

FUNDAMENTALS MID TERM EXAM JUNE 2018

1. A nurse is reviewing information about the Health Insurance Portability and Accountability Act (HIPAA) with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates a need for further teaching?
- A. "Information about a client can be disclosed to family members at any time."
 - B. "HIPAA established regulations of individually identifiable health information in verbal, electronic, or written form."
 - C. "A client's address would be an example of personally identifiable information."
 - D. "HIPAA is a federal law, not a state law."
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2. A nurse is preparing to perform hand hygiene. Which of the following actions should the nurse take?
- A. Adjust the water temperature to feel hot.
 - B. Apply 4 to 5 mL of liquid soap to the hands.
 - C. Hold the hands higher than the elbows.
 - D. Rub hands and arms to dry.
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3. A nurse is administering nasal decongestant drops for a client. Which of the following actions should the nurse take?
- A. Tell the client to blow her nose gently before the instillation.
 - B. Assist the client to a side-lying position.
 - C. Hold the dropper 2 cm (1 in) above the naris.
 - D. Instruct the client to stay in the same position for 2 min.
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4. A newly licensed nurse is applying prescribed wrist restraints on a client. Which of the following actions should the nurse take?
- A. Secure the restraints using a quick-release tie.
 - B. Ensure four fingers fit under the restraints to prevent constriction.
 - C. Secure the restraints to the lowest bar of the side rail.
 - D. Anticipate removing the restraints every 4 hr.

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5. The family of an older adult client brings him to the emergency department after finding him wandering outside. During the initial assessment, the nurse notes that the client flinches when she palpates his abdomen yet responds to questions only by nodding and smiling. Which of the following factors should the nurse identify as a likely explanation for the client's behavior?
- A. He is hard of hearing.
 - B. Pain
 - C. Confusion
 - D. Language barrier
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6. A nurse is preparing a client for outpatient surgery. After the nurse inserts the IV catheter, the client reports pain in the insertion area. Which of the following actions should the nurse take?
- A. Remove the catheter and insert another into a different site.
 - B. Administer an analgesic PO.
 - C. Request a prescription for placement of a central venous access device.
 - D. Administer a local anesthetic.
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7. A client smoking in his bathroom has dropped a cigarette butt into a wastepaper basket, which begins to smolder. Which of the following actions is the nurse's priority?
- A. Close the fire doors on the unit.
 - B. Activate the fire alarm.
 - C. Move any clients in the immediate vicinity.
 - D. Use a fire extinguisher to put out the fire.
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8. A nurse is caring for a client who refuses treatment and asks to be discharged from the hospital against medical advice. The nurse notifies the client's provider, who tells the nurse to restrain the client, if necessary, to keep her from leaving the hospital. The nurse understands that restraining this client would be considered which type of civil action by the nurse?
- A. Invasion of privacy
 - B. Assault
 - C. Battery

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D. False imprisonment

9. A nurse is performing tracheostomy care for a client and suctioning to remove copious secretions. Which of the following actions should the nurse take?

- A. Suction two to three times with a 60-second pause between passes.
 - B. Perform chest physiotherapy prior to suctioning.
 - C. Lubricate the suction catheter tip with sterile saline.
 - D. Hyperventilate the client on 100% oxygen prior to suctioning.
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10. A nurse is inserting an IV catheter for an older client in preparation for an outpatient procedure. Which of the following veins should the nurse select?

- A. Dorsal metacarpal vein
 - B. Radial vein in the wrist
 - C. Antecubital vein
 - D. Median vein in the forearm
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11. A nurse is providing oral care for a client who is immobile. Which of the following actions should the nurse take?

- A. Use a stiff toothbrush to clean the client's teeth.
 - B. Use the thumb and index finger to keep the client's mouth open.
 - C. Turn the client on his side before starting oral care.
 - D. Apply petroleum jelly to the client's lips after oral care.
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12. A nurse is caring for a client who experienced a lacerated spleen and has been on bedrest for several days. The nurse auscultates decreased breath sounds in the lower lobes of both lungs. The nurse should realize that this finding is most likely an indication of which of the following conditions?

- A. An upper respiratory infection
 - B. Pulmonary edema
 - C. Atelectasis
 - D. Delayed gastric emptying
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13. A nurse is assessing a client and discovers the infusion pump with the client's total parenteral nutrition (TPN) solution is not infusing. The nurse should monitor the client for which of the following conditions?

- A. Excessive thirst and urination
- B. Shakiness and diaphoresis
- C. Fever and chills
- D. Hypertension and crackles

14. A nurse is caring for four clients who have drainage tubes. Which of the following clients should the nurse recognize as being at risk for hypokalemia?

- A. The client who has a tracheostomy tube attached to humidified oxygen
- B. The client who has an indwelling urinary catheter to gravity drainage
- C. The client who has a chest tube to water seal
- D. The client who has a nasogastric (NG) tube to suction

15. A nurse is assessing a client's cranial nerves as part of a neurological examination. Which of the following actions should the nurse take to assess cranial nerve III?

- A. Testing visual acuity
- B. Observing for facial symmetry
- C. Eliciting the gag reflex
- D. Checking the pupillary response to light

16. An assistive personnel (AP) reports a client's vital signs as tympanic temperature 37.1° C (98.8° F), pulse 92/min, respiratory rate 18/min, and BP 98/58 mm Hg. Which of the following vital signs should the nurse re-measure?

- A. BP
- B. Respiratory rate
- C. Pulse rate
- D. Temperature

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17. A nurse accidentally administers the wrong medication to a client, which results in a severe allergic reaction and prolongs the client's hospitalization. The client could rightfully sue the nurse for which of the following?

- A. Battery
- B. Assault
- C. Malpractice
- D. Abuse

18. A nurse is caring for an older adult client who states, "I am afraid that I may fall while walking to the bathroom during the night." Which of the following actions should the nurse take?

- A. Limit the client's fluid intake in the evening.
- B. Obtain a bedside commode for the client's use.
- C. Leave a nightlight on in the client's room.
- D. Put the side rails up and tell the client to call the nurse before voiding.

19. A nurse is working with a licensed practical nurse (LPN) to care for a client who is receiving a continuous IV infusion. Which of the following findings reported by the LPN indicates to the nurse the client has phlebitis at the IV insertion site?

- A. "The infusion rate has stopped but the tubing is not kinked."
- B. "The area surrounding the insertion site feels warm to the touch."
- C. "There is fluid leaking around the insertion site."
- D. "There is no blood return when the tubing is aspirated."

20. A nurse in the emergency department is caring for a client who collapsed after playing football on a hot day. After reviewing the admission laboratory findings, the nurse recognizes that these findings are consistent with which of the following conditions?

Sodium	152 mEq/L	Glucose	102
mg/dL Potassium	3.6 mEq/L	BUN	18 mg/dL
mEq/L	Creatinine	0.7 mg/dL	Chloride
			105

- A. Renal failure
- B. Low-protein diet
- C. Dehydration
- D. Syndrome of inappropriate antidiuretic hormone (SIADH)

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21. A nurse is assisting with transferring a client from the bed to a wheelchair. Which of the following actions should the nurse take?

- A. Place the wheelchair at a 90° angle to the bed.
 - B. Lock the wheels of the bed and the wheelchair.
 - C. Acquire the help of several people to lift the client.
 - D. Elevate the bed to a position of comfort for the nurse.
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22. A nurse is teaching a class of older adults about the expected physiologic changes of aging. Which of the following changes should the nurse include in the discussion? (Select all that apply.)

- A. More difficulty seeing due to a greater sensitivity to glare
 - B. Decreased cough reflex
 - C. Decreased bladder capacity
 - D. Decreased systolic blood pressure
 - E. Dehydration of intervertebral discs
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23. A nurse is caring for a client who has an NG tube. The nurse tests the pH of the secretions to determine if the tube is correctly placed. Which of the following readings should the nurse expect?

- A. 6.0
 - B. 4.0
 - C. 7.0
 - D. 8.0
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24. A charge nurse is anticipating the admission of four clients and planning their room assignments. Which of the following clients should the nurse assign to the room closest to the nurses' station?

- A. A client who sustained a head injury and is having periods of confusion
 - B. A client who reports a severe migraine headache
 - C. A client who has a suspected diagnosis of tuberculosis (TB)
 - D. A client who has a history of atrial fibrillation and is on continuous ECG monitoring.
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25. A nurse is attending a social event when another guest coughs weakly once, grasps his throat with his hands, and cannot talk. Which of the following actions should the nurse should take?

- A. Observe the client before taking further action.
 - B. Perform the Heimlich maneuver.
 - C. Assist the client to the floor and begin mouth-to-mouth resuscitation.
 - D. Slap the client on the back several times.
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26. A nurse is assessing a client's peripheral circulation. In which of the following locations should the nurse palpate to assess the posterior tibial pulse? (Selectable areas, or "Hot Spots," are outlined in the artwork below. Select only the outlined area that corresponds to your answer.)



Answers cannot be displayed for this alternate item format.

27. A nurse is caring for a client who needs a stool specimen collected. Which of the following actions should the nurse take when obtaining the specimen?

- A. Use a sterile swab to obtain the specimen.
 - B. Place the specimen in a sterile container.
 - C. Label the paper bag in which specimen container is placed.
 - D. Send specimen container immediately to the lab.
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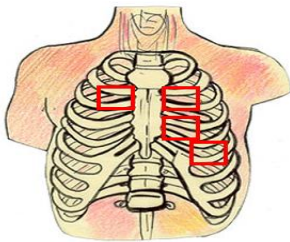
28. A nurse is caring for an older adult client who was alert and oriented at admission, but now seems increasingly restless and intermittently confused. Which of the following actions should the nurse take to address the client's safety needs?

- A. Call the family and ask them to stay with the client.

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- B. Move the client to a room closer to the nurses' station.
- C. Apply wrist and leg restraints to the client.
- D. Administer medication to sedate the client.

29. A nurse is performing a cardiac assessment. Identify where the nurse should place the stethoscope to auscultate the client's apical pulse. (You will find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.)



Answers cannot be displayed for this alternate item format.

30. A nurse in a clinic is interviewing a client who will undergo diagnostic testing. The nurse should ask about a client's potential allergies during which phase of the nursing process?

- A. Planning
- B. Evaluation
- C. Assessment
- D. Implementation

31. A nurse on a medical unit is caring for a client who suddenly becomes confused and drowsy. Additional data includes pulse 100/min, respiratory rate 24/min, BP 132/76 mm Hg, and temperature 36.8° C (98.2° F). Which of the following actions should the nurse perform?

- A. Complete a neurological check.
- B. Administer the prescribed PRN antihypertensive medication.
- C. Increase the client's fluid intake.
- D. Hold the client's evening dose of digoxin.

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32. A nurse is planning care for a client who has a decreased level of consciousness. The client is receiving continuous enteral feedings via a gastrostomy tube due to an inability to swallow. Which of the following is the priority action by the nurse?
- A. Observe client's respiratory status.
 - B. Elevate the head of the client's bed 30° to 45°.
 - C. Monitor intake and output every 8 hr.
 - D. Check residual volume every 4 to 6 hr.
-
33. A nurse is caring for a client who has fallen while getting out of bed and states, "I'm okay! I guess I should have called for help to the bathroom." After assessing the client, the nurse notifies the provider. Which of the following documentation should the nurse include in the client's medical record?
- A. "There were no injuries sustained."
 - B. "An incident report was completed."
 - C. "An incident report was forwarded to risk management."
 - D. "The provider was notified."
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34. A nurse is assisting an older adult client who sometimes loses her balance while walking. Which of the following devices should the nurse use when helping the client ambulate?
- A. Gait belt
 - B. Jacket harness
 - C. Four-wheel walker
 - D. Cane
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35. A nurse is assessing for cyanosis in a client who has dark skin. Which of the following sites should the nurse examine to identify cyanosis in this client?
- A. Pinnae of the ears
 - B. Dorsal surface of the hand
 - C. Conjunctivae
 - D. Dorsal surface of the foot

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36. A nurse is assessing an older adult client who has osteoporosis. Which of the following spinal deformities should the nurse expect to find in this client?

- A. Lordosis
 - B. Ankylosis
 - C. Kyphosis
 - D. Scoliosis
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37. A nurse is caring for a client who requires cold applications with an ice bag to reduce the swelling and pain of an ankle injury. Which of the following actions should the nurse take?

- A. Apply the bag for 30 min at a time.
 - B. Reapply the bag 30 min after removing it.
 - C. Allow room for some air inside the bag.
 - D. Place the bag directly on the skin.
-

38. A nurse is assessing a client who is experiencing prostatic hypertrophy. Which of the following findings associated with urinary retention should the nurse expect? (Select all that apply.)

- A. Report of feeling pressure
 - B. Tenderness over the symphysis pubis
 - C. Distended bladder
 - D. Voiding 30 mL frequently
 - E. Dysuria
-

39. A nurse is providing teaching to an assistive personnel (AP) about caring for clients with restraints. Which of the following statements by the AP indicates an understanding of the teaching?

- A. "I will tie restraints in double knots."
 - B. "I will tie a restraint to the portion of the bed that moves when the head of the bed is moved."
 - C. "I will ensure that restraints fit tightly against the client."
 - D. "I will put four side rails up if a client is confused."
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40. A nurse is creating a discharge plan. Which of the following nursing statements indicates the nurse understands when discharge planning should be implemented?

- A. "I will begin 48 hr before the client's discharge."
 - B. "I will begin once the client's discharge order is written."
 - C. "I will begin upon the client's admission to the facility."
 - D. "I will begin once the client's insurance company approves discharge coverage."
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41. A nurse has completed an informed consent form with a client. The client then states, "I have changed my mind and do not want to have the procedure done." Which of the following actions should the nurse take?

- A. Remind the client that a signed informed consent form is a legally binding document.
 - B. Notify the surgeon that the client wishes to withdraw informed consent for the procedure.
 - C. Inform the surgical team to cancel the client's surgery.
 - D. Proceed with preparation of the patient for the surgical procedure.
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42. A nurse is documenting information in a computerized health record. Which of the following nursing actions jeopardizes client confidentiality?

- A. Logging out of the computer before leaving a terminal
 - B. Sharing computer passwords with coworkers
 - C. Using a computer terminal in a non-public area
 - D. Preventing an unidentified health care worker from viewing a health record on the computer screen
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43. A nurse is admitting a client who reports anorexia and is experiencing malnutrition. Which of the following laboratory findings should the nurse expect to be altered?

- A. Creatine kinase
 - B. Troponin
 - C. Total bilirubin
 - D. Albumin
-

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44. A nurse is working with a team of nursing personnel within a facility. Which of the following are necessary task performance roles that members of the group or the leader must perform? (Select all that apply.)

- A. Self-confessor
 - B. Coordinator
 - C. Evaluator
 - D. Energizer
 - E. Dominator
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45. A nurse is discussing the norming stage of the group development process with a student nurse. Which of the following statements by the student indicates understanding of the discussion?

- A. "This stage involves constructive efforts on the part of the group members."
 - B. "This stage is when testing occurs to identify boundaries of interpersonal behaviors."
 - C. "Consensus evolves in this stage."
 - D. "Resistance is evident as subgroups form in this stage."
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46. A nurse is receiving a provider's prescription for a client via telephone. Which of the following actions should the nurse take to ensure the accuracy of the telephone prescription? (Select all that apply.)

- A. Repeat the order back to the provider.
 - B. Question any part of the order that is unclear or inappropriate.
 - C. Transcribe the order into the client's health record.
 - D. Obtain the provider's signature within 8 hr.
 - E. Implement a recorded order message if the nurse can hear and understand it clearly.
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47. A nurse intercepts a messenger at the nurses' station who has a flower delivery for a client on the unit. As the nurse accepts the flowers, the messenger says, "I know Mrs. Welch from the neighborhood. What happened to her?" Which of the following responses should the nurse provide?

- A. "You know it's not appropriate for you to ask me that."
 - B. "It's my responsibility to remind you that we have to respect our clients' privacy."
 - C. "It's a minor injury. I'm sure you'll see her back in the neighborhood soon."
 - D. "Oh, what lovely flowers. She will enjoy these."
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48. A nurse administers an incorrect medication to a client. Following an assessment of the client, the nurse determines that the client has experienced no untoward effects as a result of the medication. The nurse does not complete an incident report because no harm came to the client. Which of the following ethical principles did the nurse violate?
- A. Autonomy
 - B. Beneficence
 - C. Veracity
 - D. Confidentiality
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49. A nurse is preparing an educational presentation about organ donation for a group of newly licensed nurses. Which of the following information should the nurse include?
- A. The nurse caring for the client at the time of death requests organ donation.
 - B. Donation costs are the responsibility of the donor's family and estate.
 - C. The nurse may serve as a witness to informed consent for organ donation.
 - D. Clients are placed on artificial life support before organ and tissue donation can occur.
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50. A nurse receives a client care assignment from the charge nurse that he believes is unfair. The nurse voices his concern to the charge nurse. The nurse is using which level of communication at this time?
- A. Transpersonal
 - B. Intrapersonal
 - C. Interpersonal
 - D. Public
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51. A nurse in a clinic is caring for a client who reports pain, crepitus and a popping sound in his temporomandibular joint. Based on these findings, to which of the following providers should the nurse request a referral for the client?
- A. Occupational therapist
 - B. Oral surgeon
 - C. Physical therapist
 - D. Otorhinolaryngologist

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52. A nurse is giving a presentation about client confidentiality to a group of newly licensed nurses. Which of the following actions is an example of a violation of confidentiality?

- A. Discussing a client's surgical procedure with the nurse manager
 - B. Reporting laboratory findings to a member of the client's family
 - C. Notifying the provider of physical examination findings
 - D. Identifying the client by name when making a referral for home health services
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53. A nurse is preparing to administer an intramuscular (IM) injection of meperidine to a client. Which of the following is the priority assessment the nurse should complete?

- A. Apical pulse rate
 - B. Blood pressure
 - C. Level of consciousness
 - D. Respiratory rate
-

54. A nurse in a long-term care facility is planning care for several clients. Which of the following activities should the nurse delegate to the licensed practical nurse (LPN)?

- A. Admission assessment of a new client
 - B. Scheduling a diagnostic study for a client
 - C. Evaluating changes to a client's pressure ulcer
 - D. Teaching a client insulin injection technique
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55. A nurse is preparing to obtain a blood specimen from a client by venipuncture. The client is receiving IV fluids through an IV catheter inserted in the basilic vein of the right forearm. Which of the following sites should the nurse plan to use to obtain the blood specimen?

- A. Left upper arm
 - B. Right forearm
 - C. Foot
 - D. Left forearm
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56. A nurse is orienting a newly licensed nurse about documentation of a client's information in the electronic health record. Which of the following statements by the newly licensed nurse indicates understanding of the purpose of documentation?

- A. "Documentation is a communication tool for the interprofessional health care team."
 - B. "Documentation provides information to the client about financial charges for care provided."
 - C. "Documentation provides information for a client audit."
 - D. "Documentation allows providers to monitor the nurse's activities."
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57. A nurse assumes a variety of roles while working with clients. Which of the following describes the nursing role of protecting the client and supporting the client's decisions?

- A. Advocate
 - B. Caregiver
 - C. Manager
 - D. Educator
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58. A nurse is receiving change-of-shift report for a group of assigned clients. The nurse anticipates which of the following activities first in delivering client care using the nursing process?

- A. Critically analyze client data to determine priorities.
 - B. Collect and organize client data.
 - C. Set client-centered, measurable and realistic goals.
 - D. Determine effectiveness of interventions.
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59. A nurse is caring for a client who has methicillin-resistant *Staphylococcus aureus* (MRSA) in an abdominal wound. The nurse enters the room to check the client's pulse. Which of the following actions should the nurse take?

- A. Wear a gown.
 - B. Wear sterile gloves.
 - C. Wear clean gloves.
 - D. Wear protective eyewear.
-

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60. A nurse is removing personal protective equipment (PPE) after giving direct care to a client who requires isolation. Which of the following PPE items should the nurse remove first?
- A. Gown
 - B. Gloves
 - C. Face shield
 - D. Mask
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61. A nurse is caring for a group of clients on a medical-surgical unit. Which of the following situations requires that the nurse wear gloves? (Select all that apply.)
- A. Emptying urine from an indwelling urine collection bag
 - B. Providing oral care
 - C. Changing an ostomy pouch
 - D. Delivering a food tray to a client who has AIDS
 - E. Placing oral medication tablets into a client's hand
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62. A nurse is teaching an assistive personnel (AP) about using personal protective equipment while caring for clients. Which of the following statements should the nurse identify as an indication that the AP understands the instructions?
- A. "I will wear gloves whenever I am in contact with clients."
 - B. "I will wear gloves and a gown when bathing a client who has open skin lesions."
 - C. "I will wear gloves to minimize the number of times I have to wash my hands."
 - D. "I will wear gloves when measuring a client's blood pressure."
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63. A nurse accidentally sticks her hand with a syringe needle after administering an IM injection to a client. Which of the following actions should the nurse take first?
- A. Report the incident to the charge nurse.
 - B. Wash the area of the puncture thoroughly with soap and water.
 - C. Complete an incident report.
 - D. Go to employee health services.

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64. A nurse is caring for a client who has an infection. The nurse should use which of the following strategies to prevent the transmission of the client's infection?

- A. Changing the client's bed linens each day
 - B. Encouraging the client to consume a high-protein diet
 - C. Performing hand hygiene before, during, and after direct contact with the client
 - D. Placing the client in a room with positive-pressure airflow
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65. A nurse is reviewing the laboratory results of a client who has a pressure ulcer. The nurse should identify an elevation in which of the following laboratory values as an indication that the client has developed an infection?

- A. BUN
 - B. Potassium
 - C. RBC count
 - D. WBC count
-

66. A nurse is assessing a client who has diabetes mellitus and reports foot pain. The nurse should evaluate the client for which of the following alterations as indications that the client has an infection? (Select all that apply.)

- A. Bradycardia
 - B. An increase in neutrophils
 - C. An increase in RBCs
 - D. An increase in platelets
 - E. Localized edema
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67. A nurse is preparing to exit the room of a client who has methicillin-resistant *Staphylococcus aureus* (MRSA) in a draining wound. Identify the sequence the nurse should follow before leaving the client's room. (Move the steps into the box on the right, placing them in the order of performance. Use all the steps.)

- A. Perform hand hygiene.
 - B. Remove the face mask.
 - C. Remove the gown.
 - D. Remove the gloves.
-

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E. Remove the eyewear.

68. A nurse is teaching a new group of assistive personnel (AP) about the importance of hand hygiene. Which of the following statements should the nurse include?

- A. "If you wear gloves, you do not have to wash your hands."
 - B. "Rub all surfaces of your hands with an alcohol rub for 20 to 30 seconds."
 - C. "Use an alcohol rub when your hands are visibly soiled."
 - D. "If you don't have an infection, your hands won't infect others."
-

69. A client receives a wrong medication. The nurse who made the medication error should take which of the following actions first?

- A. Call the client's provider.
 - B. Assess the client.
 - C. Notify the nurse manager.
 - D. Complete an incident report.
-

70. When reviewing the admitting prescriptions for a client, the nurse notes that the dose of one medication is three times the usual dose of this medication. Which of the following actions should the nurse take?

- A. Contact the pharmacy and confirm that the dosage is safe to administer.
 - B. Ask another nurse to verify that the dosage is appropriate for the client
 - C. Contact the provider to question the dosage.
 - D. Inform the charge nurse and administer the dose of the medication the provider prescribed.
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71. A nurse is teaching a client who has a history of falls about home safety. Which of the following statements should the nurse identify as an indication that the client understands the instructions?

- A. "I will keep my walker at the end of my bed."
 - B. "I will keep the fluorescent ceiling light on in my room at night."
 - C. "I will place an area rug at the entry of my bathroom."
 - D. "I will place a bath seat in my shower to use when I bathe."
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72. A nurse in a long-term care facility is observing an assistant personnel (AP) changing the linen for a client who has fecal incontinence. Which of the following actions indicates that the AP understands the principles of infection control?
- A. Shakes the soiled linen to remove any toilet paper remnants
 - B. Places the soiled linen on the floor before bagging it
 - C. Holds the soiled linen against her body while carrying it to the linen bag
 - D. Places clean linen that touched the floor in the soiled linen bag
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73. A nurse is filling out an incident report after finding a client lying on the floor. Which of the following information should the nurse include?
- A. "The client attempted to climb over the side rails and fell."
 - B. "The client was lying on the floor next to his bed."
 - C. "The client was restless and trying to get out of bed all evening."
 - D. "The presence of a bed alarm could have prevented the client from falling."
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74. A nurse is preparing an in-service presentation for a group of newly licensed nurses about the use of restraints. Which of the following should the nurse include as a criterion for applying restraints?
- A. The provider must renew a restraint prescription every 8 hr.
 - B. The client must understand the need for the restraints.
 - C. The restraints should promote the client's safety and prevent injuries.
 - D. The nurse has already considered alternatives to restraints.
-
75. A nurse is completing discharge teaching with a client. Of the following barriers to learning the nurse identifies with this client, which should the nurse interpret as a need to postpone the session?
- A. Pain
 - B. Hearing loss
 - C. The client's culture
 - D. Motor impairment

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76. A nurse is assessing a client's cardiovascular system. To palpate for unexpected pulsations in the pulmonic area, at which anatomical location should the nurse place her fingers?

- A. The left second intercostal space
 - B. The right second intercostal space
 - C. The left fifth intercostal space
 - D. The left fifth intercostal space at the midclavicular line
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77. While auscultating a client's heart sounds, the nurse hears turbulence between the S1 and S2 heart sounds. The nurse should document this finding as which of the following?

- A. A systolic murmur
 - B. A third heart sound (S3)
 - C. An expected heart sound
 - D. A fourth heart sound (S4)
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78. A nurse is completing a client's history and physical examination. Which of the following information should the nurse consider subjective data?

- A. Blood pressure
 - B. Cyanosis
 - C. Nausea
 - D. Petechiae
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79. A nurse observes an adolescent client who has paraplegia sitting in a wheelchair crying. The client says, "Go away; no one can help me." Which of the following responses should the nurse make?

- A. "Everything will be okay."
 - B. "I will come back later and we can talk."
 - C. "Why are you crying?"
 - D. "Do you think crying will help?"
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80. A nurse is caring for a client who has a new diagnosis of chronic kidney disease. Which of the following statements should the nurse identify as an indication of anticipatory grieving?

- A. "I know that I will get a kidney transplant. I am a good candidate."
 - B. "I can now eat whatever I want. The dialysis will remove it from my system."
 - C. "I just can't believe that this dialysis is going to ruin my whole life."
 - D. "I know that kidney disease runs in my family, but I can prevent it."
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81. A nurse is developing a plan of care for a client who practices Islam. Which of the following actions should the nurse include in the plan?

- A. Serve foods that have a hot/cold balance.
 - B. Serve milk products separately from meals.
 - C. Request a meal tray without pork.
 - D. Remove tea and coffee from meal trays.
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82. A nurse notices an assistive personnel (AP) preparing to deliver a food tray to a client who practices the Orthodox Jewish faith. On the tray is a roast beef dinner with nonfat milk. Which of the following actions should the nurse take?

- A. Allow the AP to deliver the food tray to the client.
 - B. Call the dietary department and ask for a kosher tray.
 - C. Replace the nonfat milk with apple juice.
 - D. Explain to the client that he needs the protein in the milk and the beef.
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83. A nurse is reviewing the goals of the nurse-client therapeutic relationship with a client who is seeking counseling. Which of the following information should the nurse include in this discussion?

- A. The client achieves optimal personal growth.
 - B. The client assumes responsibility for the interaction.
 - C. The client expects growth, not comfort, from the relationship.
 - D. The nurse's interventions take priority over the client's needs.
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84. A nurse is caring for a client in the orientation phase of the nurse-client relationship. Which of the following communication techniques should the nurse use during this phase?

- A. Elicit information from the client.
 - B. Encourage the client to use self-exploration.
 - C. Review the client's progress toward personal objectives.
 - D. Talk with others who have information about the client.
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85. A nurse is engaging in relationship counseling with a male client. Which of the following is a characteristic of men that the nurse should consider when beginning the nurse-client relationship?

- A. They are more direct when discussing issues.
 - B. They are likely to wait for others to initiate the conversation.
 - C. They tend to use more verbal communication.
 - D. They disclose more personal information.
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86. A nurse asks a client to share personal stories. Which of the following types of intervention is the nurse using to promote the development of the nurse-client relationship?

- A. Symbolic communication
 - B. Narrative interaction
 - C. Hand-off technique
 - D. Social conversation
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87. A nurse is having difficulty caring for a client due to variables affecting the communication process. Which of the following should the nurse identify as an interpersonal variable? (Select all that apply.)

- A. Education
 - B. Feedback
 - C. Gender
 - D. Perception
 - E. Time
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88. A nurse caring for a client is using active listening skills. Which of the following actions should the nurse take?

- A. Sit side-by-side with the client.
 - B. Have a pen and paper handy.
 - C. Use intermittent eye contact.
 - D. Lean back in the chair.
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89. A nurse is preparing a sterile field. Which of the following actions should the nurse perform when opening the sterile pack?

- A. Place the pack on a sterile work surface.
 - B. Reach around the pack and open the top flap away from the body.
 - C. Open the right flap with the left hand.
 - D. Move to the opposite side of the pack to open the fourth flap.
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90. As part of an annual physical examination, a nurse is preparing a client to undergo a chest x-ray. Which of the following instructions should the nurse give the client prior to the procedure?

- A. Remove all metal necklaces.
 - B. Take several shallow breaths during the procedure.
 - C. Do not eat or drink anything the morning of the test.
 - D. Expect minor discomfort after the procedure.
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91. A nurse is assessing a client's radial pulse and determines that the pulse is irregular. Which of the following actions should the nurse take?

- A. Assess the apical pulse for a full minute.
 - B. Assess the apical pulse with a Doppler device.
 - C. Assess the pedal pulses for a full minute.
 - D. Assess the pedal pulses with a Doppler device.
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92. A nurse is assessing a client's bowel sounds. At which of the following points in the assessment should the nurse auscultate the client's abdomen?

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- A. After palpating the abdomen
 - B. Prior to percussing the abdomen
 - C. After assessing for kidney tenderness
 - D. Prior to inspecting the abdomen
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93. A nurse is teaching a client who has constipation. Which of the following should the nurse discuss as causes of constipation? (Select all that apply.)

- A. Excessive laxative use
 - B. Ignoring the urge to defecate
 - C. Inadequate fluid intake
 - D. Increased fiber in the diet
 - E. Increased activity
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94. A nurse is admitting a client from a long-term care facility. The nurse should use closed-ended questions when assessing which of the following factors?

- A. When determining if the client is eating a well-balanced diet
 - B. When asking the client about his receptiveness to the transfer
 - C. When asking the client how he completes his ADLs
 - D. When asking if the client took his medications this morning
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95. A nurse asks a client how he is feeling. The client states, "I'm feeling a bit nervous today." Which of the following responses should the nurse make?

- A. "Please explain what you mean by the word 'nervous.'"
 - B. "What is making you feel nervous?"
 - C. "Would a backrub ease your nervousness?"
 - D. "You shouldn't feel nervous."
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96. A nurse is admitting a client who has a partial hearing loss. Which of the following is the priority action by the nurse?

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- A. Speak using his usual tone of voice.
 - B. Stand directly in front of the client.
 - C. Rephrase statements the client does not hear.
 - D. Determine if the client uses hearing aids.
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97. A nurse is caring for a client whose partner asks to speak with the nurse. The partner relates her concerns about her spouse abusing alcohol and having difficulty maintaining employment. Which of the following responses should the nurse make?

- A. "Could you try contacting a support group?"
 - B. "I'm so sorry to hear about this."
 - C. "I suggest you talk with a mental health counselor about your concerns."
 - D. "What have you done in the past to cope with this issue?"
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98. A nurse is developing the plan of care for a client who does not speak the same language as the nurse. Which of the following interventions should the nurse include?

- A. Make sure a family member is present to interpret for the staff.
 - B. Determine the client's level of fluency in his primary language.
 - C. Speak directly to the interpreter when teaching the client.
 - D. Encourage the client to nod to indicate understanding.
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99. A nurse is administering a cold therapy application to a client. Which of the following manifestations should the nurse identify as an indication for discontinuing the application due to a systemic response?

- A. Hypotension
 - B. Numbness
 - C. Shivering
 - D. Reduced blood viscosity
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100. A nurse is caring for a client in a long-term care facility who is receiving enteral feedings via an NG tube. Which of the following actions should the nurse take prior to administering the tube feeding?

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- A. Warm the feeding solution to body temperature.
 - B. Place the client in low Fowler's position.
 - C. Discard any residual gastric contents.
 - D. Test the pH of gastric aspirate.
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