harm.

255. An adult male client is admitted to the emergency room following an automobile collision in which he sustained a head injury. What assessment data would provide the earliest that the client is experiencing increased intracranial pressure (ICP)?

- **Lethargy**
- Decorticate posturing
- Fixed dilated pupil
- Clear drainage from the ear.
- Rationale: Lethargy is the earliest sign of ICP along with slowing of speech and response to verbal commands. The most important indicator of increase ICP is the client's level or responsiveness or consciousness. B and C are very late signs of ICP.

256. In preparing a diabetes education program, which goal should the nurse identify as the primary emphasis for a class on diabetes self-management?

- Prepare the client to independently treat their disease process
- Reduce healthcare costs related to diabetic complications
- **Enable clients to become active participating in controlling the disease process**
- Increase client's knowledge of the diabetic disease process and treatment options.
- Rationale: The primary goal of diabetic self- management education is to enable the client to become an active participant in the care and control of disease process, matching levels of self- management to the abilities of the individual client. The goal is to place the client in a cooperative or collaborative role with healthcare professional rather than (A)

257. To reduce staff nurse role ambiguity, which strategy should the nurse manager implemented?

- Confirm that all the staff nurses are being assigned to equal number of clients.
- **Review the staff nurse job description to ensure that it is clear, accurate, and recurrent.**
- Assign each staff nurse a turn unit charge nurse on a regular, rotating basis.

- Analyze the amount of overtime needed by the nursing staff to complete assignments.
- Rationale: Role ambiguity occurs when there is inadequate explanation of job descriptions and assigned tasks, as well as the rapid technological changes that produce uncertainty and frustration. A and D may be implemented if the nurse manager is concerned about role overload, which is the inability to accomplish the tasks related to one's role. C is not related to ambiguity.

258. The nurse is assisting a new mother with infant feeding. Which information should the nurse provide that is most likely to result in a decrease milk supply for the mother who is breastfeeding?

- **Supplemental feedings with formula**
- Maternal diet high in protein
- Maternal intake of increased oral fluid
- Breastfeeding every 2 or 3 hours.
- Rationale: Infant sucking at the breast increases prolactin release and proceeds a feedback mechanism for the production of milk, the nurse should explain that supplemental bottle formula feeding minimizes the infant's time at the breast and decreases milk supply. B promotes milk production and healing after delivery. C support milk production. C is recommended routine for breast feeding that promote adequate milk supply.

259. Which assessment is more important for the nurse to include in the daily plan of care for a client with a burned extremity?

- Range of Motion
- **Distal pulse intensity**
- Extremity sensation
- Presence of exudate
- Rationale: Distal pulse intensity assesses the blood flow through the extremity and is the most important assessment because it provides information about adequate circulation to the extremity. Range of motions evaluates the possibility of long term contractures sensation. C evaluates neurological involvement, and exudate. D provides information about wound infection, but this assessment do not have the priority of determining perfusion to the extremity.

260. An elderly client with degenerative joint disease asks if she should use the rubber jar openers that are available. The nurse's response should be based on which information about assistive devices?

- **They decrease the risk for joint trauma**

261. When assessing a 6-month old infant, the nurse determines that the anterior fontanel is bulging. In which situation would this finding be most significant?

- Crying
- Straining on stool
- Vomiting
- **Sitting upright.**
- Rationale: The anterior fontanel closes at 9 months of age and may bulge when venous return is reduced from the head, but a bulging anterior fontanel is most significant if the infant is sitting up and may indicated an increase in cerebrospinal fluid. Activities that reduce venous return from the head, such as crying, a Valsalva maneuver, vomiting or a dependent position of the head, cause a normal transient increase in intracranial pressure.

262. A client with angina pectoris is being discharge from the hospital. What instruction should the nurse plan to include in this discharge teaching?

- Engage in physical exercise immediately after eating to help decrease cholesterol levels.
- Walk briskly in cold weather to increase cardiac output
- Keep nitroglycerin in a light-colored plastic bottle and readily available.
- **Avoid all isometric exercises, but walk regularly.**
- Rationale: Isometric exercise can raise blood pressure for the duration of the exercise, which may be dangerous for a client with cardiovascular disease, while walking provides aerobic conditioning that improves ling, blood vessel, and muscle function. Client with angina should refrain from physical exercise for 2 hours after meals, but exercising does not decrease cholesterol levels. Cold water cause vasoconstriction that may cause chest pain. Nitroglycerin should be readily available and stored in a dark-colored glass bottle not C, to ensure freshness of the medication.

263. What is the priority nursing action when initiating morphine therapy via an intravenous patient-controlled analgesia (PCA) pump?

- **Initiate the dosage lockout mechanism on the PCA pump**
- Instruct the client to use the medication before the pain becomes severe
- Assess the abdomen for bowel sounds.

- Assess the client ability to use a numeric pain scale

264. While undergoing hemodialysis, a male client suddenly complains of dizziness. He is alert and oriented, but his skin is cool and clammy. His vital signs are: heart rate 128 beats/minute, respirations 18 breaths/minute, and blood pressure 90/60. Which intervention should the nurse implement first?

- **Raise the client's legs and feet**

265. The nurse receives a newborn within the first minutes after a vaginal delivery and intervenes to establish adequate respirations. What priority issue should the nurse address to ensure the newborn's survival?

- **Heat loss**
- Hypoglycemia
- Fluid balance
- Bleeding tendencies

266. The fire alarm goes off while the charge nurse is receiving the shift report. What action should the charge nurse implement first?

- **Tell the staff to keep all clients and visitors in the client rooms with the doors closed**

267. A 60-year-old female client asks the nurse about hormones replacement therapy (HRT) as a means preventing osteoporosis. Which factor in the client's history is a possible contraindication for the use of HRT?

- **Her mother and sister have a history of breast cancer**

268. A male client, who is 24 hours postoperative for an exploratory laparotomy, complains that he is "starving" because he has had no "real food" since before the surgery. Prior to advancing his diet, which intervention should the nurse implement?

- **Auscultate bowel sounds in all four quadrants**

269. The nurse working in the psychiatric clinic has phone messages from several clients. Which call should the nurse return first?

- **A family member of a client with dementia who has been missing for five hours**

270. During change of shift, the nurse reports that a male client who had abdominal surgery yesterday increasingly confused and disoriented during the night. He wandered into other clients rooms, saying that there are men in his room trying to hurt him. Because of continuing disorientation and the client's multiple attempts to get of bed, soft restrains

were applied at 0400. In what order should the nurse who is receiving report implement these interventions? (Arrange from first action on top to last on the bottom).

1. **Assess the client's skin and circulation for impairment related to the restrains**
2. **Evaluate the client's mentation to determine need to continue the restrains**
3. **Assign unlicensed assistive personnel to remove restrains and remain with client**
4. **Contact the client's surgeon and primary healthcare provider**

271. A mother brings her 3-year-old son to the emergency room and tells the nurse the he has had an upper respiratory infection for the past two days. Assessment of the child reveals a rectal temperature of 102 F. he is drooling and becoming increasingly more restless. What action should the nurse take first?

- **Notify the healthcare provider and obtain a tracheostomy tray**

272. After receiving the first dose of penicillin, the client begins wheezing and has trouble breathing. The nurse notifies the healthcare provider immediately and received several prescriptions. Which medication prescription should the nurse administer first?

- **Epinephrine Injection, USP IV**

273. Two clients ring their call bells simultaneously requesting pain medication. What action should the nurse implement first?

- **Evaluate both client's pain using a standardized pain scale**

274. A client receives a new prescription for simvastatin (Zocor) 5 mg PO daily at bedtime. What action should the nurse take?

- **Administer the medication as prescribed with a glass of water**

275. Which client should the nurse assess frequently because of the risk for overflow incontinence? A client

- **Who is confused and frequently forgets to go to the bathroom**

276. While monitoring a client during a seizure, which interventions should the nurse implement? (Select all that apply)

- **Move obstacle away from client**
- **Monitor physical movements**
- **Observe for a patent airway**

- **Record the duration of the seizure**

277. A male client with a long history of alcoholism is admitted because of mild confusion and fine motor tremors. He reports that he quit drinking alcohol and stopped smoking cigarettes one month ago after his brother died of lung cancer. Which intervention is most important for the nurses to include in the client's plan of care?

- Determine client's level current blood alcohol level.
- **Observe for changes in level of consciousness.**
- Involve the client's family in healthcare decisions.
- Provide grief counseling for client and his family.
- Rationale: Based on the client's history of drinking, he may be exhibiting sing of hepatic involvement and encephalopathy. Changes in the client's level of consciousness should be monitored to determine if he able to maintain consciousness, so neurological assessment has the highest priority.

278. An older adult female admitted to the intensive care unit (ICU) with a possible stroke is intubated with ventilator setting of tidal volume 600, PlO2 40%, and respiratory rate of 12 breaths/minute. The arterial blood gas (ABG) results after intubation are PH
7.31. PaCO2 60, PaO2 104, SPO2 98%, HCO3 23. To normalize the client's ABG finding, which action is required?

- Report the results to the healthcare provider.
- **Increase ventilator rate.**
- Administer a dose of sodium carbonate.
- Decrease the flow rate of oxygen.
- Rationale: This client is experience respiratory acidosis. Increasing the ventilator rate depletes CO2 a, which returns the PH toward normal. Report findings is important but only after increasing ventilator rate.

279. The mother of the 12- month-old with cystic fibrosis reports that her child is experiencing increasing congestion despite the use of chest physical therapy (CPT) twice a day, and has also experiences a loss of appetite. What instruction should the nurse provide?

- Perform CPT after meals to increase appetite and improve food intake.
- **CPT should be performed more frequently, but at least an hour before meals.**
- Stop using CPT during the daytime until the child has regained an appetite.

- Perform CPT only in the morning, but increase frequency when appetite improves.
- Rationale: CPY with inhalation therapy should be performed several times a day to loosen the secretions and move them from the peripheral airway into the central airways where they can be expectorated. CPT should be done at least one hour before meals or two hours after meals.

280. The nurse is evaluating the diet teaching of a client with hypertension. What dinner selection indicates that the client understands the dietary recommendation for hypertension?

- **Baked pork chop, applesauce, corn on the cob, 2% milk, and key-lime pie**

281. A client with type 2 diabetes mellitus is admitted for frequent hyperglycemic episodes and a glycosylated hemoglobin (HbA1c) of 10%. Insulin glargine 10 units subcutaneously once a day at bedtime and a sliding scale with insulin aspart q6h are prescribed. What action should the nurse include in this client's plan of care?

- **Fingerstick glucose assessment q6h with meals**
- Mix bedtime dose of insulin glargine with insulin aspart sliding scale dose
- **Review with the client proper foot care and prevention of injury**
- Do not contaminate the insulin aspart so that it is available for iv use
- **Coordinate carbohydrate controlled meals at consistent times and intervals**
- **Teach subcutaneous injection technique, site rotation and insulin management**

282. Which problem reported by a client taking lovastatin requires the most immediate fallow up by the nurse?

- Diarrhea and flatulence
- Abdominal cramps
- **Muscle pain**
- Altered taste
- Rationale: statins can cause rhabdomyolysis, a potentially fatal disease of skeletal muscle characterized by myoglobinuria and manifested with muscle pain, so this symptom should immediately be reported to the HCP.

283. While assessing a client's chest tube (CT), the nurse discovers bubbling in the water seal chamber of the chest tube collection device. The client's vital signs are: blood pressure of 80/40 mmHg, heart rate 120 beats/minutes, respiratory rate 32

breaths/minutes, oxygen saturation 88%. Which interventions should the nurse implement?

- **Provide supplemental oxygen**
- **Auscultate bilateral lung fields**
- Administer a nebulizer treatment
- **Reinforce occlusive CT dressing**
- Give PRN dose of pain medication
- Rationale: the air bubbles indicate an air leak from the lungs, the chest tube site, or the chest tube collection system. Providing oxygen improves the oxygen saturation until the leak has been resolved. Auscultating the lung fields helps to identify absent or decrease lung sound due to collapsing lung.

284. Before leaving the room of a confused client, the nurse notes that a half bow knot was used to attach the client's wrist restraints to the movable portion of the client's bed frame. What action should the nurse take before leaving the room?

- **Ensure that the knot can be quickly released.**
- Tie the knot with a double turn or square knot.
- Move the ties so the restraints are secured to the side rails.
- Ensure that the restraints are snug against the client's wrist.

285. Oral antibiotics are prescribed for an 18-month-old toddler with severe otitis media. An antipyrine and benzocaine-otic also prescribed for pain and inflammation. What instruction should the nurse emphasize concerning the installation of the antipyrine/benzocaine otic solution?

- Place the dropper on the upper outer ear canal and instill the medication slowly.
- Warm the medication in the microwave for 10 seconds before instilling.
- Keep the medication refrigerated between administrations.
- **Have the child lie with the ear up for one to two minute after installation.**

286. An older adult male is admitted with complications related to chronic obstructive pulmonary disease (COPD). He reports progressive dyspnea that worsens on exertion and his weakness has increased over the past month. The nurse notes that he has dependent edema in both lower legs. Based on these assessment findings, which dietary instruction should the nurse provide?

- Limit the intake of high calorie foods.

- Eat meals at the same time daily.
- Maintain a low protein diet.
- **Restrict daily fluid intake.**
- Rationale: the client is exhibiting signs of cor pulmonale, a complication of COPD that causes the right side of the heart to fail. Restricting fluid intake to
  1000 to 2000 ml/day, eating a high-calorie diet at small frequent meals with foods that are high in protein and low in sodium can help relive the edema and decrease workload on the right-side of the heart.

287. The nurse inserts an indwelling urinary catheter as seen in the video what action should the nurse take next?

- Remove the catheter and insert into urethral opening
- Observe for urine flow and then inflate the balloon.
- Insert the catheter further and observe for discomfort.
- **Leave the catheter in place and obtain a sterile catheter.**
- Rationale: the catheter is in the vaginal opening.

288. A client with coronary artery disease who is experiencing syncopal episodes is admitted for an electrophysiology study (EPS) and possible cardiac ablation therapy. Which intervention should the nurse delegate to the unlicensed assistive personnel (UAP)?

- **Prepare the skin for procedure.**
- Identify client's pulse points
- Witness consent for procedure
- Check telemetry monitoring

289. Fallowing an outbreak of measles involving 5 students in an elementary school, which action is most important for the school nurse to take?

- Review the immunization records of all children in the elementary school
- Report the measles outbreak to all community health organizations
- Schedule a mobile public health vehicle to offer measles inoculations to unvaccinated children.
- **Restrict unvaccinated children from attending school until measles outbreak is resolved.**

290. A preeclamptic client who delivered 24h ago remains in the labor and delivery recovery room. She continues to receive magnesium sulfate at 2 grams per hour. Her total input is limited to 125 ml per hour, and her urinary output for the last hour was 850 ml. What intervention should the nurse implement?

- discontinue the magnesium sulfate immediately
- Decrease the client's iv rate to 50 ml per hour
- **Continue with the plan of care for this client**
- Change the client's to NPO status
- Rationale: continue with the plan. Diuresis in 24 to 48h after birth is a sign of improvement in the preeclamptic client. As relaxation of arteriolar spasms occurs, kidney perfusion increases. With improvement perfusion, fluid is drawn into the intravascular bed from the interstitial tissue and then cleared by the kidneys

291. The nurse is planning care for a client who admits having suicidal thoughts. Which client behavior indicates the highest risk for the client acting on these suicidal thoughts?

- Express feelings of sadness and loneliness
- Neglects personal hygiene and has no appetite
- Lacks interest in the activity of the family and friends
- **Begin to show signs of improvement in affect**
- Rationale: when a depressed client begins to show signs of improvement, it can be because the client has "figured out" how to be successful in committing suicide. Depressed clients, particularly those who have shown signs of potentially becoming suicidal, should be watched with care for an impending suicide attempt might be greater when the client appear suddenly happy, begin to give away possessions, or becomes more relaxed and talkative.

292. When assessing a multigravida the first postpartum day, the nurse finds a moderate amount of lochia rubra, with the uterus firm, and three fingerbreadths above the umbilicus. What action should the nurse implement first?

- Massage the uterus to decrease atony
- **Check for a destined bladder**
- Increase intravenous infusion
- Review the hemoglobin to determined hemorrhage

- Rationale: a fundus that is dextroverted (up to the right) and elevated above the umbilicus is indicative of bladder distension/urine retention.

293. A 12 year old client who had an appendectomy two days ago is receiving 0.9% normal saline at 50 ml/hour. The client's urine specific gravity is 1.035. What action should the nurse implement?

- Evaluate postural blood pressure measurements
- Obtain specimen for uranalysis
- **Encourage popsicles and fluids of choice**
- Assess bowel sounds in all quadrants
- Rationale: specific gravity of urine is a measurement of hydration status (normal range of 1.010 to 1.025) which is indicative of fluid volume deficit when Sp Gr increases as urine becomes more concentrated.

294. An older male client arrives at the clinic complaining that his bladder always feels full. He complains of weak urine flow, frequent dribbling after voiding, and increasing nocturia with difficulty initiating his urine stream. Which action should the nurse implement?

- Obtain a urine specimen for culture and sensitivity
- **Palpate the client's suprapubic area for distention**
- Advise the client to maintain a voiding diary for one week
- Instruct in effective technique to cleanse the glans penis
- Rationale: the client is exhibiting classic signs of an enlarge prostate gland, which restricts urine flow and cause bothersome lower urinary tract symptoms (LUTS) and urinary retention, which is characterized by the client's voiding patterns and perception of incomplete bladder emptying.

295. The nurse is preparing to administer 1.6 ml of medication IM to a 4 month old infant. Which action should the nurse include?

- Select a 22 gauge 1 ½ inch (3.8 cm) needle for the intramuscular injection
- Administer into the deltoid muscle while the parent holds the infant securely
- **Divide the medication into two injection with volumes under 1ml**
- Use a quick dart-like motion to inject into the dorsogluteal site.
- Rationale: IM injection for children under 3 of age should not exceed 1ml. divide the dose into smaller volumes for injection in two different sites.

296. A client who had a below the knee amputation is experiencing severe phantom limb pain (PLP) and ask the nurse if mirror therapy will make the pain stop. Which response by the nurse is likely to be most helpful?

- **Research indicates that mirror therapy is effective in reducing phantom limb pain**
- You can try mirror therapy, but do not expect to complete elimination of the pain
- Transcutaneous electrical nerve stimulators (TENS) have been found to be more effective
- Where did you learn about the use of mirror therapy in treating in treating phantom limb pain?
- Rationale: pain relief associated with mirror therapy may be due to the activation of neurons in the hemisphere of the brain that is contralateral to the amputated limb when visual input reduces the activity of systems that perceive protopathic pain.

297. An older adult client with heart failure (HF) develops cardiac tamponade. The client has muffled, distant, heart sounds, and is anxious and restless. After initiating oxygen therapy and IV hydration, which intervention is most important for the nurse to implement?

- Observe neck for jugular vein distention
- **Notify healthcare provider to prepare for pericardiocentesis**
- Asses for paradoxical blood pressure
- Monitor oxygen saturation (Sp02) via continuous pulse oximetry
- Rationale: Cardiac tamponade is pressure on the heart that occurs when blood or fluid builds up in the space between the heart muscle (myocardium) and the outer covering sac of the heart (pericardium). In this condition, blood or fluid collects in the pericardium, the sac surrounding the heart. This prevents the heart ventricles from expanding fully. The excess pressure from the fluid prevents the heart from working properly. As a result, the body does not get enough blood.

298. A new member joins the nursing team spreads books on the table, puts items on two chairs, and sits on a third chair. The members of the group are forced to move closer and remove their possessions from the table what action should the nurse leader take?

- Move to welcome and accommodate a new person
- **Ask the new person to move belonging to accommodate others**
- Tell the new person to move belongings because of limited space

- Bring in additional chairs so that all staff members can be seated

299. The nurse is caring for a one week old infant who has a ventriculoperitoneal (VP) shunt that was placed 2 days after birth. Which findings are an indication of a postoperative complication?

- **Poor feeding and vomiting**
- **Leakage of CSF from the incisional site**
- Hyperactive bowel sound
- **Abdominal distention**
- WBC count of 10000/mm3

300. The nurse is preparing a heparin bolus dose of 80 units/kg for a client who weighs 220 pounds. Heparin sodium injection, USP is available in a 3o ml multidose vial with the concentration of 1,000 USP units/ml. how many ml of heparin should the nurse administer? (Enter numeric value only)

- **8**
- Calculate the client's weigh in kg: 220 pounds divides by 2.2 pounds/kg =100 kg Calculate the client's dose, 80 units x 100 kg = 8,000 units Use the formula, D / H X Q = 8,000 units / 1,000 units x 1ml = 8

301. In monitoring tissue perfusion in a client following an above the knee amputation (aka), which action should the nurse include in the plan of care?

- **Evaluate closet proximal pulse.**
- Asses skin elasticity of the stump.
- Observe for swelling around the stump.
- Note amount color of wound drainage.
- Rationale: A primary focus of care for a client with an AKA is monitoring for signs of adequate tissue perfusion, which include evaluating skin color and ongoing assessment of pulse strength.

302. The leg of a client who is receiving hospice care have become mottled in appearance. When the nurse observes the unlicensed assistive personal (UAP) place a heating pad on the mottled areas, what action should the nurse take?

- **Remove the heating pads and place a soft blanket over the cl ie nt's leg a nd feet.**
- Advise the UAP to observe the client's skin while the heating pads are in place.

- Elevate the client's feet on a pillow and monitor the client's pedal pulses frequently.
- Instruct the UAP to reposition the heating pads to the sides of the legs and feet.

303. A client who underwent an uncomplicated gastric bypass surgery is having difficult with diet management. What dietary instruction is most important for the nurse to explain to the client?

- Chew food slowly and thoroughly before attempting to swallow
- **Plan volume-controlled evenly-space meal thorough the day**
- Sip fluid slowly with each meal and between meals
- Eliminate or reduce intake fatty and gas forming food
- Rationale: It is most important for the client to learn how to eat without damaging the surgical site and to keep the digestive system from dumping the food instead of digesting it. Eating volume-control and evenly-space meals thorough the day allows the client to fill full, avoid binging, and eliminate the possibility of eating too much one time. Chewing slowly and thoroughly helps prevent over eating by allowing a filling of fullness to occur. Taking sips, rather than large amounts of fluids keeps the stomach from overfilling and allow for adequate calories to be consumed. Gas forming foods and fatty foods should be avoiding to decrease risk of dumping syndrome and flatulence.

304. If the nurse is initiating IV fluid replacement for a child who has dry, sticky mucous membranes, flushed skin, and fever of 103.6 F. Laboratory finding indicate that the child has a sodium concentration of 156 mEq/L. What physiologic mechanism contributes to this finding?

- The intravenous fluid replacement contains a hypertonic solution of sodium chloride
- Urinary and Gastrointestinal fluid loss reduce blood viscosity and stimulate thirst
- **Insensible loss of body fluids contributes to the hemoconcentration of serum solutes**
- Hypothalamic resetting of core body temperature causes vasodilation to reduce body heat
- Rationale: Fever causes insensible fluid loss, which contribute to fluid volume and results in hemoconcentration of sodium (serum sodium greater than 150 mEq/L). Dehydration, which is manifested by dry, sticky mucous membranes, and flushed skin, is often managed by replacing lost fluids and electrolytes with IV fluids that contain varying concentration of sodium chloride. Although other

options are consistent with fluid volume deficit, the physiologic response of hypernatremia is explained by hem concentration.

305. During a Woman's Health fair, which assignment is the best for the Practical Nurse (PN) who is working with a register nurse (RN)

- Encourage the woman at risk for cancer to obtain colonoscopy.
- Present a class of breast-self examination
- **Prepare a woman for a bone density screening**
- Explain the follow-up need it for a client with prehypertension.
- Rationale: A bone density screening is a fast, noninvasive screening test for osteoporosis that can be explained by the PN. There is no additional preparation needed (A) required a high level of communication skill to provide teaching and address the client's fear. (B) Requires a higher level of client teaching skill than responding to one client. (D) Requires higher level of knowledge and expertise to provide needed teaching regarding this complex topic.

306. An adult client present to the clinic with large draining ulcers on both lower legs that are characteristics of Kaposi's sarcoma lesions. The client is accompanied by two family member. Which action should the nurse take?

- Ask family member to wear gloves when touching the patient
- **Send family to the waiting area while the client's history is taking**
- Obtain a blood sample to determine is the client is HIV positive
- Complete the head to toes assessment to identify other sign of HIV
- Rationale: To protect the client privacy, the family member should be asked to wait outside while the client's history is take. Gloves should be worn when touching the client's body fluids if the client is HIV positive and these lesion are actually Kaposi sarcoma lesion. HIV testing cannot legally be done without the client explicit permission. A further assessment can be implemented after the family left the room.

307. An adult client is exhibit the maniac stage of bipolar disorder is admitted to the psychiatric unit. The client has lost 10 pounds in the last two weeks and has no bathed in a week "I'm trying to start a new business and "I'm too busy to eat". The client is oriented to time, place, person but not situation. Which nursing problem has the greatest priority?

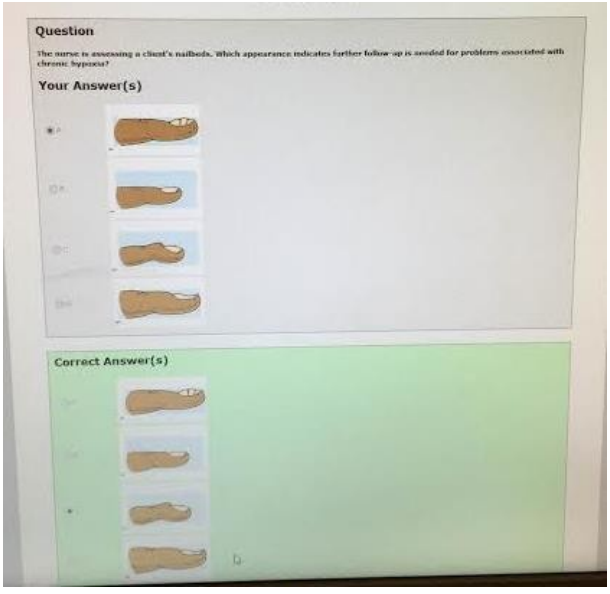
- Hygiene-self-care deficit
- **Imbalance nutrition**

- Disturbed sleep pattern
- Self-neglect
- Rationale: The client's nutritional status has the highest priority at this time, and finger foods are often provided, so the client who is on the maniac phase of bipolar disease can receive adequate nutrition. Other options are nursing problems that should also be addresses with the client's plan of care, but at this stage in the client's treatment, adequate nutrition is a priority

308. The nurse is preparing a discharge teaching plan for a client who had a liver transplant. Which instruction is most important to include in this plan?

- Limit intake fatty foods for one month after surgery.
- Notify the healthcare provider if edema occurs.
- Increase activity and exercise gradually, as tolerated.
- **Avoid crowds for first two months after surgery.**
- Rationale: Cyclosporine immunosuppression therapy is vital in the success of liver transplantation and can increase the risk for infection, which is critical in the first two months after surgery. Fever is often.

309. The nurse is assessing a client's nailbeds. Witch appearance indicates further follow-up is needed for problems associated with chronic hypoxia?

- 

310. A client who had a percutaneous transluminal coronary angioplasty (PTCA) two weeks ago returns to the clinic for a follow up visit. The client has a postoperative ejection fraction ejection fraction of 30%. Today the client has lungs which are clear, +1 pedal edema, and a 5pound weight gain. Which intervention the nurse implement?

- Arrange transport for admission to the hospital.
    - Insert saline lock for IV diuretic therapy.
    - **Assess compliance with routine prescriptions.**
    - Instruct the client to monitor daily caloric intake.
    - Rationale: Fluid retention may be a sign that the client is not taking the medication as prescribed or that the prescriptions may need adjustment to manage cardiac function post-PTCA (normal ejection fraction range is 50 to 75%)

311. The RN is assigned to care for four surgical clients. After receiving report, which client should the nurse see first? The client who is

- Two days postoperative bladder surgery with continuous bladder irrigation infusing.
- One day postoperative laparoscopic cholecystectomy requesting pain medication.
- **Three days postoperative colon resection receiving transfusion of packed RBCs.**
- Preoperative, in buck's traction, and scheduled for hip arthroplasty within the next 12 hours.

312. The nurse is preparing an older client for discharge following cataract extraction. Which instruction should be include in the discharge teaching?

- Do not read without direct lighting for 6 weeks.
- **Avoid straining at stool, bending, or lifting heavy objects.**
- Irrigate conjunctiva with ophthalmic saline prior to installing antibiotic ointment.
- Limit exposure to sunlight during the first 2 weeks when the cornea is healing.
- Rationale: after cataract surgery, the client should avoid activities which increase pressure and place strain on the suture line.

313. The healthcare provider prescribes potassium chloride 25 mEq in 500 ml D_5W to infuse over 6 hours. The available 20 ml vial of potassium chloride is labeled, "10 mEq/5ml." how many ml of potassium chloride should the nurse add the IV fluid? (Enter numeric value only. If is rounding is required, round to the nearest tenth.)

- **12.5**
- Rationale: Using the formula D / H X Q: 25 mEq / 10 mEq x 5ml =12.5ml

314. At 40 week gestation, a laboring client who is lying is a supine position tells the nurse that she has finally found a comfortable position. What action should the nurse take?

- Encourage the client to turn on her left side.
- Place a pillow under the client's head and knees.
- Explain to the client that her position is not safe.
- **Place a wedge under the client's right hip.**
- Rationale: Hypotension from pressure on the vena cava is a risk for the full-term client. Placing a wedge under the right hip will relieve pressure on the vena cava. Other options will either not relieve pressure on the vena cava or would not allow the client the remaining her position of choice.

315. A client with a history of diabetes and coronary artery disease is admitted with shortness of breath, anxiety, and confusion. The client's blood pressure is 80/60 mmHg, heart rate 120 beats/minute with audible third and fourth heart sounds, and bibasilar crackles. The client's average urinary output is 5 ml/hour. Normal saline is infusing at
124 ml/hour with a secondary infusion of dopamine at mcg/kg/minute per infusion pump. With intervention should the nurse implement?

- Irrigate the indwelling urinary catheter.
- Prepare the client for external pacing.
- Obtain capillary blood glucose measurement.
- **Titrate the dopamine infusion to raise the BP.**
- Rationale: the client is experiencing cardiogenic shock and requires titration per protocol of the vasoactive secondary infusion, dopamine, to increase the blood pressure. Low hourly urine output is due to shock and does not indicate a need for catheter irrigation. Pacing is not indicated based on the client's capillary blood glucose should be monitored, but is not directly indicated at this time.

316. The nurse ends the assessment of a client by performing a mental status exam. Which statement correctly describes the purpose of the mental status exam?

- Determine the client's level of emotional functioning'
- Assess functional ability of the primary support system.
- **Evaluate the client's mood, cognition and orientation.**
- Review the client's pattern of adaptive coping skill

- Rational: the mental status exam assesses the client for abnormalities in cognitive functioning; potential thought processes, mood and reasoning, the other options listed are all components of the client's psychosocial assessment.

317. An older adult resident of a long-term care facility has a 5-year history of hypertension. The client has a headache and rate the pain 5 on a pain scale 0 to 10. The client's blood pressure is currently 142/89. Which interventions should the nurse implement? (Select all that apply)

- **Administer a daily dose of lisinopril as scheduled.**
- Assess the client for postural hypotension.
- Notify the healthcare provider immediately
- **Provide a PRN dose of acetaminophen for headache**
- Withhold the next scheduled daily dose of warfarin.
- Rational: the client' routinely scheduled medication, lisinopril, is an antihypertensive medication and should be administered as scheduled to maintain the client's blood pressure. A PRN dose of acetaminophen should be given for the client's headache. The other options are not indicated for this situation.

318. When conducting diet teaching for a client who is on a postoperative soft diet, which foods should eat? (Select all that apply)

- **Pasta, noodles, rice.**
- **Egg, tofu, ground meat.**
- **Mashed, potatoes, pudding, milk.**
- Brussel sprouts, blackberries, seeds.
- Corn bran, whole wheat bread, whole grains.
- Rational: a client's postoperative diet is commonly progressed as tolerated. A soft diet includes foods that are mechanically soft in texture (pasta, egg, ground meat, potatoes, and pudding. High fiber foods that require thorough chewing and gas forming foods, such as cruciferous vegetables and fresh fruits with skin, grains and seeds are omitted.

319. The nurse is preparing a 4-day-old I infant with a serum bilirubin level of 19 mg/dl (325 micromol/L) for discharge from the hospital. When teaching the parents about home phototherapy, which instruction should the nurse include in the discharge teaching plan?

- **Reposition the infant every 2 hours.**

- Perform diaper changes under the light.
- Feed the infant every 4 hours.
- Cover with a receiving blanket.
- Rational: An infant, who is receiving phototherapy for hyperbilirubinemia, should be repositioned every two hours. The position changes ensure that the phototherapy lights reach all of the body surface areas. Bathing, feedings, and diaper changes are ways for the parents to bond with the infant, and can occur away from the treatment. Feedings need to occur more frequently than every 4 hours to prevent dehydration. The infant should wear only a diaper so that the skin is exposed to the phototherapy.

320. When planning care for a client with acute pancreatitis, which nursing intervention has the highest priority?

- **Withhold food and fluid intake.**
- Initiate IV fluid replacement.
- Administer antiemetic as needed.
- Evaluate intake and output ratio.
- Rational: The pathophysiologic processes in acute pancreatitis result from oral fluid and ingestion that causes secretion of pancreatic enzymes, which destroy ductal tissue and pancreatic cells, resulting in auto digestion and fibrosis of the pancreas. The main focus of the nursing care is reducing pain caused by pancreatic destruction through interventions that decrease GI activity, such as keeping the client NPO. Other choices are also important intervention but are secondary to pain management.

321. Assessment by the home health nurse of an older client who lives alone indicates that client has chronic constipations. Daily medications include furosemide for hypertension and heart failure and laxatives. To manage the client's constipation, which suggestions should the nurse provide? (Select all that apply)

- Decrease laxative use to every other day, and use oil retention enemas as needed.
- **Include oatmeal with stewed pruned for breakfast as often as possible.**
- **Increase fluid intake by keeping water glass next to recliner.**
- **Recommend seeking help with regular shopping and meal preparation.**
- Report constipation to healthcare provider related to cardiac medication side effects.

- Rational: older adult are at higher risk for chronic constipation due to decreased gastrointestinal muscle tone leading to reduce motility. Oatmeal with prunes increases dietary fiber and bowel stimulation, thereby decreasing need for laxatives. Increased fluid intake also decreases constipations. Assistance with food preparation might help the client eat more fresh fruits and vegetables and result on less reliance on microwaved and fast foods, which are usually high in sodium and fat with little fiber. Laxatives can be reduced gradually by improving the diet, without resorting to using enemas.

322. A young boy who is in a chronic vegetative state and living at home is readmitted to the hospital with pneumonia and pressure ulcers. The mother insists that she is capable of caring for her son and which action should the nurse implement next?

- Report the incident to the local child protective services.
- Find a home health agency that specializes in brain injuries.
- **Determine the mother's basic skill level in providing care.**
- Consult the ethics committee to determine how to proceed.
- Rational: Although the mother states she is a capable caregiver, the client is manifesting disuse syndrome complications, and the mother's skill in providing basic care should be determined. Further assessment is needed before implementing other nursing actions.

323. After the risk and benefits of having a cardiac catheterization are reviewed by the healthcare provider, an older adult with unstable angina is scheduled for the procedure. When the nurse presents the consent form for signature, the client asks how the wires will keep a heart heating during the procedure. What action should the nurse take?

- Explain the procedure again in detail and clarify any misconceptions.
- **Notify the healthcare provider of the client's lack of understanding.**
- Call the client's next of kin and have them provide verbal consent.
- Postpone the procedure until the client understands the risk and benefits.
- Rational: the nurse is only witnessing the signature, and is not responsible for the client's understanding of the procedure. The healthcare provider needs to clarify any questions and misconceptions. Explaining the procedure again is the healthcare provider's legal responsibility. The other options are not indicated.

324. In assessing a client at 34-weeks' gestation, the nurse notes that she has a slightly elevated total T4 with a slightly enlarged thyroid, a hematocrit of 28%, a heart rate of 92 beats per minute, and a systolic murmur. Which finding requires follow-up?

- Elevated thyroid hormone level.

- **Hematocrit of 28%.**
- Heart rate of 92 beats per minute.
- Systolic murmur.
- Rational: although physiologic anemia is expected in pregnancy, a hematocrit of 28% is below pregnant norms and could signify iron-deficiency anemia.
  Other options are normal finding pregnancy

325. A client with osteoporosis related to long-term corticosteroid therapy receives a prescription for calcium carbonate. Which client's serum laboratory values requires intervention by the nurse?

- Total calcium 9 mg/dl (2.25 mmol/L SI)
- **Creatinine 4 mg/dl (354 micromol/L SI)**
- Phosphate 4 mg/dl (1.293 mmol/L SI)
- Fasting glucose 95 mg/dl (5.3 mmol/L SI)

326. A clinical trial is recommended for a client with metastatic breast cancer, but she refuses to participate and tells her family that she does not wish to have further treatments. The client's son and daughter ask the nurse to try and convince their mother to reconsider this decision. How should the nurse respond?

- Ask the client with her children present if she fully understands the decision she has made.
- Discuss success of clinical trials and ask the client to consider participating for one month.
- Explain to the family that they must accept their mother's decision.
- **Exp lore th e cl ie nt's d ecis io n to ref us e treatm ent a nd offer s up p ort**
- Rationale: as long as the client is alert, oriented and aware of the disease prognosis, the healthcare team must abide by her decisions. Exploring the decision with the client and offering support provides a therapeutic interaction and allows the client to express her fears and concerns about her quality of life.
  Other options are essentially arguing with the client's decisions regarding her end
  of life treatment or diminish the opportunity for the client to discuss her feelings

327. An adult client with severe depression was admitted to the psychiatric unit yesterday evening. Although the client ran one year ago, his spouse states that the client no longer runs, bur sits and watches television most of the day. Which is most important for the nurse to include in this client's plan of care for today?

- **Assist client in identifying goals for the day.**

- Encourage client to participate for one hour in a team sport.
- Schedule client for a group that focuses on self-esteem.
- Help client to develop a list of daily affirmations.
- Rationale: clients with severe depression have low energy and benefit from structured activities because concentration is decreased. The client participate in care by identifying goals for the day is the most important intervention for the client's first day at the unit. Other options can be implemented over time, as the depression decreases.

328. An adult who is 5 feet 5 inches (165.1 cm) tall and weighs 90 lb. (40.8 Kg) is admitted with a diagnosis of chronic anorexia. The client receives a regular diet for 2 days, and the client's medical records indicates that 100% of the diet provided has been consumed. However the client's weight on the third day morning after admission is 89 lb. (40.4 Kg). What action should the nurse implement?

- Examine the client's room for hidden food.
- **Assign staff to monitor what the client eats.**
- Ask the client if the food provided is being eaten or discarded.
- Provide the client with a high calorie diet.
- Rationale: clients with an eating disorder have an unhealthy obsession with food. The client's continued weight loss, despites indication that the client has consumed 100% of the diet, should raise questions about the client's intake of the food provided, so the client should be observed during meals to prevent hiding or throwing away food. Other options may be accurate but ineffective and unnecessary.

329. A client exposed to tuberculosis is scheduled to begin prophylactic treatment with isoniazid. Which information is most important for the nurse to note before administering the initial dose?

- Conversion of the client's PPD test from negative to positive.
- Length of time of the exposure to tuberculosis.
- **Current diagnosis of hepatitis B.**
- History of intravenous drug abuse.
- Rationale: prophylactic treatment of tuberculosis with isoniazid is contraindicated for persons with liver disease because it may cause liver damage. The nurse should withhold the prescribed dose and contact the healthcare provider. Other

options do not provide data indicating the need to question or withhold the prescribed treatment.

330. The nurse walks into a client's room and notices bright red blood on the sheets and on the floor by the IV pole. Which action should the nurse take first?

- Clean up the spilled blood to reduce infection transmission.
- Notify the healthcare provider that the client appears to be bleeding.
- Apply direct pressure to the client's IV site.
- **Identify the source and amount of bleeding.**
- Rationale: the nursed should first assess the client to determine the action that should be taken. Patient safety is the priority; other options are not priority.

331. During a routine clinic visit, an older female adult tells the nurse that she is concerned that the flu season is coming soon, but is reluctant to obtain the vaccination. What action should the nurse take first?

- Determine when the client last had an influenza vaccination.
- **Discuss the concerns expressed by the client about the vaccination.**
- Ask about any recent exposure to persons with the flu or other viruses.
- Review the informed consent form for the vaccination with the client.
- Rationale: the nurse should first address the concerns identified by the client, before taking other actions, such as obtaining information about past vaccinations, exposure to the flu, or reviewing the informed consent form.

332. A client is admitted with acute pancreatitis. The client admits to drinking a pint of bourbon daily. The nurse medicates the client for pain and monitors vital signs q2 hours. Which finding should the nurse report immediately to the healthcare provider?

- **Confusion and tremors**
- Yellowing and itching of skin.
- Abdominal pain and vomiting
- Anorexia and abdominal distention
- Rationale: daily alcohol is the likely etiology for the client's pancreatitis. Abrupt cessation of alcohol can result in delirium tremens (DT) causing confusion and tremors, which can precipitate cardiovascular complications and should be reported immediately to avoid life-threatening complications. The other options are expected findings in those with liver dysfunction or pancreatitis, but do not require immediate action.

333. The nurse is teaching a mother of a newborn with a cleft lip how to bottle feed her baby using medela haberman feeder, which has a valve to control the release of milk and
a slit nipple opening. The nurse discusses placing the nipple's elongated tip in the back of the oral cavity. What instructions should the nurse provide the mother about feedings?

- Squeeze the nipple base to introduce milk into the mouth
- Position the baby in the left lateral position after feeding
- Alternate milk with water during feeding
- **Hold the newborn in an upright position**
- Rationale: the mother should be instructed to hold the infant during feedings in a sitting or upright position to prevent aspiration. Impaired sucking is compensated by the use of special feeding appliances and nipples such as the haberman feeder that prevents aspiration by adjusting the flow of mild according to the effort of the neonate. Squeezing the nipple base may introduce a volume that is greater than
the neonate can coordinate swallowing. The preferred positon of an infant after feeding is on the right side to facilitate stomach emptying. Sucking difficulty impedes the neonate's intake of adequate nutrient needed for weight gain and water should be provided after the feeding to cleanse the oral cavity and not fill up the neonate's stomach.

334. Following and gunshot wound, an adult client a hemoglobin level of 4 grams/dl (40 mmol/L SI). The nurse prepares to administer a unit of blood for an emergency transfusion. The client has AB negative blood type and the blood bank sends a unit of type A Rh negative, reporting that there is not type AB negative blood currently available. Which intervention should the nurse implement?

- **Transfuse Type A negative blood until type AB negative is available.**
- Recheck the client's hemoglobin, blood type and Rh factor.
- Administer normal saline solution until type AB negative is available
- Obtain additional consent for administration of type A negative blood
- Rationale: those who have type AB blood are considered universal recipients using A or B blood types that is the same Rh factor. The client's hemoglobin is critically low and the client should receive a unit of blood that is type A, which must be Rh negative blood. Other options are not indicated in this situation.

335. A young adult female college student visits the health clinic in early winter to obtain birth control pills. The clinic nurse asks if the student has received an influenza vaccination. The student stated she did not receive vaccination because she has asthma. How should the nurse respond?

- **Offer to provide the influenza vaccination to the student while she is at the clinic**
- Encourage the student to obtain a vaccination prior to the next influenza season.
- Confirm that a history of asthma can increase risks associated with the vaccine.
- Advise the student that the nasal spray vaccine reduces side effects for people with asthma.
- Rationale: person with asthma are at increased risk related to influenza and should receive the influenza vaccination prior to or during influenza season. Waiting
  until the start of the next season places the student at risk for the current season. The vaccination does not increase risk for persons with asthma but the nasal spray may result in increased wheezing after receiving that form of the vaccination.

336. A client with eczema is experiencing severe pruritus. Which PRN prescriptions should the nurse administer? (Select all that apply)

- **Topical corticosteroid.**
- Topical scabicide.
- Topical alcohol rub.
- Transdermal analgesic.
- **Oral antihistamine**
- Rationale: anti-inflammatory actions of topical corticosteroids and oral antihistamines provide relief from severe pruritus (itching). Other options are not indicated.

337. The nurse is using a straight urinary catheter kit to collect a sterile urine specimen from a female client. After positioning am prepping this client, rank the actions in the sequence they should be implemented. (Place to first action on the top on the last action on the bottom.)

- Correct : ODCP
- **1. Open the sterile catheter kit close to the client's perineum.**
- **2. Don sterile gloves and prepare to sterile field**
- **3. Cleanse the urinary meatus using the solution, swabs, and forceps provided**
- **4. Place distal end of the catheter in sterile specimen cup and insert catheter into meatus**

- Rationale: First the kit should be open near the clients to minimize the risk of contamination during the collection of the sterile specimen. Once the kit is opened, sterile gloves should be donned to prepare the sterile field. Then the
clients' meatus should be cleansed, and the catheter inserted while to distal end of the catheter drains urine into the sterile specimen cup or receptacle.

338. An adult male was diagnosed with stage IV lung cancer three weeks ago. His wife approaches the nurse and asks how she will know that her husband's death is imminent because their two adult children want to be there when he dies. What is the best response by the nurse?

- **Explain that the client will start to lose consciousness and his body system will slow down**
- Reassure the spouse that the healthcare provider will let her know when to call the children
- Offer to discuss the client's health status with each of the adult children
- Gather information regarding how long it will take for the children to arrive
- Rationale: Expected signs of approaching death include noticeable changes in the client's level of consciousness and a slowing down of body systems. The nurse should answer the spouse's questions about the signs of imminent death rather
than offering reassurance that may or may not be true. Other options listed may be implemented but the nurse should first answer the spouse's question directly.

339. When should intimate partner violence (IPV) screening occur?

- As soon as the clinician suspects a problem
- Only when a client presents with an unexplained injury
- **As a routine part of each healthcare encounter**
- Once the clinician confirms a history of abuse
- Rationale: Universal screening for IPV is a vital means to identify victims of abuse in relationship. The suspicious of different clinicians vary greatly, so screening would not be implemented consistently. The client should be screened regardless of the presence of injury. Although history of abuse is difficult to confirm, screening should occur regardless, and this incident may know may be initial case of abuse.

340. A child newly diagnosed with sickle cell anemia (SCA) is being discharged from the hospital. Which information is most important for the nurse to provide the parents prior to discharge?

- **Instructions about how much fluid the child should drink daily**

- information about non-pharmaceutical pain reliever measures
- Referral for social services for the child and family
- Signs of addiction to opioid and medications
- Rationale: It is essential that the child and family understands the importance of adequate hydration in preventing the stasis-thrombosis-ischemia cycle of a crisis that has a specific plan for hydration is developed so that a crisis can be delayed. Other choices listed are not the most important topics to include in the discharge teaching.

341. What action should the school nurse implement to provide secondary prevention to a school-age children?

- Collaborate with a science teacher to prepare a health lesson
- Prepare a presentation on how to prevent the spread of lice
- **Initiate a hearing and vision screening program for first-graders**
- Observe a person with type 1 diabetes self-administer a dose of insulin
- Rationale: Community care occurs at primary, secondary, and tertiary levels of prevention. Primary prevention involves interventions to reduce the incidence of disease. Secondary prevention includes screening programs to detect disease. Tertiary prevention provides treatment directed toward clinically apparent disease. Secondary prevention focuses on screaming children for a specific disease processes such as hearing and vision screening. The other options are not examples of secondary prevention.

342. While assisting a client who recently had a hip replacement into a bed pan, the nurse notices that there is a small amount of bloody drainage on the surgical dressing, the client's skin is warm to the touch, and there is a strong odor from the urine. Which action should the nurse take?

- Obtain a urine sample from the bed pan
- Remove dressing and assess surgical site
- Insert an indwelling urinary catheter
- **Measure the client's oral temperature**
- Rationale: The strong odor from the urine and skin that is warm to the touch may indicate that the client has a urinary tract infection. Assessing the client's temperature provides objective information regarding infection that can be reported to the healthcare provider. Urine should be obtained via a clean catch, not the bed pan where it has been contaminated. The drainage on the dressing is

normal and does not require direct conservation at this time. An indwelling catheter should be avoided if possible because it increases the risk of infection.

343. While making rounds, the charge nurse notices that a young adult client with asthma who was admitted yesterday is sitting on the side of the bed and leaning over the bed-side-table. The client is currently receiving at 2 litters/minute via nasal cannula. The client is wheezing and is using pursed-lip breathing. Which intervention should the nurse implement?

- Assist the client to lie back in bed
- Call for an Ambu resuscitating bag
- Increase oxygen to 6 litters/minute
- **Administer a nebulizer Treatment**
- Rationale: The client needs an immediate medicated nebulizer treatment. Sitting in an upright position with head and arms resting on the over-bed table is an ideal position to promote breathing because it promotes lung expansion. Other actions me be accurate but not yet indicated.

344. A client with emphysema is being discharged from the hospital. The nurse enters the client's room to complete discharge teaching. The client reports feeling a little short of breath and is anxious about going home. What is the best course of action?

- Postpone discharge instructions at this time and offer to contact the client by phone in a few days
- Invite the client to return to the unit for discharge teaching in a few days, when there is less anxiety
- **Provide only necessary information in short, simple explanations with written instructions to take home**
- Give detailed instructions speaking slowly and clearly while looking directly at the client when speaking
- Rationale: Simple, short explanations should be provided. Information is not retained when the recipient is anxious, and too much information can increase worry. Ethically, discharge instructions may not be postponed.

345. An older adult male who had an abdominal cholecystectomy has become increasingly confused and disoriented over the past 24 hours. He is found wandering into another client's room and is return to his room by the unlicensed assistive personnel (UAP). What actions should the nurse take? (Select all that apply).

- Apply soft upper limb restrains and raise all four bed rails

- **Report mental status change to the healthcare provider**
- **Assess the client's breath sounds and oxygen saturation**
- Assign the UAP to re-assess the client's risk for falls
- **Review the client's most recent serum electrolyte values**
- Rationale: The healthcare provider should be informed of changes in the client's condition (B) because this behavior may indicate a postoperative complication. Diminished oxygenation (C) and electrolyte imbalance (E) may cause increased confusion in the older adult. Raising all four bed rails (A) may lead to further injury if the client climbs over the rails and falls and restrains should not be applied until other measures such as re-orientation are implemented. The nurse should assess the client's increased risk for falls, rather than assigning this to the UAP (D).

346. A client is admitted to a medical unit with the diagnosis of gastritis and chronic heavy alcohol abuse. What should the nurse administered to prevent the development of Wernicke's syndrome?

- Lorazepam (Ativan)
- Famotidine (Pepcid)
- **Thiamine (Vitamin B1)**
- Atenolol (Tenormin)
- Rationale: Thiamine replacement is critical in preventing the onset of Wernickes encephalopathy, an acute triad of confusion, ataxia, and abnormal extraocular movements, such as nystagmus related to excessive alcohol abuse. Other medications are not indicated.

347. When conducting diet teaching for a client who was diagnosed with nutritional anemia in pregnancy, which foods should the nurse encourage the client to eat? (Select all that apply)

- Seeds, spices, lettuce
- Consomme, celery, carrot
- Oranges, orange juice, bananas
- **Fortified whole wheat cereals, whole-grain pasta, brown rice**
- **Spinach, kale, dried raisins and apricots**
- Rationale: Nutritional anemia in pregnancy should be supplemented with additional iron in the diet. Foods that are high in iron content are often protein

based, whole grains (D), green leafy vegetables and dried fruits (E). (A, B, and C) are not iron rich sources

348. A client with type 2 diabetes mellitus is admitted for antibiotic treatment for a leg ulcer. To monitor the client for the onset of hyperosmolar hyperglycemic nonketotic syndrome (HHNS), what actions should the nurse take? (Select all that apply)

- Check urine for ketones
- **Measure blood glucose**
- **Monitor vital signs**
- **Assessed level of consciousness**
- Obtain culture of wound
- Rationale: Blood glucose greater than 600 mg/dl (33.3 mmol/L SI), vital sign changes in mental awareness are indicators of possible HHNS. Urine ketones are monitored in diabetic ketoacidosis. Wound culture is performed prior to treating the wound infection but is not useful in monitoring for HHNS.

349. An infant is receiving penicillin G procaine 220,000 units IM. The drug is supplied as 600,000 units/ml. How many ml should the nurse administer? (Enter numeric value only. If rounding is required, round to the nearest tenth)

- **0.4**
- Rationale: Calsulate using the formula, desired dose (220,000 units) over dose on hand (600,000 units) x the volume of the available dose (1 ml). 220,000 / 600,000 x 1 ml = 0.36 = 0.4 ml

350. After receiving report, the nurse can most safely plan to assess which client last? The client with…

- A rectal tube draining clear, pale red liquid drainage
- A distended abdomen and no drainage from the nasogastric tube
- **No postoperative drainage in the Jackson-Pratt drain with the bulb compressed**
- Dark red drainage on a postoperative dressing, but no drainage in the Hemovac®.
- Rationale: The most stable client is the one with a functioning drainage device and no drainage. This client can most safely be assesses last. Other clients are either actively bleeding, have an obstruction in the nasogastric tube which may result in vomiting, or may be bleeding and / or may have a malfunction in the Hemovac® drain.

351. The nurse instructs an unlicensed assistive personnel (UAP) to turn an immobilized elderly client with an indwelling urinary catheter every two hours. What additional action should the nurse instruct the UAP to take each time the client is turned?

- Empty the urinary drainage bag
- Feed the client a snack
- **Offer the client oral fluids**
- Assess the breath sounds
- Rationale: Increasing oral fluid intake reduces the risk of problems associated with immobility, so the UAP should be instructed to offer the client oral fluids every two hours, or whenever turning he client. It is not necessary to empty the urinary bag or feed the client every two hours. Assessment is a nursing function, and UAPs do not have the expertise to perform assessment of breath sounds.

352. The nurse is preparing a client who had a below-the-knee (BKA) amputation for discharge to home. Which recommendations should the nurse provide this client? (Select all that apply)

- **Inspect skin for redness**
- **Use a residual limb shrinker**
- Apply alcohol to the stump after bathing
- **Wash the stump with soap and water**
- Avoid range of motion exercises
- Rationale: Several actions are recommended for home care following an amputation. The skin should be inspected regularly for abnormalities such as redness, blistering, or abrasions. A residual limb shrinker should be applied over the stump to protect it and reduce edema. The stump should be washed daily with a mild soap and carefully rinse and dried. The client should avoid cleansing with alcohol because it can dry and crack the skin. Range of motion should be done daily.

353. When assessing the surgical dressing of a client who had abdominal surgery the previous day, the nurse observes that a small amount of drainage is present on the dressing and the wound's Hemovac suction device is empty with the plug open. How should the nurse respond?

- Replace the dressing and remove the drainage device
- Reposition the drainage device and keep the plug open
- Notify the healthcare provider that the drain is not working

- **Recompress the wound suction device and secure to plug**
- Rationale: The plug of a wound suction device, such as a Hemovac, should be closed after compressing the device to apply gentle suction in a closed surgical wound to facilitate the evacuation of subcutaneous fluids into the device. Compressing the device and securing the plug should restore function of the closed wound device. A small amount of drainage should be marked on the dressing, but replacing the dressing is not necessary and the nurse should not remove the device. Other options are not indicated.

354. A mother brings her 4-month-old son to the clinic with a quarter taped over his umbilicus, and tells the nurse the quarter is supposed to fix her child's hernia. Which explanations should the nurse provide?

- **This hernia is a normal variation that resolves without treatment.**
- Restrictive clothing will be adequate to help the hernia go away.
- An abdominal binder can be worn daily to reduce the protrusion.
- The quarter should be secured with an elastic bandage wrap.
- Rational: an umbilical hernia is a normal variation in infants that occurs due to an incomplete fusion of the abdominal musculature through the umbilical ring that usually resolves spontaneously as the child learns to walk. Other choices are ineffective and unnecessary.

355. A client who is admitted to the intensive care unit with syndrome of inappropriate antidiuretic hormone (SIADH) has developed osmotic demyelination. Which intervention should the nurse implement first?

- Patch one eye.
- Reorient often.
- Range of motion.
- **Evaluate swallow**
- Rational: Osmotic demyelination, also known as central pontine myelinolysis, is nerve damage caused by the destruction of the myelin sheath covering nerve cells in the brainstem. The most common cause is a rapid, drastic change in sodium levels when a client is being treated for hyponatremia, a common occurrence in SIADH. Difficulty swallowing due to brainstem nerve damage should be care, but determining the client's risk for aspiration is most important.

356. A client with possible acute kidney injury (AKI) is admitted to the hospital and mannitol is prescribed as a fluid challenge. Prior to carrying out this prescription, what intervention should the nurse implement?

- Collect a clean catch urine specimen.
    - Instruct the client to empty the bladder.
    - **Obtain vital signs and breath sounds.**
    - No specific nursing action is required
    - Rational: the client's baseline cardiovascular status should be determined before conducting the fluid challenge. If the client manifests changes in the vital signs and breath sounds associated with pulmonary edema, the administration of the fluid challenge should be terminate. Other options would not assure a safe administration of the medication.

357. A male client with COPD smokes two packs of cigarettes per day and is admitted to the hospital for a respiratory infection. He complains that he has trouble controlling respiratory distress at home when using his rescue inhaler. Which comment from the client indicates to the nurse that he is not using his inhaler properly?

- "I have a hard time inhaling and holding my breath after I squeeze the inhaler, but I do my best"
- " I never use the inhaler unless I am feeling really short of breath"
- I always shake the inhaler several times before I start"
- **"A fter I s q ueeze t he in hal er a nd s wallo w, I al way s feel a s lig ht wav e of naus ea, b it it goes away"**

358. A nurse is planning to teach infant care and preventive measures for sudden infant death syndrome (SIDS) to a group of new parents. What information is most important
for the nurse to include?

- **Ensure that the infant's crib mattress is firm**

359. A 6 -years-old who has asthma is demonstrating a prolonged expiratory phase and wheezing, and has 35% personal best peak expiratory flow rate (PEFR). Based on these finding, which action should the nurse implement first?

- **Administer a prescribed bronchodilator.**
- Report finding to the healthcare provider.
- Encourage the child to cough and deep breath
- Determine what trigger precipitated this attack.
- Rationale: If the PEFR is below 50% in as asthmatic child, there is severe narrowing of the airway, and a bronchodilator should be administered

immediately. Be should be implemented after A. C will not alleviate the symptoms and D is not a priority.

360. A client is receiving lactulose (Portalac) for signs of hepatic encephalopathy. To evaluate the client's therapeutic response to this medication, which assessment should the nurse obtain?

- **Level of consciousness**
- Percussion of abdomen
- Serum electrolytes
- Blood glucose.
- Rationale: Colonic bacteria digest lactulose to create a drug-induces acidic and hyperosmotic environment that draws water and blood ammonia into the colon and coverts ammonia to ammonium, which is trapped in the intestines and cannot be reabsorbed into the systemic circulation. This therapeutic action of lactulose is to reduce serum ammonia levels, which improves the client's level of consciousness and metal status.

361. When administering an immunization in an adult client, the nurse palpates and administer the injection one inch below the acromion process into the center of the muscle mass. The nurse should document that the vaccine was administered at what site?

- Rectus femenis
- Ventrogluteous
- Vastus lateralis
- **Deltoid**
- Rationale: The acromion process is a parameter identified for the deltoid site.

362. A primigravida a 40-weeks gestation with preeclampsia is admitted after having a seizure in the hot tub at a midwife's birthing center. Based on documentation in the medical record, which action should the nurse implement? (Click on each chart tab for additional information. Please be sure to scroll to the bottom right corner of each tab to view all information contained in the client's medical record.)

- **Continue to monitor the client's blood pressure hourly**

363. A female nurse who took drugs from the unit for personal use was temporarily released from duty. After completion of mandatory counseling, the nurse has asked administration to allow her to return to work. When the nurse administrator approaches the charge nurse with the impaired nurse request, which action is best for the charge nurse to take?

- Since treatment is completed, assign the nurse to the route RN responsibilities
    - Ask to meet with impaired nurse's therapist before allowing her back on the unit.
    - **Allow the impaired nurse to return to work and monitor medication administration**
    - Meet with staff to assess their feelings about the impaired nurse's return to the unit.
    - Rationale: provides essential monitoring and helps ensure nurse compliance and promote client safety.

364. In making client care assignment, which client is best to assign to the practical nurse (PN) working on the unit with the nurse?

- **An immobile client receiving low molecular weight heparin q12 h.**
- A client who is receiving a continuous infusion of heparin and gets out of bed BID
- A client who is being titrated off heparin infusion and started on PO warfarin (Coumadin)
- An ambulatory client receiving warfarin (Coumadin) with INR of 5 second.
- Rationale: A describe the most stable client. The other ones are at high risk for bleeding problems and require the assessment skills.

365. A client who is admitted to the intensive care unit with a right chest tube attached to a THORA-SEAL chest drainage unit becomes increasingly anxious and complain of difficulty breathing. The nurse determine the client is tachypneic with absent breath sounds in the client's right lungs fields. Which additional finding indicates that the client has developed a tension pneumothorax?

- Continuous bubbling in the water seal chamber
- Decrease bright red blood drainage
- Tachypnea and difficulty breathing
- **Tracheal deviation toward the left lung.**
- Rationale: Tracheal deviation toward the unaffected left lung with absent breath sounds over the affected right lung are classic late signs of a tension pneumothorax.

366. A low-risk primigravida at 28-weeks gestation arrives for her regular antepartal clinic visit. Which assessment finding should the nurse consider within normal limits for this client?

- **Pulse increase of 10 beats/minute**
- Proteinuria
- Glucosuria
- Fundal height 0f 22 centimeters

367. The nurse discovers that an elderly client with no history of cardiac or renal disease has an elevated serum magnesium level. To further investigate the cause of this electrolyte imbalance, what information is most important for the nurse to obtain from the client's medical history?

- **Frequency of laxative use for chronic constipation**

368. Which action should the nurse implement with auscultating anterior breath sounds? (Place the first action on top and last action on the bottom)

- Correct order: (PADD)

1. **Place stethoscope in suprasternal area to auscultate for bronchial sounds**
2. **Auscultate bronchovesicular sounds from side to side the first and second intercostal spaces**
3. **Displace female breast tissue and apply stethoscope directly on chest wall to hear vesicular sounds**
4. **Document normal breath sounds and location of adventitious breath sounds**

369. A client with chronic alcoholism is admitted with a decreased serum magnesium level. Which snack option should the nurse recommend to this client?

- Cheddar cheese and crackers.
- Carrot and celery sticks.
- Beef bologna sausage slices.
- **Dry roasted almonds.**
- Rational: alcoholism promotes inadequate food intake and gastrointestinal loss of magnesium include green leafy vegetables and nuts and seeds. Other snacks listed provide much lower amounts of magnesium per serving.

370. The nurse is preparing a teaching plan for an older female client diagnosed with osteoporosis. What expected outcome has the highest priority for this client?

- Identifies 2 treatments for constipation due to immobility.

- **Names 3 home safety hazards to be resolve immediately.**
- State 4 risk factors for the development of osteoporosis.
- Lists 5 calcium-rich foods to be added to her daily diet.
- Rational: a major teaching goal for an elderly client with osteoporosis is maintenance of safety to prevent falls. Injury due to a fall, usually resulting in a hip fracture, can result in reduced mobility and associated complications. Other goals are also important when teaching clients who have osteoporosis, but they do not have the priority of preventing falls, which relates to safety.

371. The nurse is teaching a male adolescent recently diagnosed with type 1diabetes mellitus (DM) about self-injecting insulin. Which approach is best for the nurse to use to evaluate do you effectiveness of the teaching?

- Ask the adolescent to describe his level of comfort with injecting himself with insulin.
- **Observe him as he demonstrates self-injection technique in another diabetic adolescent**
- Have the adolescent list the procedural steps for safe insulin administration.
- Review his glycosylated hemoglobin level 3 months after the teaching session.
- Rational: watching the adolescent perform the procedure with another adolescent provides peer support the most information regarding his skill with self-injection. Other options do not provide information about the effectiveness of nurse's teaching.

372. A young adult woman visits the clinic and learns that she is positive for BRCA1 gene mutation and asks the nurse what to expect next. How should the nurse respond?

- **Explain that counseling will be provided to give her information about her cancer risk**
- Gather additional information about the client's family history for all types of cancer.
- Offer assurance that there are a variety of effective treatments for breast cancer.
- Provide information about survival rates for women who have this genetic mutation.
- Rational: BRACA1or BRACA2 genetic mutation indicates an increased risk for developing breast or ovarian cancer and genetic counseling should be provided to explain the increased risk (A)to the client along with options for increased screening or preventative measures. (B) Is completed by the genetic counselor

before the client undergoes genetic testing. a positive BRACA1test is not an indicator of the presence of cancer and (C and D) are not appropriate responses prior to genetic counseling.

373. A mother runs into the emergency department with s toddler in her arms and tells the nurse that her child got into some cleaning products. The child smells of chemicals on hands, face, and on the front of the child's clothes. After ensuring the airway is patent, what action should the nurse implement first?

- Call poison control emergency number.
- **Determine type of chemical exposure.**
- Obtain equipment for gastric lavage.
- Assess child for altered sensorium.
- Rational: once the type of chemical is determined, poison control should be called even if the chemical is unknown. If lavage is recommended by poison control, intubation and nasogastric tube may be needed as directed by poison control. Altered sensorium, such as lethargy, may occur if hydrocarbons are ingested

374. The nurse assigned unlicensed assistive personnel (UAP) to apply antiembolism stockings to a client. The nurse and UAP enters the room, the nurse observes the stockings that were applying by the UAP. The UAP states that the client requested application of the stockings as seen on the picture, for increased comfort. What action should the nurse take?

- Ask the client if the stocking feel comfortable.
- Supervise the UAP in the removal of the stockings.
- Place a cover over the client’s toes to keep them warm.
- **Discussed effective use of the stockings with the client on UAP**
- Rational: antiembolism stockings are designed to fit securely and should be applied so that there are no bands of the fabric constricting venous return. The nurse should discuss the need for correct and effective use of the stockings with both the client and UAP to improve compliance. Other options do not correct the incorrect application of the stockings.

375. Nurses working on a surgical unit are concerned about the physicians treatment of clients during invasive procedures, such as dressing changes and insertion of IV lines. Clients are often crying during the procedures, and the physician is usually unconcerned or annoyed by the client’s response. To resolve this problem, what actions should the nurses take? (Arrange from the first action on the top of the list on the bottom)

1. Talk to the physician as a group in a non-confrontational manner.

2. Document concerns and report them to the charge nurse.
3. Submit a written report to the director of nursing.
4. Contact the hospital's chief of medical services.
5. File a formal complaint with the state medical board.

- Rational: nurses have both an ethical and legal responsibility to advocate for clients' physical and emotional safety. Talking with the physician in a non-confrontational manner is the first step in conflict resolution. If this is not effective, the organizational chain of ineffective, a formal complaint with the state medical board should be implemented.

376. While changing a client's chest tube dressing, the nurse notes a crackling sensation when gentle pressure is applied to the skin at the insertion site. What is the best action for the nurse to take?

- Apply a pressure dressing around the chest tube insertion site.
- Assess the client for allergies to topical cleaning agents.
- **Measure the area of swelling and crackling.**
- Administer an oral antihistamine per PRN protocol.
- Rational: a crackling sensation, or crepitus, indicates subcutaneous emphysema, or air leaking into the skin. This area should be measured and the finding documented. Other options are not indicated for crepitus.

377. To prevent infection by auto contamination during the acute phase of recovery from multiple burns, which intervention is most important for the nurse to implement?

- **Dress each wound separately.**
- Avoid sharing equipment between multiple clients.
- Use gown, mask and gloves with dressing change.
- Implement protective isolation.
- Rational: each wound should be dressed separately using a new pair of sterile glove to avoid auto contamination (the transfer of microorganisms form one infected wound to a non-infected wound). The other choices do not prevent auto contamination.

378. The nurse is preparing an intravenous (IV) fluid infusion using an IV pump. Within 30 seconds of turning on the machine, the pump's alarm beeps "occlusion". What action should the nurse implement first?

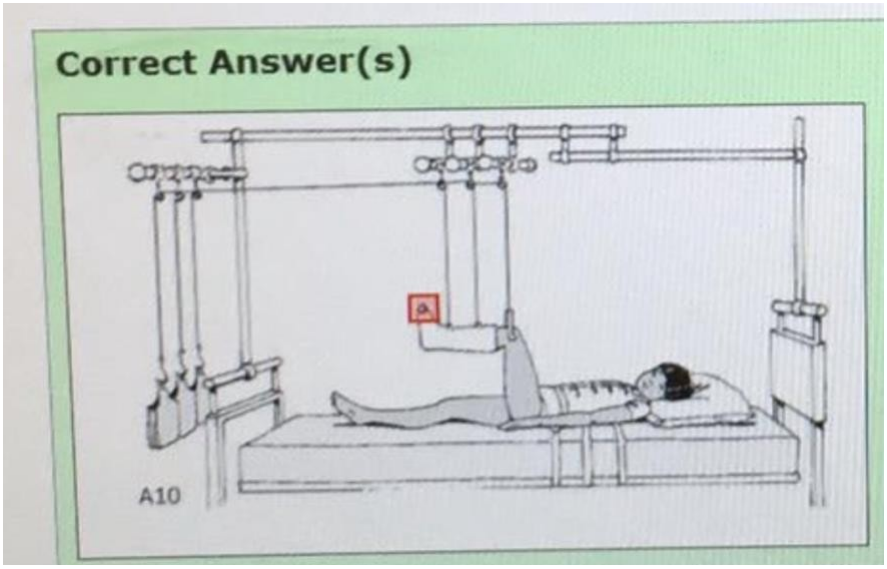
- Flush the vein with 3 ml of sterile normal saline.

- Assess the IV catheter insertion site for infiltration.
- Verify the threading of the tubing through the IV pump.
- **Determine if the clamp on the IV tubing is released**
- Rational: When the pump immediately beeps, it is often because the IV tubing clamp is occluding the flow, so the clamp should be checked first to ensure that it is open. If the alarm is not eliminated after the tubing clamp is released, flushing the IV site with saline is a common practice to clean the needle or to identify resistance due to another source. Local signs of infiltration may indicate the need to select another vein, but the pump's beeping-this early in the procedure is likely due to a mechanical problem. If beeping continues after verifying that the clamp
  is released the placement or threading of the tubing through the pump should be verified.

379. A client with arthritis has been receiving treatment with naproxen and now reports ongoing stomach pain, increasing weakness, and fatigue. Which laboratory test should
the nurse monitor?

- Sed rate (ESR)
- **Hemoglobin**
- Calcium
- Osmolality.
- Rational: naproxen can cause gastric bleeding, so the nurse should monitor the client's hemoglobin to assess for possible bleeding. Other options are not likely to be affected by the used of naproxen and are not related to the client's current symptoms.

380. The nurse assesses a child in 90-90 traction. Where should did nurse assess for signs of compartment syndrome?



- Rationale: compartment syndrome is the result of swelling and subsequent reduction in circulation to the area distal to the compartment. This can be a complication of traumatic injury and cast administration, so it is important to assess circulation distal to the casted prolonged capillary refill.

381. After receiving the Braden scale findings of residents at a long-term facility, the charge nurse should to tell the unlicensed assistive personnel (UAP) to prioritize the skin care for which client?

- An older adult who is unable to communicate elimination needs.
- **An older man whose sheets are damped each time he is turned.**
- A woman with osteoporosis who is unable to bear weight.
- A poorly nourished client who requires liquid supplement.
- Rational: a Braden score of less than 18 indicates a risk for skin breakdown, and clients with such score require intensive nursing care. Constant moisture places the client at a high risk for skin breakdown, and interventions should be implemented to pull moisture away from the client's skin. Other options may be risk factors but do not have as high a risk as constant exposure to moisture.

382. A client with acute renal failure (ARF) is admitted for uncontrolled type 1 diabetes Mellitus and hyperkalemia. The nurse administers an IV dose of regular insulin per sliding scale. Which intervention is the most important for the nurse to include in this client's plan of care?

- **Monito r th e cl ie nt's card iac act ivity via t elem etry .**

- Maintain venous access with an infusion of normal saline.
- Assess glucose via fingerstick q4 to 6 hours.
- Evaluate hourly urine output for return of normal renal function.
- Rational: as insulin lowers the blood glucose of a client with diabetic ketoacidosis (DKA), potassium returns to the cell but may not impact hyperkalemia related to acute renal failure. The priority is to monitor the client for cardiac dysrhythmias related to abnormal serum potassium levels. IV access, assessment of glucose level, and monitoring urine output are important interventions, but do not have the priority of monitoring cardiac function.

383. A client with C-6 spinal cord injury rehabilitation. In the middle of the night the client reports a severe, pounding headache, and has observable piloerection or "goosebumps". The nurse should asses for which trigger?

- Loud hallway noise.
- Fever
- **Full bladder**
- Frequent cough.
- Rational: a pounding headache is a sign of autonomic hyperreflexia, an acute emergency that occurs because of an exaggerated sympathetic response in a client with a high level spinal cord injury. Any stimulus below the level of injury can trigger autonomic hyperreflexia, but the most common cause is an overly distended bladder. The other options are unlikely to produce the manifestation of autonomic hyperreflexia.

384. A nurse working on an endocrine unit should see which client first?

- An adolescent male with diabetes who is arguing about his insulin dose.
- An older client with Addison's disease whose current blood sugar level is 62mg/dl (3.44 mmol/l).
- An adult with a blood sugar of 384mg/dl (21.31mmol/l) and urine output of 350 ml in the last hour.
- **A client taking corticosteroids who has become disoriented in the last two hours.**
- Rational: meeting the client's need for safety is a priority intervention. Mania and psychosis can occur during corticosteroids therapy, places the client at risk for injury, so the patient taking corticosteroids should be seen first.

385. A client is receiving and oral antibiotic suspension labeled 250 mg/2ml. The healthcare provider prescribes 200mg every 6 hours. How many ml should the nurse administer at each dose? (Enter numerical value only. If rounding is required, round to the nearest tenth)

- **Answer: 1.6**
- Rational: using the formula D/H x Q
- 200mg/250 mg x 2ml = 200/250 = 1.6 ml

386. Four hours after surgery, a client reports nausea and begins to vomit. The nurse notes that the client has a scopolamine transdermal patch applied behind the ear. What action should the nurse take?

- Reposition the transdermal patch to the client's trunk.
- Remove the transdermal patch until the vomiting subsides.
- **Notify the healthcare provider of the vomiting.**
- Explain that this is a side effect of the medication in the patch.
- Rational: transdermal scopolamine is used to prevent nausea and vomiting from anesthesia and surgery. The nurse should notify the healthcare provider if the medication is ineffective. The patch should be applied behind the ear and should remain in place to reduce the nausea and vomiting. Nausea and vomiting are no side effects of the medication.

387. The nurse identifies an electrolyte imbalance, an elevated pulse rate, and elevated BP for a client with chronic kidney disease. Which is the most important action for the nurse to take?

- Monitor daily sodium intake.
- Record usual eating patterns.
- Measure ankle circumference.
- **Auscultate for irregular heart rate.**
- Rational: Chronic kidney failure (CKF) is a progressive, irreversible loss of kidney functions, decreasing glomerular filtration rate (GFR), and the kidney's inability to excrete metabolic waste products and water, resulting in fluid overload, elevated pulse, elevated BP and electrolytes imbalances. The most important action for the nurse to implement is to auscultate for irregular heart rate (D) due to the decreased excretion of potassium by the kidneys. (A, B, and C) are not as important as monitoring for fatal cardiac dysrhythmias related to hyperkalemia.

388. A client with persistent low back pain has received a prescription for electronic stimulator (TENS) unit. After the nurse applies the electrodes and turns on the power, the client reports feeling a tingling sensation. How should the nurse respond?

- **Determine if the sensation feels uncomfortable.**
- Decrease the strength of the electrical signals.
- Remove electrodes and observe for skin redness.
- Check the amount of gel coating on the electrodes.
- Rational: electronic stimulators, such as a transelectrical nerve stimulator (TENS) unit, have been found to be effective in reducing low back pain by "closing the gate" to pain stimuli. A tingling sensation should be felt when the power is turned on, and the nurse should assess whether the sensation is too strong, causing discomfort or muscle twitching. Decreasing the electrical signal may be indicated if the sensation is too strong. Other options are not necessary because the tingling sensation is expected.

389. A female client is extremely anxious after being informed that her mammogram was abnormal and needs to be repeated. Client is tearful and tells the nurse her mother died of breast cancer. What action should the nurse take?

- Provide the client with information about treatment options for breast cancer.
- Reassure the client that the final diagnosis has not been made.
- **Encourage the client to continue expressing her fears and concerns.**
- Suggest to the client that she seek a second opinion.
- Rational: the nurse should show support for the client by encouraging her to continue expressing her concerns. A diagnosis has not yet been made, so it is too early to discuss treatment options. Other options dismiss the client's feelings or are premature given that the diagnosis is not yet made.

390. The psychiatric nurse is talking to a newly admitted client when a male client diagnosed with antisocial behavior intrudes on the conversation and tells the nurse, "I have to talk to you right now! It is very important!" how should the nurse respond to this client?

- Put his behavior on extinction and continue talking with the newly admitted.
- **Inform him that the nurse is busy admitting a new client and will talk to him later.**
- Encourage him to go to the nurse's station and talk with another nurse.

- Introduce him to the newly admitted client and ask him to him to join in the conversation.
- Rational: the psychiatric nurse must set limits with antisocial behavior so that appropriate behavior is demonstrated. Interrupting a conversation is rude and inappropriate, so telling the client that they can talk later is the best course of action. Other options may cause the client to become angry and they do not address the client's behavior. The nurse should not involve this client with newly admitted client's admission procedure.

391. The charge nurse is planning for the shift and has a registered nurse (RN) and a practical nurse (PN) on the team. Which client should the charge nurse assign to the RN?

- A 64 year old client who had a total hip replacement the previous day.
- A 75 year old client with renal calculi who requires urine straining.
- An adolescent with multiple contusions due to a fall that occurred 2 days ago.
- **A 30 year old depressed client who admits to suicide ideation.**
- RATIONALE: A client who is suicidal requires psychological assessment, therapeutic communication and knowledge beyond the educational level of a practical nurse (RN). Other clients could be cared for by the PN or the UAP, with supervision by the registered nurse.

392. A female client presents in the Emergency Department and tells the nurse that she was raped last night. Which question is most important for the nurse to ask?

- Does she knows the person who raped her?
- **Has she taken a bath since the raped occurred?**
- Is the place where she lived a safe place?
- Did she report the rape to the police Department?
- RATIONALE: The priority action is collected the forensic evidence, so asking if the has taken a bath since the rape occurred is the most important information to obtain. Other options are used by law enforcement to determine the perpetrator and are not vital in providing client care at this time.

393. While caring for a client's postoperative dressing, the nurse observes purulent drainage at the wound. Before reporting this finding to the healthcare provider, the nurse should review which of the client's laboratory values?

- Serum albumin
- Creatinine level

- **Culture for sensitive organisms.**
- Serum blood glucose (BG) level
- RATIONALE: A client who has a postoperative dressing with purulent drainage from the wound is experiencing an infection. The nurse should review the client's laboratory culture for sensitive organisms (C) before reporting to the healthcare provider. (A, B and D) are not indicated at this time.

394. The nurse is demonstrating correct transfer procedures to the unlicensed assisted personnel (UAP) working on a rehabilitation unit. The UAPs ask the nurse how to safely move a physically disabled client from the wheelchair to a bed. What action should the nurse recommended?

- Hold the client at arm's length while transferring to better distribute the body weight.
- Apply the gait belt around the client's waits once standing position has been assumed.
- **Place a client's locked wheelchair on the client's strong side next to the bed.**
- Pull the client into position by reaching from the opposite side of the bed.
- RATIONALE: Placing the wheelchair on the client's strong side offers the greatest stability for the transfer. Holding the client arm's length or pulling from the opposite site of the bed reflect poor body mechanism. Using a gait belt offers additional safety for the client, but should be done after the wheelchair has be put into the proper place and the wheels have been locked and before the client has assumed a standing position.

395. A client who is experiencing musculoskeletal pain receives a prescription for ketorolac 15mg IM q6 hours. The medication is depended in a 39mg/ml pre-filled syringe. Which action should the nurse implement when giving the medication?

- Administer the entire pre-filled syringe deep in the dorsogluteal site.
- Use a separate syringe to remove 15mg from the pre-filled syringe and give in the back of the arm.
- **Waste 0.5 ml from the pre-filled syringe and inject the medication in the ventrogluteal site.**
- Call the healthcare provider to request a prescription change to match the dispensed 30mg dose.
- RATIONALE: The pre-filled contain 30mg /1ml, so 0.5ml should be wasted to obtain the correct dosage of 15mg for administration in the preferred IM ventrogluteal site. The nurse is responsible for calculating and preparing the

prescribed dose using the available concentration, so other options are not indicated.

396. A client with a lower respiratory tract infection receives a prescription for ciprofloxacin 500mg PO q 12hours. When the client request an afternoon snack, which dietary choice should the nurse provide?

- Vanilla-flavored yogurt
- Low fat chocolate milk.
- Calcium fortified juice
- **Cinnamon applesauce**
- RATIONALE: Dairy products and calcium fortified dairy products decrease the absorption of ciprofloxacin. Cinnamon applesauce contains no calcium, so this is the best snack selection. Since other options contains calcium, these snack should be avoided by a client who is taking ciprofloxacin.

397. The healthcare provider prescribes a low-fiber diet for a client with ulcerative colitis. Which food selection would indicate to the nurse the client understands they prescribed diet?

- **Roasted turkey canned vegetables**
- Baked potatoes with skin raw carrots
- Pancakes whole-grain cereal's
- Roast pork fresh strawberries
- Rationale: Foods allowed on a low-fiber diet includes roasted or baked turkey and canned vegetables the foods in the other options are not low in fiber

398. An adult client with schizophrenia begin treatment three days ago with the Antipsychotic risperidone. The client also received prescription for trazodone as needed for sleep and clonazepam as needed for severe anxiety. When the client reports difficulty with swallowing, what action should the nurse take?

- **Obtain a prescription for an anticholinergic medication**
- Determine how many hours declined slept last night
- Administer the PRN prescription for severe anxiety
- Watch the thyroid cartilage move while the client swallows
- Rationale: Antipsychotic medications have an extrapyramidal side effects one of which is difficult to swallowing the nurse should obtain a prescription for an anticholinergic medication which is used for the treatment of extrapyramidal

symptoms. Other options are not warranted actions based on the symptoms presented.

399. One year after being discharged from the burn trauma unit, a client with a history of 40% full-thickness burns is admitted with bone pain and muscle weakness. Which intervention should the nurse include in the clients plan of care?

- Encourage Progressive active range of motion
- **Teach need for dietary and supplementary vitamin D3**
- Explain the need for skin exposure to sunlight without sunscreen
- Instruct the client to use of muscle strengthening exercises
- Rationale: Burn injury results in the acute loss of bone as well as the development of progressive vitamin D deficiency because burn scar tissue and adjacent normal- appearing skin cannot convert normal quantities of the precursors for vitamin D3 that is synthesized from ultraviolet sun rays which is needed for strong bones. Clients with a history of full thickness burns should increase their dietary
  resources of vitamin D and supplemental D3 (B). range of motion (A) and muscle strengthening exercises (D) do not treat he underlying causes of the bone pain and weakness unprotected sunlight (C) should be avoided.

400. When teaching a group of school-age children how to reduce the risk of Lyme disease which instruction should the camp nurse include?

- Wash hands frequently
- Avoid drinking lake water
- **Wear long sleeves and pants**
- Do not share personal products
- Rationale: Lyme disease is it tick bone disorder and is transmitted to a child via a tick bite. Keeping the skin covered reduces the risk of being bitten by a tick. Other options are not reduce the risk for tick bites.

401. A native-American male client diagnosed with pneumonia, states that in addition to his prescribed medical treatment of IV antibiotics he wishes to have a spiritual cleaning performed. Which outcome statement indicates that the best plan of care was followed?

- Identifies his ethnocentric values and behaviors
- States an understanding of the medical treatment
- **Participated actively in all treatments regimens**

- Expresses a desire for cultural assimilation
- Rationale: indicates active participation by the client, which is required for treatment to be successful. The best plan of care should incorporate the valued and treatments of both cultures and in this case there is no apparent cultural clash between the two forms of treatment. The client has already identify he's cultural values (A). (B) Only considers one of the two treatment modalities desired by the client the client has already chosen how he wishes to assimilate his cultural values with the prescribed medical treatment (D).

402. A male client with cancer is admired to the oncology unit and tells the nurse that he is in the hospital for palliative care measures. The nurse notes that the client's admission prescription include radiation therapy. What action should the nurse implement?

- **Ask the client about his expected goals for the hospitalization**
- Explain the palliative care measures can be provided at home
- Notify do radiation department to withhold the treatment for now
- Determine if the client wishes to cancel further radiation treatment
- Rationale: Palliative care measures provide relief or control of symptoms, so it is important for the nurse to determine the client's goals for symptom control while receiving treatment in the hospital. Although home care is available the client may not be legible for palliative care at home. Radiation therapy is an effective positive care measure used to manage symptoms and would be appropriate unless the radiation conflicts with the client goals.

403. A client with myasthenia Gravis (MG) is receiving immunosuppressive therapy. Review recent laboratory test results show that the client's serum magnesium level has decreased below the normal range. In addition to contacting the healthcare provider, what nursing action is most important?

- Check the visual difficulties
- Note most recent hemoglobin level
- Assessed for he and Hand joint pain
- **Observe rhythm on telemetry monitor**
- Rationale: If not treated a low little Serum magnesium level can affect myocardial depolarization leading to a lethal arrhythmia, and the nurse should assess for dysrhythmias before contacting the healthcare provider. Other choices are common in MG but do not contribute the Safety risk of low magnesium levels.