front 1

An ambulatory client calls the clinic to report edema around both ankles and feet during the day that disappears while sleeping at night. Which is an appropriate follow-up question for the nurse to ask?

"Have you been using more pillows to sleep comfortably?"

"Do you smoke or use other tobacco products?"

"Have you had a recent heart attack?"
"Do you become short of breath during your normal daily activities?"

back 1

"Do you become short of breath during your normal daily activities?"

The client is reporting a possible finding of heart failure, which can impair a person's normal daily function. The nurse's first question should focus on the client's functional ability as this would also be consistent with heart failure. Although it would be helpful to ask about the use of more pillows when sleeping, this is a finding that usually occurs after the development of dyspnea on exertion. The other options may be helpful, but they are not the primary focus.

front 2

The licensed practical nurse (LPN) is assigned to a client who is receiving intravenous potassium replacement. Which finding indicates that the LPN needs to advise the registered nurse (RN) to evaluate the client's potassium replacement?

Pain radiating down the outer part of the client's arm

Reports of abdominal pain and cramping

Repeated arrhythmia alarms on the monitor

Fast and bounding pulse

back 2

Repeated arrhythmia alarms on the monitor

Hyperkalemia may result in cardiac rhythm abnormalities. Moderate hyperkalemia can result in changes to the ECG monitor and set off the alarm. Pain down the outer arm is less likely cardiac in origin; cardiac pain is typically down the inside of the arm. Abdominal cramps or pain is more characteristic of low serum potassium levels. Bradycardia and a weak pulse are serious symptoms of hyperkalemia.

front 3

The nurse is collecting data on a client with portal hypertension. Which finding should the nurse expect?

Obesity

Blurred vision

Ascites

Expiratory wheezes

back 3

Ascites

Portal hypertension can occur in a client with right-sided heart failure or cirrhosis of the liver. Portal hypertension can lead to the accumulation of fluid in the peritoneal cavity (ascites) due to the increased portal pressure as well as a lowered osmotic pressure. Ascites can lead to shortness of breath, not expiratory wheezing.

front 4

A client is admitted in respiratory alkalosis after ingesting excessive amounts of aspirin. The nurse should recognize that respiratory alkalosis was most likely caused by which of the following findings?

Minimal use of accessory muscles

Diminished respiratory effort

Temperature of 96.8 F (36 C)

Respiratory rate of 34

back 4

Respiratory rate of 34

Stimulation of respiratory center leads to hyperventilation. Thus, decreased CO_2 levels result in respiratory alkalosis. Associate a fast respiratory rate with the loss of CO_2 and a loss of acid; the loss of acid results in alkaline states. Hypoventilation will cause respiratory acidosis.

front 5

The nurse detects blood-tinged fluid leaking from the nose and ears of a client diagnosed with head trauma. What is the appropriate nursing action?

Pack the nose and ears with sterile gauze

Position an ice pack at the back of the neck

Put manual pressure on the sites that are draining

Apply bulky, loose sterile dressings to the nose and ears

back 5

Apply bulky, loose sterile dressings to the nose and ears

Applying bulky, loose sterile dressings to the nose and ears permits the fluid to drain while providing a visual reference for the amount of drainage. With the history of trauma and locations of drainage, this may be cerebrospinal fluid (CSF). The drainage should be tested for glucose; if it's positive for glucose, the drainage would contain cerebrospinal fluid and the client would be at risk for a cerebral infection. The nurse should contact the RN charge nurse with these findings.

front 6

A neonate born 12 hours ago to a methadone-maintained woman is exhibiting a hyperactive Moro reflex and slight tremors. The newborn passed one loose, watery stool. Which action is a nursing priority?

Administer the ordered PRN paregoric to stop the diarrhea

Observe for neonatal abstinence syndrome

Offer fluids to prevent dehydration

Hold the infant at frequent intervals

back 6

Observe for neonatal abstinence syndrome

Neonatal abstinence syndrome (NAS) is a cluster of findings that signal the withdrawal of the infant from the opiates. The findings seen in methadone withdrawal are often more severe than for other substances. Initial findings are central nervous system hyperirritability and gastrointestinal findings. If withdrawal signs are severe, mortality risk is increased. Close monitoring of the infant ensures proper treatment during the period of withdrawal

front 7

A 72-year old client reports having discomfort immediately after a below-the-knee amputation. Which initial action by the nurse is most appropriate?

Wrap the stump snugly in an elastic bandage

Ensure that the stump is elevated

Administer opioid narcotics as ordered

Conduct guided imagery or distraction

back 7

Ensure that the stump is elevated

Elevating the stump is the priority intervention for the first 24 hours after surgery. This will help prevent pressure due to postoperative swelling, which will minimize pain or discomfort. Without this action, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Analgesics appropriate to the level of pain should be administered as needed in the postoperative period to promote client comfort. After the first day, the residual limb should be flat on the bed.

front 8

The nurse is making rounds at the beginning of the shift and asks how each client is feeling. Which statement made by a client would require immediate action by the nurse?

"I feel pressure in the middle of my chest like an elephant is sitting on my chest."

"When I take in a deep breath, it stabs like a knife."

"When I turn in bed to reach the remote for the TV, my chest hurts."

"The pain came on after dinner. That soup seemed very spicy."

back 8

"I feel pressure in the middle of my chest like an elephant is sitting on my chest."

This is a classic description of chest pain in men caused by myocardial ischemia, requiring immediate assessment and intervention to prevent possible damage to the heart muscle. Pain after spicy food is often the result of irritation and gastric indigestion. The pain with a deep breath is typically from an inflammation of the pleural covering of the lung, called pleurisy. Pain with movement of the chest, such as turning in bed, is typically caused by costochondritis, which is inflammation of the cartilage between the ribs and the sternum, and can be reproduced by palpation of the the painful area.

front 9

The practical nurse (PN) is collecting data on a 1 month-old infant in the emergency department. Which finding should the nurse report to the registered nurse (RN) immediately?

Inspiratory grunting

Abdominal respirations

Increased heart rate with crying

Irregular breathing rate

back 9

Inspiratory grunting

Inspiratory grunting is abnormal and may be a sign of respiratory distress in this infant. The other options are expected findings in newborns.

front 10

The client is diagnosed with infective endocarditis (IE) and has been receiving antibiotic therapy for four days. Which finding suggests that the antibiotic therapy has not been effective and must be reported to the health care provider (HCP) immediately?

Temperature of 103 F (39.5 C)

Muscle tenderness

Streaks of red under the nails

Nausea with vomiting

back 10

Temperature of 103 F (39.5 C)

Findings of IE include skin rash (petechiae) and small areas of bleeding (splinter hemorrhages) under the fingernails. Muscle or joint pain or weakness are also common symptoms of IE. Nausea and vomiting may be side effects of the treatment; these findings probably would have appeared shortly after beginning treatment. Prolonged fever after 72 hours of antibiotic therapy indicates the antibiotic regime is not effective against the strain of microorganism - the nurse must call the HCP about this finding. Surgical intervention may be indicated for persistent sepsis after 72 hours of appropriate antibiotic treatment.

front 11

A client completes a fecal occult blood screening and the results come back positive. Which factor could have influenced this outcome? (Select all that apply.)
Teeth cleaning during regular dental visit

Aspirin (ASA) therapy

Eating green, leafy vegetables

Recent use of corticosteroids

Eating a steak dinner

Drinking fruit juices that contain vitamin C

back 11

Teeth cleaning during regular dental visit

Aspirin (ASA) therapy

Recent use of corticosteroids

Eating a steak dinner

Eating red meat, NSAIDs and steroid use can cause a false positive result; even bleeding gums can cause a false positive result. Using vitamin C supplements and fruit juices can cause a false negative result (because it interferes with the chemical reaction that indicates blood is present.) The test should be repeated and the client should be given specific instructions about special dental, dietary and drug restrictions.

front 12

The nurse is preparing a client scheduled for an intravenous pyelogram (IVP). What is the most important factor to be obtained by the nurse prior to the procedure?

Allergy history

Measurement of urine output

Time of the last meal

Comparison of the radial pulses

back 12

Allergy history

The nurse should review any allergies with the client, especially a reaction to previous tests using contrast media. The elderly and those with diabetes and/or heart disease are at greater risk of developing kidney failure following administration of the dye. To avoid this complication, kidney function should be tested (creatinine). The client may be instructed to use a laxative or enema prior to the test and to be NPO for 8-12 hours before the test is done. The client should void prior to the procedure.

front 13

A nurse is caring for a client who was recently admitted following an episode of status epilepticus. Which of the following data is most important to collect?

Level of consciousness (LOC)

Injuries to the extremities

Amount of intravenous fluid infused

Pulse and respiration

back 13

Level of consciousness (LOC)

Cerebral blood flow undergoes a significant increase during seizure activity with a depletion of oxygen at the neuronal level. Cerebral anoxia may result in progressive brain tissue injury and destruction. The nurse should continuously monitor the client's LOC. Even when seizures are controlled, the client may be unconscious for a period of time. Note that this is a neurological question and requires a neurological answer and monitoring LOC is the only neurological response.

front 14

An x-ray initially confirms the placement of a nasogastric (NG) feeding tube in the stomach. The nurse is now preparing to administer a medication through the tube. What action will the nurse take to verify tube placement?

Place the end of the tube in water and observe for bubbling

Auscultate for the sound of air produced by forcing air through the NG tube

Measure the pH of aspirated gastric contents

Assess for client coughing during administration of the medication

back 14

Measure the pH of aspirated gastric contents

Bubbling or coughing would indicate the possibility of the tube being in the airway, but neither are used to determine placement in the stomach. Forcing air through the NG tube and auscultating the abdomen for the sound of the air is an unreliable method to determine tube placement. Measuring the pH of aspirated stomach contents confirms gastric placement.

front 15

A respiratory therapist (RT) is collecting an arterial blood gas (ABG) sample. The RT must respond to an emergency and asks the nurse to manage the puncture site. Which actions should be completed? (Select all that apply.)

Apply snug gauze and secure with tape

Check for distal capillary refill

Thoroughly wash the site with saline, then apply an antibacterial solution

Apply pressure for 5 to 10 minutes

Remove dressing in one hour

back 15

Apply snug gauze and secure with tape

Check for distal capillary refill

Apply pressure for 5 to 10 minutes

Five to 10 minutes of pressure ensures adequate coagulation at the site. Checking capillary refill indicates if there are any changes to blood flow to the hand. The dressing can be removed prior to the next stick or within 24 hours.

front 16

A nurse notes that a 2 year-old child recovering from a tonsillectomy has a temperature of 98.2 F (36.7 C) at 11:00 am. At 1:00 pm the child's parent reports that the child "feels very warm" to touch. What should the nurse do first?

Reassess the child's temperature

Reassure the parent that this is normal

Offer the child cold oral fluids

Administer the prescribed acetaminophen

back 16

Reassess the child's temperature

The nurse should listen to and show respect for what the parent is saying, because the parent is more sensitive to the variations in the child's condition. However, the nurse knows that a low-grade fever (99-101 F or 37.2-38.3 C) is common after surgery, which is why the nurse should first reassess the temperature before implementing any intervention. Usually the surgeon is contacted if the temperature is higher than 101.5 F (38.6 C).

front 17

The 55 year-old female is scheduled for abdominal surgery. Which factor in the client's history indicates that the client is at risk for thrombus formation in the postoperative period?

Estrogen replacement therapy for the past three years

History of acute hepatitis A

Hypersensitivity to heparin 20 years ago

10 percent less than ideal body weight for past year

back 17

Estrogen replacement therapy for the past three years

Post-menopausal women using hormone replacement therapy have a higher risk of deep vein thrombosis and pulmonary embolism. The estrogen in hormone replacement therapy (and in birth control pills) can increase clotting factors in the blood, especially if the woman is a smoker and/or overweight. The other information in the client's history is unremarkable for postoperative complications.

front 18

The nurse is assisting with the admission of a toddler who had a seizure at home. Which statement by the child's parent would be important in determining the etiology of the seizure?

"My child was diagnosed with an ear infection two days ago."

"My child has been drinking more liquids than usual."

"My child has been eating more red meat lately."

"My child has been taking long naps for a week."

back 18

"My child was diagnosed with an ear infection two days ago."

Contributing factors of seizures in children include age (more common in the first two years of life), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention. Although drinking more fluids may be an indication of infection, the statement that the child has an active infection is the best response.

front 19

An older adult client diagnosed with active tuberculosis has difficulty in appropriately coughing up secretions for a sputum specimen. Which nursing intervention might be the most helpful at this time?

Force fluids for the next eight hours

Spray the oropharynx with saline

Ask the client to drink a warm liquid

Have the client sit up on the side of the bed

back 19

Have the client sit up on the side of the bed

Correct!Placing the client in sitting position will promote lung expansion and effective coughing, facilitating the sputum specimen collection. While drinking liquids helps to loosen secretions over time, they should not be given when collecting a specimen. Spraying the throat with saline may cause irritation, coughing, and reduce oxygenation. The specimen needs to come from deep in the lungs, not the nose or mouth.

front 20

A client is receiving heparin and warfarin (Coumadin) after a total hip replacement. Lab results show an international normalized ratio (INR) of 5.5. Which action should the nurse consider as a priority?

Check the prior INR reports

Stop the warfarin

Notify the health care provider (HCP)

Check for bruising or bleeding

back 20

Notify the health care provider (HCP)

INR is used to evaluate the therapeutic effectiveness of warfarin. The therapeutic range for INR is 2 to 3; a client with a 5.5 INR is at risk for bleeding (and the nurse will probably find bleeding with an INR at this level). The warfarin should be held until the nurse has communicated with the HCP. Because the half-life of warfarin is about 40 hours, there is no need to stop it prior to notifying the provider. Heparin has no influence on an INR.

front 21

The client is admitted with a diagnosis of ulcerative colitis. Which laboratory values should the nurse be sure to check? (Select all that apply.)

Hematocrit and hemoglobin

Albumin

T3 and T4 count

White blood cell count (WBC)

Blood urea nitrogen (BUN)

Erythrocyte sedimentation rate (ESR)

back 21

White blood cell count (WBC)

Hematocrit and hemoglobin

Albumin

Erythrocyte sedimentation rate (ESR)

Decreased hematocrit and hemoglobin may reveal the client has anemia as a result of the bloody diarrhea characteristic of this inflammatory bowel disease A low protein albumin level would indicate that the client is experiencing a nutritional deficit due to malabsorption. Increased numbers of white blood cells and an elevated erythrocyte sedimentation rate (ESR) indicate active inflammation. Blood urea nitrogen is related to kidney function and T3 and T4 are related to thyroid function; these lab values do not provide information related to the diagnosis.

front 22

A client is scheduled for a CT scan with contrast. What interventions should be taken by the nurse prior to sending the client to the imaging department? (Select all that apply.)

Reassess the client's allergies

Ensure the client is well-hydrated

Ask the client to remove all metal jewelry

Confirm that a signed consent is in the chart

Administer prescribed medication to sedate the client

back 22

Reassess the client's allergies

Ask the client to remove all metal jewelry

Confirm that a signed consent is in the chart

Usually the client is NPO prior to a CT scan, particularly when contrast material is being used. Allergies and past reactions to contrast media should be reviewed with the client. Any metal, including body piercings, jewelry, hearing aids and removable dental work should be removed and safely stored prior to the test. Sedation is necessary only in cases of extreme anxiety.

front 23

Following a surgical procedure, a pneumatic compression device is applied to the adult client. The client reports that the device is hot and the client is sweating and itching. Which of the following steps should the nurse take? (Select all that apply.)

Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Explain that the health care provider ordered the device and it cannot be removed

Confirm pressure setting of 45 mm Hg

Check for appropriate fit

Inform the client that removing the device will likely result in the formation of deep vein thrombosis

back 23

Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Confirm pressure setting of 45 mm Hg

Check for appropriate fit

In any situation in which a client has discomfort associated with a medical device, the nurse should ensure it is applied correctly and functioning safely. The usual safe and effective pressure range is 35 to 55 mm Hg. Explanations to the clients should support their informed decision-making capabilities and should not be phrased to intimidate or remove client autonomy. Applying anti-embolism stockings under the disposable sleeves of the device may help with the sweating and itching.

front 24

The order states: acetaminophen suspension 6 mL by mouth four times a day. The label on the container states: acetaminophen 80 mg per 5 mL. How many milligrams will the nurse administer?

back 24

96mg.

6 mL/1 x 80 mg/5 mL = 480/5 = 96 mg

Or

Ratio:
80 mg/5 mL = x/6 mL
5x = 480
x = 96 mg

front 25

A client diagnosed with Raynaud's disease and hypertension is prescribed nifedipine (Procardia). Which finding would indicate that the client may be having a side effect of the medication?

Facial flushing

Cyanosis of the lips

Decreased urinary output

Increased pain in fingers

back 25

Facial flushing

Treatment for Raynaud's and for hypertension is the use of a vasodilator such as nifedipine. As a result of the vasodilating effect facial flushing can occur. Cyanosis of the lips is not a documented finding. The urinary output may increase due to the vasodilation and the resulting increased blood flow through the kidneys. The pain in the fingers should decrease.

front 26

A client receives 3 units of insulin lispro at 11:00 am to cover a blood glucose finger stick of 322 mg/dL (17.89 mmol/L). When can the nurse expect this type of insulin to begin to act?

12 noon

3:00 pm

1:00 pm

11:15 am

back 26

11:15 am

The onset of action and peak for lispro (Humalog), a rapid-acting insulin is about 10 to 15 minutes. Other rapid-acting insulins are insulin aspart (NovoLog) and insulin glulisine (Apidra).

front 27

A client has been taking alprazolam for three days. Data collection by the nurse should reveal which expected effect of the medication?

Sedation, analgesia

Relief of insomnia, phobias

Diminished tachycardia, tremors associated with anxiety

Tranquilization, numbing of emotions

back 27

Tranquilization, numbing of emotions

Most antianxiety medications, such as alprazolam (Xanax), work quickly. They produce tranquilizing effects and may numb the emotions. Don't forget that if part of an answer is incorrect, the entire answer is incorrect. The three incorrect options each contain incorrect information (analgesia, phobias and tachycardia). Also note that the question is asking for "expected effects" and not side effects.

front 28

A client calls the clinic and states to the triage nurse: "I had an upset stomach and took Pepto-Bismol and now my tongue looks black. What's happening to me?" What would be the nurse's best response?

"This is a common and temporary side effect of this medication."

"Are your stools also black?"

"How long have you had an upset stomach?"

"Come to the clinic so you can be seen by the health care provider."

back 28

"This is a common and temporary side effect of this medication."

The best response would be to explain that a dark tint of the tongue is a common and temporary side effect of bismuth subsalicylate (Pepto-Bismol). Although it may also turn stools a darker color, do not confuse this with black, tarry stools, which is a sign of bleeding in the intestinal tract. After addressing the client's initial concern and the reason for the call, the nurse can ask about the upset stomach and then ask the client to come to the clinic if necessary.

front 29

A nurse notes an abrupt onset of confusion in an 85 year-old client. Which recently ordered medication would most likely have contributed to this change in mental status?

Anticoagulant

Antihistamine

Beta blocker

Thrombolytic

back 29

Antihistamine

Older adults are susceptible to the side effect of anticholinergic medications, such as antihistamines. Antihistamines often cause confusion, especially at higher doses. In fact, first-generation antihistamines are included in the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.

front 30

A client is recovering from hip replacement and is taking acetaminophen with codeine (Tylenol No. 3) every three hours for pain. Which finding associated with opioid analgesics does the nurse anticipate when assessing the client?

No bowel movement for three days

Itching and bruising at the incision site

Dry, unproductive cough

Elevated serum glucose

back 30

No bowel movement for three days

Side effects of opioid analgesic use include respiratory depression, sedation and constipation. The incision site may be bruised after surgery and it may itch, pull or feel numb, but this is unrelated to oral opioid use. Dry mouth is a possible side effect of acetaminophen with codeine, but not necessarily dry cough.

front 31

An older adult client is to receive IV gentamicin. What diagnostic finding indicates the client may have difficulty eliminating this medication?

Reduced peristalsis

Gastric acid reflux

Protein deficiency

Borderline renal function

back 31

Borderline renal function

Gentamicin is not metabolized; it is excreted by glomerular filtration. This aminoglycoside is highly toxic to the kidneys and requires close monitoring of renal function, including creatinine levels. Aminoglycosides are used to treat severe infections, such as septicemia, and are only given for a short period of time due to their toxic effects.

front 32

The hospice nurse is visiting an 85 year-old client diagnosed with end-stage cancer. What should the nurse understand about chronic malignant pain management?

Maximum doses of analgesics are needed

Heart rate, respirations and blood pressure will be elevated

Pain therapy is based on a client's report of pain

Relief of temporary pain should be achieved quickly

back 32

Pain therapy is based on a client's report of pain

Every person’s unique pain experience must be assessed, understood and treated. Because older adults have a slower metabolism and a greater ratio of body fat to muscle fat than younger people do, smaller doses of analgesics may be sufficient to relieve pain and may be effective longer. Therefore, the amount of medication needed is dependent on the client's needs and reports of pain relief; the nurse should not automatically give the maximum ordered dose. Immediate pain relief relates more to acute pain than chronic pain management.

front 33

The nurse is assigned to a client diagnosed with a deep vein thrombosis who has been on heparin therapy for five days. The nurse notes that enoxaparin is added to the medication administration record (MAR). Which action should the nurse take?

Plan to check the aPTT result after the enoxaparin is given

Stop the heparin and begin the enoxaparin 30 minutes later

Notify the charge nurse that the client is already receiving heparin

Monitor the urine, stool and skin for bleeding

back 33

Notify the charge nurse that the client is already receiving heparin

Enoxaparin (Lovenox) and heparin should not be given together because of the increased anticoagulant effect. Enoxaparin can be given 30 minutes after the heparin is discontinued. The aPTT lab is not routinely assessed while a client is taking enoxaparin.

front 34

The nurse receives an order for several medications for a client. Which combination of medications would require the nurse to contact the provider to discuss the orders? (Select all that apply.)

Finasteride (Propecia, Proscar)

Amlodipine (Norvasc)

Lithium (Eskalith, Lithobid)

Furosemide (Lasix)

Insulin

back 34

Lithium (Eskalith, Lithobid)

Furosemide (Lasix)

Lithium generally should not be given with diuretics. Furosemide may reduce excretion of lithium, which could result in lithium toxicity. Additionally, side effects of lithium are polyuria and polydipsia. The nurse should clarify the order before administering lithium and furosemide together.

front 35

The nurse receives an order to give a client iron by deep injection. What does the nurse understand about the reason for using this method of administration?

Prevents the medication from tissue irritation

Enhances absorption of the medication

Provides more even distribution of the drug

Ensures that the entire dose of medication is given

back 35

Prevents the medication from tissue irritation

Deep injection, or Z-track, is a special method of giving medications via the intramuscular route. Use of this technique prevents irritating or staining medications from being tracked through tissue. Use of Z-track does not affect dose, absorption, or distribution of the medication. Oil-based or thick medication is commonly given in this manner for the same reason.

front 36

A nurse is reviewing and order that reads: administer conjugated estrogen 1.25 mg daily. The only available tablet strength is 625 mcg. How much medication will the nurse administer?

back 36

2tablet(s).

1.25 mg = 1250 mcg: 1250 mcg/625 mcg = 2 or 2 tablets. Using Dimensional Analysis: Tablet = (1.25 mg/625 mcg) X (1000 mcg/1 mg) = 2

front 37

A client is prescribed trimethoprim/sulfamethoxazole for recurrent urinary tract infections. Which comment by the nurse is correct about this medication?

"It is safe to take with oral contraceptives."

"Drink at least eight glasses of water a day."

"Stop the medication after five days."

"Be sure to take the medication with food."

back 37

"Drink at least eight glasses of water a day."

Trimethoprim/sulfamethoxazole (Bactrim, Septra, Sulfatrim) is a highly insoluble medication and requires a large volume of fluid intake. This medication can be taken with or without regard to food. The full prescribed amount should be taken at evenly spaced intervals until the medication is finished. Unlike many other antibiotics, trimethoprim/sulfamethoxazole does not seem to affect hormonal birth control such as pills, the patch or ring.

front 38

A nurse is reinforcing instruction to a client diagnosed with osteoporosis. What is the most important approach to exercise the nurse should reinforce for this client?

Incorporate daily exercise to reduce weight

Avoid exercise activities that increase the risk of fracture

Exercise to strengthen muscles with a protection of the bones

Exercise by doing weight-bearing activities

back 38

Exercise by doing weight-bearing activities

Weight-bearing exercises are beneficial in the prevention and treatment of osteoporosis. Although loss of bone cannot be substantially reversed, further loss can be greatly reduced and prevented if the client includes weight-bearing exercises, vitamin D and calcium supplements in the treatment protocol.

front 39

On the burn unit, the nurse is assigned to a child who weighs 30 kg. Which observation best indicates adequate fluid replacement?

Moist oral mucus membranes

Urinary output of 32 mL per hour

Normal skin turgor

No reports of being thirsty

back 39

Urinary output of 32 mL per hour

For children, the expected urine output is about 1 mL/kg/hour of urine. For a child who weighs 30 kg, 32 mL/hour is adequate urinary output. You will note that since the question is indirectly asking about intake (fluid replacement), the best response will probably have something to do with output.

front 40

A nurse is caring for a client with an unstable spinal cord injury at the T-7 level. Which nursing intervention should be a priority for this client?

Maintain caloric intake for nutritional balance

Place client on a pressure-reducing mattress

Increase fluid intake to prevent dehydration

Use skin care products designed for use with incontinence

back 40

Place client on a pressure-reducing mattress

The client with a spinal cord injury is risk for skin breakdown due to immobility and decreased sensation. A cushion should be used on the wheelchair and the bed should have a foam pad, air mattresses or a pressure-reducing mattress. Reducing the risk of skin breakdown also includes repositioning the client, using skin care products to protect the skin and adequate liquid and nutritional intake.

front 41

A client has been diagnosed with mild dysphagia. What is the appropriate nursing intervention for this client?

Alternate clear liquids with more solid foods

Tilt head back to facilitate the swallowing process

Position client in an upright position while eating

Offer finger foods such as crackers or pretzels

back 41

Position client in an upright position while eating

An upright position facilitates proper chewing and swallowing. To prevent aspiration, thicker foods should be offered or thickening should be added to liquids. Tilting the chin down helps swallowing. Dry foods such as crackers or pretzels may increase the risk for choking.

front 42

The nurse is preparing to manually remove the fecal impaction on an 80 year-old client. What information is the most important to understand before performing this procedure?

The procedure should be done prior to a bath

Increased dietary fiber, fluids and activity can minimize fecal impaction

The presence of hemorrhoids is a contraindication for manual removal of the impaction

The client may experience bradycardia during the procedure

back 42

The client may experience bradycardia during the procedure

Cardiac dysrhythmias, including bradycardia, can result from vagal nerve stimulation during fecal impaction removal. The risk is higher in older adults or clients who have had cardiac surgery. Although it is correct that removing a fecal impaction should be done prior to a bath and that diet, exercise and fluids can help prevent an impaction, these are not the priority for this client in this situation. The presence of hemorrhoids is not a contraindication for manually removing fecal impactions.

front 43

A client has a nasogastric tube draining bile-colored liquids. Which nursing intervention will provide the most comfort to the client?

Swab the mouth using glycerin swabs

Allow the client to melt ice chips in the mouth

Perform frequent oral care

Provide mints to freshen the breath

back 43

Perform frequent oral care

Frequent cleansing and stimulation of the mucous membrane is important for clients with a nasogastric tube to prevent development of lesions, infection and to promote comfort. Ice chips or mints may be contraindicated and need to be ordered specifically when NG tubes are present. Lemon and glycerin swabs have no mechanical or cleansing value and should not be used.

front 44

A 3 year-old child who is diagnosed with celiac disease attends a day care center. Which of the following foods would be an appropriate snack?

Vanilla cookies

Peanut butter sandwich

Cheese crackers

Potato chips

back 44

Potato chips

Children with celiac disease should eat a gluten-free diet. Gluten is found mainly in grains of wheat and rye and in smaller quantities in barley and oats. Corn, rice, soybeans and potatoes are digestible by persons diagnosed with celiac disease.

front 45

Upon examining the mouth of a 3 year-old child, the nurse discovers that the teeth have chalky white-to-yellowish staining with pitting of the enamel. Which condition would most likely explain these findings?

Ingestion of tetracycline within the past year

Excessive oral iron therapy over the past six months

Recent poor dental hygiene

Excessive fluoride intake on a regular basis

back 45

Excessive fluoride intake on a regular basis

The findings indicate fluorosis, a condition characterized by an increase in the extent and degree of the enamel's porosity. This problem can be associated with repeated swallowing of toothpaste with fluoride or drinking water with high levels of fluoride. You will notice that two of the options address medications but there is nothing in the stem of this question to indicate that the child is taking any medications. Poor dental hygiene can damage teeth, but it would not appear chalky-white.

front 46

The RN has provided care instructions to the parents of a toddler diagnosed with atopic dermatitis. Which of these actions will the LPN/VN now reinforce to the parents?

Wrap the child's hand in mittens or socks to prevent scratching

Clean the affected areas with tepid water and antibacterial soap

Keep the child away from other children for the duration of the rash

Dress the child warmly to avoid chilling

back 46

Wrap the child's hand in mittens or socks to prevent scratching

Toddlers with atopic dermatitis need to have fingernails cut short and hands covered so they will not be able to scratch the skin lesions. Prevention of new lesions is important due to the risk of possible secondary infections. The clue in the stem is that the client is a toddler. Because toddlers have a short attention span and minimal self-control, and dermatitis is inflammation of the skin, the best response is to place the child's hands in mittens or socks to prevent scratching.

front 47

The client is diagnosed with coronary artery disease (CAD). What information should the nurse emphasize when reinforcing nutritional information to this client?

Avoid heavy, large meals

Eat three well-balanced meals a day

Add complex carbohydrates and proteins

Limit sodium to 5 grams per day

back 47

Avoid heavy, large meals

Controlling portion size is important for a heart-healthy diet. Eating large, heavy meals can pull blood away from the heart for digestion, possibly resulting in angina. Thus, it increases the risk of myocardial infarction. The client should also reduce sodium intake to about 2,300 mg/day (or less). Clients should also limit unhealthy fats and cholesterol; select low-fat protein sources; and eat more fruits, vegetables and whole grains.

front 48

A couple experiences intense anxiety after their home is destroyed by a fire. One of the partners escaped from the fire with only minor injuries. The nurse knows that the most important initial intervention should be to take which approach?

Suggest that the clients rent an apartment with a sprinkler system

Explore with the couple the feelings of grief associated with the loss

Provide a brochure on methods to promote relaxation

Determine available community and personal resources

back 48

Determine available community and personal resources

The couple has experienced a sudden loss event that has resulted in disequilibrium. The most important initial crisis intervention focuses on identifying resources and obtaining assistance for housing and other immediate needs. Information on home safety, relaxation exercises and grief counseling are of value after meeting the initial needs for shelter.

front 49

A teenaged client is paralyzed after being in a car accident. Which statement used by the client would indicate that the client is using "repression" as an ego-defense mechanism?

"I'm not ready to talk about it right now."

"It's all his fault! He was going 90 miles an hour on the freeway."

"My mother is heartbroken about this situation."

"I don't remember anything about what happened to me."

back 49

"I don't remember anything about what happened to me."

Repression is unconscious and involuntary forgetting of painful events, ideas, conflicts; there is no memory of the topic. One response is a statement indicating the use of suppression as an ego-defense mechanism, but this is incorrect because suppression is under conscious and voluntary control. Another incorrect response is an example of projection, where someone else is blamed for the situation.

front 50

The client diagnosed with paranoid-type schizophrenia sits alone alertly watching the activities of other clients and staff. The client is hostile when approached with medication and asserts that the medication controls the mind. Which option might best explain the reason for the client's behavior?

Feelings of increased anxiety related to paranoia

Sensory perceptual alteration related to withdrawal from environment

Impaired verbal communication related to impaired judgment

Social isolation related to altered thought processes

back 50

Social isolation related to altered thought processes

Hostility and absence of involvement are data supporting a diagnosis of social isolation. The psychiatric diagnosis and the client's idea of the purpose of the medication suggests altered thinking processes. When answering this question, be sure to compare the data in the stem to each of the options. Notice that the incorrect options can be eliminated because there's no mention of anxiety or difficulties with sensory or verbal communication.

front 51

After the death of a client, the family approaches a nurse and requests that a family member be allowed to perform a ritual bath on the deceased prior to moving the body. What would be the most appropriate response by the nurse?

"These procedures have to be carried out by our staff."

"A ritual bath will have to wait until after postmortem care"

"Is there anything you need from me to perform the ritual bath?"

"I will have to check on hospital regulations and policies."

back 51

"Is there anything you need from me to perform the ritual bath?"

Rituals are processes that allow the bereaved to acknowledge the reality of death. Religious rituals specifically offer meaning and provide hope within the context of the particular faith tradition. Nurses should inquire about rituals or observances following death and respect these. The other options are inappropriate and culturally insensitive.

front 52

The interdisciplinary team is reviewing charts for potential candidates for hospice care. Which of the following clients meet the criteria for hospice care? (Select all that apply.)

72 year-old with prostate cancer metastasized to the bone, who is receiving palliative radiation therapy

8 year-old client with acute myelogenous leukemia, for whom all treatment options have failed

91 year-old with Alzheimer's disease, who is no longer able to eat or drink oral fluids

53 year-old client with chronic, unrelieved pain, who is addicted to narcotics following a back injury

46 year-old with end stage liver disease, on a wait list for a donor organ

back 52

72 year-old with prostate cancer metastasized to the bone, who is receiving palliative radiation therapy

8 year-old client with acute myelogenous leukemia, for whom all treatment options have failed

91 year-old with Alzheimer's disease, who is no longer able to eat or drink oral fluids

Hospice care provides services for clients who are at the end of their life, usually with less than 6 months to live. There are no age requirements. Palliative care is provided by a multi-disciplinary team in a variety of settings, including the home, hospital or extended-care facilities. Clients actively seeking a cure or treatment for their disease do not meet the criteria for hospice care.

front 53

The postpartum Hispanic client refuses hospital food because it is "cold." What action should the nurse take initially?

Send the food to be reheated

Ask the client what foods are acceptable

Encourage the client to eat for strength

Consult with the dietitian as soon as possible

back 53

Ask the client what foods are acceptable

Many Hispanic clients subscribe to the rebalancing of "hot" and "cold" in the postpartum period. After giving birth, when a woman has lost blood, she is considered to be in a cold state; therefore, she needs to restore her humoral balance. What defines "cold" and "hot" can best be explained by the client and this needs to be incorporated into the plan of care. Note that the correct response is a “data collection” response, which allows for client feedback about what the client is really saying about the food. Notice that it is the only client-centered option.

front 54

The nurse is working to establish a therapeutic relationship with a client. A therapeutic nurse-client interaction occurs when the nurse takes which approach?

Advises about resources for resolving problems

Interprets any covert communications

Praises the client for appropriate behavior

Clarifies the meaning of client communication

back 54

Clarifies the meaning of client communication

Clarification is both a facilitating and therapeutic communication strategy. Approval, changing the focus or subject, and advising are non-therapeutic or barriers to effective communication.

front 55

A client has just been diagnosed with breast cancer. As the nurse enters the room, the client states "You are stupid." Which approach by the nurse would be the most therapeutic?

Make no comment or response

Explore what is going on with the client

Accept the client’s statement

Tell the client that the comment is inappropriate

back 55

Explore what is going on with the client

The nurse should assist this verbally aggressive client to put angry feelings into words and then to engage in problem solving. The client exhibits being in the angry stage of loss.

front 56

A client is admitted to the hospital following an automobile accident. Upon admission the client's blood alcohol concentration was 0.18%. Twelve hours after admission the client is diaphoretic, tremulous, and irritable; pulse and blood pressure measurements are elevated. The client states: "I have to get out of here." What is the most likely cause for these findings?

Early stage of alcohol withdrawal

Dissatisfaction with hospital care

Shock related to the injuries

Anxiety related to being hospitalized

back 56

Early stage of alcohol withdrawal

This client's blood alcohol concentration is more than twice the legal limit in most states. After a period of heavy or prolonged alcohol use, people will experience alcohol withdrawal symptoms, such as insomnia, tremors, hyperactivity, hypertension, tachycardia and diaphoresis. The client must be treated immediately to prevent progression to more severe alcohol withdrawal symptoms, including seizures (which may begin 6-48 hours after cessation of alcohol intake) and delirium tremens (DTs).

front 57

During a meeting with the nurse at the community clinic, an individual being battered in the home tells the batterer, "I need a little time away." How might the nurse expect the batterer to respond?

With acceptance and understanding that the relationship is in trouble

With fear of rejection resulting in increased rage toward the battered individual

With relief and anticipation of a separation as a way to have some personal time

With a new commitment to seek counseling to assist with problems

back 57

With fear of rejection resulting in increased rage toward the battered individual

In the absence or potential absence of the battered individual, the fear of rejection and loss only serve to increase the batterer's rage at the partner. Behaviors that are common in the batterer include extreme jealousy, refusing to take responsibility for the abuse and denying or minimizing the seriousness of the violence and its effects on the victim.

front 58

The client is diagnosed with post-traumatic stress disorder (PTSD). What are the some of the more common treatment options for PTSD? (Select all that apply.)

Opioid analgesics

Eye movement desensitization and reprocessing (EMDR)

Selective serotonin reuptake inhibitors (SSRIs)

Cognitive behavioral therapies

back 58

Eye movement desensitization and reprocessing (EMDR)

Selective serotonin reuptake inhibitors (SSRIs)

Cognitive behavioral therapies

The only two FDA approved medications for the treatment of PTSD are the SSRIs sertraline (Zoloft) and paroxetine (Paxil). There are other medications that are helpful for specific PTSD symptoms, but narcotics should not be used since they don't relieve psychogenic pain and there's a risk of dependence. Most people who experience PTSD undergo some type of psychotherapy, most commonly cognitive-behavioral therapy and/or group psychotherapy, EMDR and hypnotherapy.

front 59

A 14 year-old boy with a history of hemophilia A was admitted after a fall while playing basketball. In understanding his behavior and assisting in planning care for this client, what should the nurse recognize concerning the behavior of adolescents with a chronic disease?

Need to have structured activities

Often take part in active sports

Avoid physical risks after bleeding episodes

Share information about disease limitations with peers

back 59

Often take part in active sports

Adolescent hemophiliacs should be aware that contact sports may trigger bleeding. However, developmental characteristics of adolescents, such as impulsivity, inexperience and peer pressure, often place them in unsafe situations. Adolescents do not want to appear differently to their peers and would probably not willingly offer information about their disease to others.

front 60

A home health nurse is making an initial visit to a 70 year-old client. What should be the first action to meet the client's health needs?

Identify learning needs

Assist with meal planning

Discuss past health history

Review the list of medications

back 60

Identify learning needs

With the focus on health promotion, the nurse should first identify any learning needs. Once learning needs are identified, the nurse would know if meal planning assistance is needed. Reviewing medications and discussing health history are part of the initial assessment. Helpful hint: since this is a very general question, you should look for a response that's more general.

front 61

The registered nurse is preparing a client and her healthy newborn for discharge and provides information about hormonal effects in newborns. The licensed practical nurse understands that which finding in the newborn is due to the maternal hormones?

Edema of the scrotum

Enlargement of the breasts

Mongolian spots

Lanugo on the extremities

back 61

Enlargement of the breasts

Of all the options, the most commonly expected physical finding due to maternal hormones is breast engorgement. This can occur in both boys and girls. Mongolian blue spots commonly appear at birth or shortly thereafter; they are flat, blue, or blue-gray skin markings near the buttocks. The newborn scrotum can be filled with clear fluid (which was squeezed into the scrotum during the birth process); it will be reabsorbed over the next few months. Lanugo is the fine downy hair that may be present on the backs and shoulders of newborns, particularly premature infants.

front 62

The nurse is discussing modifiable cardiac risk factors with a group of adults. Which topic should the nurse reinforce as the priority intervention?

Smoking cessation

Stress management

Physical exercise

Weight reduction

back 62

Smoking cessation

Stopping smoking is the priority for clients at risk for cardiac disease because of the effects of reduced oxygenation and constriction of blood vessels. Notice that three of the options are all actions that indirectly reduce cardiac risk factors. Ask yourself which of the options should happen first or which one would have an immediate impact on the body: weight, stress, exercise or smoking?

front 63

The nurse practices in a long-term care facility and understands that older adults are at greater risk for experiencing adverse effects from medications. What physiologic changes could contribute to these adverse effects?

Decrease in blood flow to the kidneys and increase in kidney mass

Decrease in total body water and an increase in proportion body fat

Increased peristalsis and increased production of gastric acid

Increase in blood flow to the liver and decrease in liver mass

back 63

Decrease in total body water and an increase in proportion body fat

Because older clients have a decline in lean body mass and changes in total body water in which to distribute medications, more medication remains in the circulatory system with potential for medication toxicity. Increased proportion of body fat results in greater amounts of fat-soluble medications being absorbed, leaving less in the circulation, and thus increasing the duration of action of the medication.

front 64

The nurse is measuring blood pressure at a community health fair. When the nurse tells someone that his blood pressure is 160/96 mm Hg, he states, “My blood pressure is usually much lower.” What is the best response to this statement?

"Check your blood pressure again in a few months."

"Get your blood pressure checked again within the next 48 to 72 hours"

"Make an appointment to see your health care provider next week"

"See your health care provider immediately."

back 64

"Get your blood pressure checked again within the next 48 to 72 hours"

The blood pressure reading is moderately high and should be rechecked within a few days. Since the client states it is "usually much lower" the elevated BP could be a concern but it is not clear what the client considers to be a "much lower" BP. The nurse should measure the blood pressure in the other arm and compare the two readings. Waiting two or three weeks for follow-up is too long.

front 65

The nurse is providing care for an adolescent. Which intervention best demonstrates the nurse's sensitivity to an adolescent's need for autonomy?

Explore an adolescent’s feelings of resentment to identify causes

Provide discussion of concerns without the presence of parents or guardians

Express identification of feelings about body image

Allow young siblings to interact via various communication routes

back 65

Provide discussion of concerns without the presence of parents or guardians

While the family is an important component in the care of an adolescent, it is also important to spend time alone with the adolescent. This is an opportunity for the nurse to hear the teen's perspective and to really listen to his/her concerns.

front 66

A nurse observes a newborn whose Apgar score was 8 at one minute and then 9 at the five-minute evaluation. These scores would be more commonly related to abnormalities in which of these areas?

Cry

Color

Heart rate

Muscle tone

back 66

Color

Acrocyanosis (blue hands and feet) is the most common Apgar score deduction and is a normal adaptation in the newborn in response to the environment. If the environment is cool, then the hands and feet would display a more bluish discoloration. On average it lasts for about 48 to 72 hours. Recall that the maximum score is 10 for Apgar, so 1 or 2 points lower would suggest a problem that is probably not as severe as a problem related to heart rate, muscle tone or cry (respirations).

front 67

An anxious parent of a 4 year-old discusses with the nurse how to answer the child's question: "Where do babies come from?" What is the best response by the nurse to the parent?

"This question indicates interest in sex beyond this age."

"When a child of this age asks a question, give a simple answer."

"Children ask many questions, but are not looking for answers."

"Full and detailed answers should be given to all questions."

back 67

"When a child of this age asks a question, give a simple answer."

During discussions related to sexuality, honesty is very important. However, honesty does not mean imparting every fact of life associated with the question. When children ask one question, they are looking for one answer. When they are ready, they will ask about the other pieces of information by the use of specific questions.

front 68

A client is forgetful and experiences short-term memory loss. When collecting data about short-term memory loss, which action should the nurse take first?

Ask the client to state when he was born

Confirm that no hearing loss

Observe the client during an activity

Suggest the client read from a newspaper

back 68

Confirm that no hearing loss

Hearing loss may result in the client answering questions inappropriately, which may be misinterpreted as a short-term memory loss. Asking clients to state their birthdate is used to assess long-term memory. Observing the client during activity may be done for mobility concerns or deficits. Having the client read something can be used to assess vision problems.

front 69

The nurse is reinforcing information about accidental poisoning in the home to a group of parents. What information should the nurse be sure to include?

Do not move the child if a toxic substance is inhaled

Empty the child's mouth in any case of suspected poisoning

Induce vomiting if the child is suspected of swallowing something poisonous

Start treatment before calling the Poison Control Center

back 69

Empty the child's mouth in any case of suspected poisoning

Emptying the mouth of the poison prevents any further ingestion. It should be done first to minimize further contact with the substance. Vomiting should never be induced unless told to do so by the Poison Control Center or a health care professional. First aid for inhaling toxic substances is to move the child to fresh air.

front 70

The nurse is collecting data about the home care for a client with Alzheimer's disease. Which piece of information should be the priority for the nurse to document?

The family’s use of respite care

Any nutritional intake changes

The use of over-the-counter medications

The presence of environmental hazards

back 70

The presence of environmental hazards

A safe environment for the client with increasing memory loss is a priority focus of home care. Note that the other options would be included in the documentation – with importance being in this order: "environmental hazards,""over-the-counter medications," "intake changes" and then "respite care." The question is asking the reader to prioritize, which usually means that all the responses are correct but one is more important than the rest.

front 71

An outpatient client is scheduled to receive an oral solution of radioactive iodine. In order to reduce hazards, the practical nurse should reinforce which information?

Wash laundry separately and rinse twice in hot water

Wait to have guests visit at home for 48 hours after the first dose

Urine and saliva will be radioactive for 24 hours after ingestion

No solid food may be eaten for six hours after ingestion of the solution

back 71

Urine and saliva will be radioactive for 24 hours after ingestion

The client's urine and saliva are radioactive for 24 hours after ingestion. The practical nurse should reinforce the RN's teaching to double flush the commode after use, use disposable utensils, and avoid close contact with children and pregnant women for 48 to 72 hours. Because the treatment may cause nausea, it's best if the client doesn't eat two hours before or after iodine administration. It is not necessary to wash laundry separately or in hot water.

front 72

At 3 months, the infant has cleft lip and soft palate repair. In the immediate postoperative period for a cleft lip repair, which action is the priority?

Initiate clear liquid feedings by mouth when alert and acting hungry

Provide written instructions about care of the suture line

Remove soft elbow/arm restraints every 2 hours under supervision

Position the infant on side or back

back 72

Remove soft elbow/arm restraints every 2 hours under supervision

The goal after surgery is to protect the new repair and stitches, which requires some temporary changes in feeding, positioning and activity for the infant. The priority is to wear arm restraints (for the first 10 days after surgery) to keep him from putting his hands in his mouth; the restraints can be removed only for bathing or for exercising the arms. When the infant acts hungry, he will be given a clear liquid feeding using either a syringe fitted with a special soft tubing or a special cleft lip feeder. The infant can be positioned on his side or back to keep him from rubbing his face in the bed. The RN will provide instructions about care of the incision line prior to discharge.

front 73

The child is newly diagnosed with hepatitis A. Which teaching instructions would the nurse reinforce with the child's parents?

Return to daycare two days after starting antibiotic treatment

Use gentle cleansers to protect jaundiced skin from breakdown

Wash hands thoroughly with soap and warm water after contact with the child

Bedrest for several weeks before gradually resuming activity

back 73

Wash hands thoroughly with soap and warm water after contact with the child

Hepatitis A virus spreads through contaminated food or water, as well as unsanitary conditions in childcare facilities or schools. The infection resolves spontaneously and symptom relief is usually the only treatment. The child does not have to be confined to bed and s/he can safely return to daycare or school one week after symptoms began. Infants and young children usually do not develop jaundice.

front 74

The nurse is in a crowded shopping area in an urban setting when a radiologic dispersal device (RDD) explodes scattering radioactive dust and material into the environment. What should the nurse instruct the victims in proximity to the explosion to do first?

Keep the nose and mouth covered

Remove all exposed clothing right away

Stay out of any buildings until help arrives

Lie down flat and cover the head with anything available

back 74

Keep the nose and mouth covered

An RRD, or "dirty bomb," generates radioactive dust and smoke, which can be dangerous if inhaled. The nurse should initiate measures to limit contamination, instructing victims to cover their noses and mouths. Neither lying down or covering the head does anything to limit exposure. Victims should move into a building where the walls and windows have not been broken and then remove their outer layer of clothing (sealing them in a plastic bag, if available) to help minimize exposure.

front 75

The client is diagnosed with active tuberculosis (TB) and the case has been reported to the health department. What is the most important reason for notifying the public health department?

Contacts need to be traced and screened

Treatment options need to be documented

The incidence of tuberculosis is tracked

Disease statistics need to be maintained

back 75

Contacts need to be traced and screened

Active tuberculosis is a reportable disease because people who had contact with the client must be traced, evaluated for the disease, and possibly treated prophylactically. Statistics are kept and trends documented, but that is not the primary reason for required reporting.

front 76

A severely injured client is moved into an examination area of the emergency department. The family member who accompanied the client to the ED is screaming at the nurse, saying that someone better start doing something right away. What is the best response by the nurse?

"I need you to go to the waiting area. You can come back when you're more in control."

"I know you are upset. But please control yourself and sit down. Otherwise I will have to call security."

"I can't think when you are yelling at me. Talk to me in a normal voice."

"I'm going to give you a few minutes alone so you can calm down."

back 76

"I know you are upset. But please control yourself and sit down. Otherwise I will have to call security."

Most violent behavior is preceded by warning signs, such as yelling or swearing. The challenge for nurses is to apply interventions that de-escalate a person's response to stressful or traumatic events. The keys to effective limit setting are using commands to express the desired behavior and providing logical and enforceable consequences for noncompliance. Nurses should acknowledge the agitated person's feelings and be empathetic, reminding him or her that they are there to help.

front 77

A client reports feeling dizzy when getting up from a lying position. Which is the correct action for the nurse to take before assisting the client to ambulate?

Support the client in a standing position for several minutes before walking

Support the client in a sitting position until the dizziness subsides

Encourage the client to stand and slowly move to a chair

Apply a gait belt and ask another person to assist with ambulation

back 77

Support the client in a sitting position until the dizziness subsides

The findings suggest postural or orthostatic hypotension. The nurse should help the client to sit and dangle on the side of the bed until the dizziness subsides and the blood pressure stabilizes. This will prevent the client from potential injury.

front 78

The nurse attends an interdisciplinary meeting on the topic of fall prevention. What specific tactics can be used to reduce falls in health care settings? (Select all that apply.)

Regularly reorient clients

Identify vulnerable clients

Raise side rails

Use a "two to transfer" policy

Install and use bed alarms

back 78

Identify vulnerable clients

Use a "two to transfer" policy

Install and use bed alarms

Use "low beds" for at-risk clients

Fall prevention involves managing a client's underlying fall risk factors and then implementing strategies to reduce falls. Using restraints, including side rails, can actually increase the risk of fall-related injuries and deaths. Clients with neurocognitive disorders cannot process the information we provide when we attempt to reorient them to our reality. The other techniques listed are used (in combination) to help prevent falls in health care facilities.

front 79

The adult client is alert and cooperative. The client has a short leg cast and can only partially bear weight on the casted leg. Which technique can be safely used to transfer the client from the bed into a chair?

Two caregivers use a friction-reducing device and wide base of support when transferring the client

Two caregivers lift the client from the bed and move the client into the chair

One caregiver applies a gait belt and transfers the client toward the weak side

One caregiver applies a transfer belt and uses the stand-and-pivot technique

back 79

One caregiver applies a transfer belt and uses the stand-and-pivot technique

The algorithm for safe client handling and transferring an alert and cooperative client to a chair states: one caregiver applies a gait/transfer belt, uses the stand-and-pivot technique and transfers the client toward the strong side. A friction-reducing device is placed under the client to assist in turning or moving the person in bed, not transferring to a chair. A two person lift is unsafe.

front 80

A nurse is stuck in the hand by an exposed needle left in a client's bed linens. What immediate action should the nurse take?

Contact employee health services

Notify the supervisor and risk management

Immediately wash hands with vigor

Look up the policy on needle sticks

back 80

Immediately wash hands with vigor

The immediate action of vigorously washing the hands will help remove any possible contamination. If the site bleeds it will help remove the contaminate. Then, the sequence of actions would be options "notify," "look up" and "contact."

front 81

The nurse is assessing the client during a home health visit and the client states: "I had physical therapy yesterday. I thought it was supposed to help but my back hurts so much after each visit." The nurse's responsibilities include which of the following actions? (Select all that apply.)

Report the client's findings to the physical therapist

Offer to help the client make an appointment with the physician about the back pain

Tell the client to take the prescribed pain medication

Gather more information about the location, duration and intensity of the pain

Report the client's findings to the nursing supervisor for further assessment

back 81

Report the client's findings to the physical therapist

Gather more information about the location, duration and intensity of the pain

Report the client's findings to the nursing supervisor for further assessment

The needs of the client can be best addressed by further assessment of the client (collecting more information about the findings of pain) and then communicating the client's needs to the interdisciplinary team members. Before any medication is given or any appointments are made, more information about the pain is needed.

front 82

A client states: "I do not want to be interrupted for breakfast because it interferes with my meditation time." What is the next action for the nurse to take?

Consult with the nurse manager to get suggestions

Contact the client's provider

Contact the nutritionist or dietitian

Talk with the client to work out a mutual plan

back 82

Talk with the client to work out a mutual plan

The nurse should talk with the client to determine how the practice of meditation can be incorporated into the morning schedule. Respect for differences must be incorporated into a client's plan of care.

front 83

An 80 year-old client is hospitalized for a chronic condition. The client informs family members that a living will has been prepared and the client wants no life-prolonging measures performed. The client's condition deteriorates and the client becomes unresponsive. Which of the following nursing actions is most appropriate?

Consult the charge nurse and prepare to transfer the client to an intensive care unit

Notify the attending physician

Contact the family member indicated in the admission forms

Call the rapid response team

back 83

Notify the attending physician

The first action would be to notify the attending physician for further orders. Then the family member(s) can be contacted about his condition. When a client has an advanced directive, it is not appropriate to perform CPR on him.

front 84

During a discussion with the nurse manager, a staff nurse confides that she is attracted to a client regularly assigned to her. Which of the following actions should be implemented following this discussion?
The nurse transfers the care of the client to another nurse

The nurse reassigns all personal care of the client to the nursing assistant

The nurse waits until after discharge to tell the client about her feelings

The nurse continues to provide care for the client

back 84

The nurse transfers the care of the client to another nurse

Nurses must practice in a manner consistent with professional standards and be knowledgeable about professional boundaries. A nurse’s challenge is to be aware of feelings and to always act in the best interest of the client, avoiding inappropriate involvement. In this case, the nurse did all the right things - aware of her feelings, she consulted with her supervisor and together they decided it would be best if this client were no longer assigned to this nurse. If the nurse had acted on her feelings, this would have been a boundary violation and she could have been subject to board of nursing disciplinary action.

front 85

The practical nurse has been assigned to four residents. Which resident should be seen first on the initial shift rounds?

An 81 year-old female with a history of coronary artery disease (CAD) reporting dyspnea, nausea, and unusual discomfort in the upper back

An 86 year-old male diagnosed with hypertension whose last recorded BP was 180/90 after learning that a close friend was hospitalized

A 94 year-old female diagnosed with peripheral artery disease (PAD) reporting cramp-like pains in both calf muscles following physical therapy

A 70 year-old male with history of heart failure (HF) who reported going to the bathroom "too much" after taking a diuretic

back 85

An 81 year-old female with a history of coronary artery disease (CAD) reporting dyspnea, nausea, and unusual discomfort in the upper back

These findings suggest a myocardial infarction (MI). Older adults and women of any age may not always have the classic findings of chest, inner arm, or jaw pain, numbness or tingling of the left arm. The stress of a tragic event can elevate BP temporarily; the nurse can retake the client's BP at a later time. Increased urinary output is an expected finding after taking a diuretic and intermittent claudication is a common and expected finding in PAD.

front 86

A registered nurse in a charge position is reinforcing goals to the health care team. Which of these items best describes the goal of continuous quality improvement (CQI) in a health care setting?

Conduct chart audits for common error discovery

Improve the quality of care in a proactive manner

Create a flow chart of department or staff interactions

Perform actions based on reactive problem solving

back 86

Improve the quality of care in a proactive manner

Continuous quality improvement is used to identify ways to correctly do the right thing at the right time. It involves proactive problem-solving. The overall goal of CQI is to improve health care.

front 87

The client who recently experienced a stroke has an order to ambulate with assistance. Which statement by the nurse provides the best instructions to the unlicensed assistive person (UAP) to assist the client to ambulate?

"If the client gets dizzy when walking, ask the client to stop and take 10 fast, deep breaths."

"Have the client lift and move the walker out at arms length then walk into the walker."

"As you assist the client to the chair, let me know if the client uses the quad cane correctly."

"Stand on the client's strong side when you assist the client to the bathroom."

back 87

"Have the client lift and move the walker out at arms length then walk into the walker."

The nurse should give clear and concise information to the UAP about what is expected to safely complete any task, which is why the option about using the walker is correct. The person assisting the client to ambulate should walk on the client's weak, not strong, side. UAP cannot assess or evaluate a client ("let me know if the client uses the quad cane correctly"; only nurses can perform the steps of the nursing process. If a client gets dizzy, the UAP should assist the client to sit (or ease the client to the floor is s/he begins to fall.)

front 88

When walking past a client's room, the nurse hears an unlicensed assistive person (UAP) talking to another UAP. Which of these statements requires further intervention by the nurse?

"This client seems confused, we need to watch the client closely."

"I'll come back and make the bed after I go to the lab."

"If we work together we can get all of the client care completed."

"Since I am late for lunch, would you perform my client's blood glucose test?"

back 88

"Since I am late for lunch, would you perform my client's blood glucose test?"

Only registered nurses (RNs) and licensed practical or vocational nurses (LPN/VNs) can assign tasks and activities. UAPs cannot re-assign tasks or activities to other UAPs. Nurses are accountable for all nursing care; if UAPs cannot complete assignments, they should notify the nurse, who will reassign the task.

front 89

A 90 year-old is readmitted to the hospital, less than 2 weeks after being discharged, for the same health concern. What factors contribute to hospital readmissions among older adults? (Select all that apply.)

Client health status

Excellent primary care

Poor communication among providers

Family preferences

Reconciliation of medications

back 89

Client health status

Poor communication among providers

Family preferences

Avoidable hospitalization, especially among older adults living in skilled nursing facilities, usually results from multiple system failures. The reasons most often cited include inadequate primary care (including inadequate discharge planning and lack of reconciliation of medications), poor care coordination, poor skilled nursing facility quality of care, poor communication among providers and even family preferences. Not all illnesses can be anticipated and clients with more complex health issues are readmitted more often, regardless of quality or coordination of care.

front 90

A client with a diagnosis of bipolar disorder has been referred to a halfway house to be considered for placement. A social worker telephones the hospital unit and asks for information about the client's mental status and adjustment. What must the nurse understand in order to respond to this request for information?

The request for information can be given to the social worker in the case of a referral

Only the health care provider can give referral information

Information can be released if there is written consent from the client

Information about a client is never given to anyone by telephone

back 90

Information can be released if there is written consent from the client

HIPAA guidelines are strict as to who has access to and can relay information. In order to release written, verbal or electronic information about a client there must be a signed consent form (unless the client is a threat of harm to self or others). In addition, a written request for information is commonly asked for prior to release of any client information.

front 91

The nurse is using the SBAR technique to communicate with the health care provider. Which of the following phrases would be associated with "B-Background"?

"Vital signs are..."

"I'm not sure what the problem is, but the client's condition is deteriorating."

"I would like you to..."

"The client's treatments are..."

back 91

"The client's treatments are..."

The correct option gives the health care provider background information about the client, including age, primary diagnosis, treatments, etc. Stating that the client's condition is deteriorating is the situation (S). Stating, "I would like you to..." is the request or recommendation (R). Vital signs are part of the assessment (A). Using SBAR is an effective technique used to improve communication with other members of the health care team. This, in turn, helps to foster a culture of safety.

front 92

A nurse must use an interpreter to collect data from a client. Which action should the nurse take to help communicate with the client?

Face the client while asking questions as the interpreter translates the information

Include a family member and direct comments to that person

Talk to the interpreter in advance and leave the client and interpreter alone for discussion

Speak directly to the interpreter while asking questions

back 92

Face the client while asking questions as the interpreter translates the information

Communication is important, especially when the nurse and client do not share the same cultural heritage. Even if the nurse uses an interpreter, it is critical that the nurse use conversational style and spacing, personal space, eye contact, touch, and orientation to time strategies that are acceptable to the client. Therefore, the nurse should face the client and allow the interpreter to translate the content. Facing the client allows nonverbal communication to take place between the client and nurse. Notice that only one option includes the content of this question (collecting data from a client). The other options focus on the "interpreter or the family." Usually, the client-centered option is the best choice.

front 93

The nurse, who is caring for a client with complex and unique health needs, describes the nature of the illness in an online social forum for nurses. Neither the client's real name nor any other personal identifiers are used. What, if any, consequence could result from posting this information online?

There won't be any consequences because the information was posted on a website for nursing professionals

There won't be any consequences because the client's real name was not used

The nurse could be fired for breach of confidentiality

The nurse could be reprimanded for not clearing the information first with hospital administration

back 93

The nurse could be fired for breach of confidentiality

Even though the client was not identified by name, someone could probably figure out who the nurse was writing about. Many health care facilities have adopted a social media policy; it is important to understand that nurses can be fired for posting personal information about clients online, because this is an invasion of privacy. In addition to being a HIPAA violation, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) gives states attorneys the right to pursue violations of patient privacy.

front 94

Which nursing practice best reduces the chance of communication errors that might otherwise lead to negative client outcomes?

Speak using a professional tone on the telephone

Maintain respectful working relationships with all staff

Use standardized forms for client handoffs

Document nursing care at the end of the shift

back 94

Use standardized forms for client handoffs

Standardized forms improve information for communication between caregivers. Most problems/poor outcomes involve some element of poor communication. The options of keeping good working relationships and using a professional tone of voice on the phone is good practice but not as useful for minimizing the chance of errors. Documenting at the end of the shift is incorrect practice and may lead to poor communication, as critical findings may be forgotten and not recorded.

front 95

The client states to the nurse: "I am ready to stop all of these treatments. I just want to go home and enjoy my family for the little bit of time I have left." Which action is most appropriate?

Tell the family members that the client's preference is to go home to die

No action is needed at this time unless the client repeats the statement to another caregiver

Encourage the client to discuss this decision with the health care provider and family

Call in a referral to a social worker and explain that the request will need to be discussed in more detail at a later time

back 95

Encourage the client to discuss this decision with the health care provider and family

The client has the right to stop treatment and should be supported in clearly communicating this decision with the health care provider and family. The nurse needs to act as an advocate for the client. It is factually incorrect to wait until the request is repeated; clients should not need to express their wishes repeatedly before caregivers listen to them. The nurse should not be the one to share sensitive information with the family; the client controls that information. Social services may get involved but time is of the essence for those who are terminally ill.

front 96

Two members of the interdisciplinary team are arguing about the plan of care for a client. Which action could any one of the members of the team use as a de-escalation strategy?

Bring the communication focus back to the client

Adjourn the meeting and reschedule when everyone has calmed down

Interrupt, apologize for interruption, and change the subject

Tell the violators they must calm down and be reasonable

back 96

Bring the communication focus back to the client

Bringing the subject of the communication back to the client refocuses attention on the client's care, instead of the manner of communication. It is the most effective strategy because it is an example of collaboration. The other options are non-productive and may even make matters worse.

front 97

During a discussion about a living will with a 75 year-old client and the client's son, the son says, “I do not understand the need for a living will.” Which of these statements would be accurate and appropriate for the nurse to say in a response to this question?

“Specific instructions are listed for specific diseases.”

“Health care decisions can be made based on the client's wishes."

“Do-not-resuscitate orders (DNR) are automatic under these conditions.”

“A designated family member can make all decisions.”

back 97

“Health care decisions can be made based on the client's wishes."

Health wishes are written in a legal document such as a living will or advanced directives. These wishes are obtained when clients are medically and cognitively able to do so. Such instructions are to be followed if clients are no longer able to make decisions because of cognitive impairment or unconsciousness. One incorrect response defines a health care surrogate or a durable power of attorney. Another incorrect response defines medical directives and not part of a living will. The final incorrect response is associated with the DNR, which may be predetermined by the client as written in a legal document.

front 98

The client is admitted with a diagnosis of hyperglycemia and poor glycemic control. Which task can the nurse assign to an unlicensed assistive person (UAP)?

Reinforce findings of hypoglycemia when the client asks

Measure blood pressure, pulse and respirations

Check sensation in the extremities

Observe for mental status changes every four hours

back 98

Measure blood pressure, pulse and respirations

UAP can perform standard tasks with predictable outcomes, such as measuring vital signs. They are trained to assist the client with activities of daily living. UAPs cannot assess, plan, teach or evaluate clients.

front 99

The licensed practical nurse (LPN) is reassigned to work on an acute care unit. Which of these clients would be most appropriate for the LPN to accept?

A client, admitted for a possible stroke, with unstable neurological findings

A trauma victim with multiple lacerations requiring complex dressings

A confused client whose family complains about the nursing care given after the client’s surgery

An older adult client diagnosed with cystitis who has an indwelling urethral catheter

back 99

An older adult client diagnosed with cystitis who has an indwelling urethral catheter

LPNs who are reassigned to work on a different unit should be assigned to clients who are stable. The older adult diagnosed with cystitis is the most stable and the outcomes for care are fairly predictable. The other clients have more complex problems, as well as a higher risk for instability. LPNs should not accept an assignment that is beyond their knowledge or skills.

front 100

The nurse is named in a lawsuit. Which of these factors will offer the best protection for the nurse in a court of law?

Complete and accurate documentation of assessments and interventions

Above-average performance reviews prepared by nurse manager

Sworn statement that health care provider orders were followed

Clinical specialty certification by an accredited organization

back 100

Complete and accurate documentation of assessments and interventions

The medical record is a legal document. Documentation should include all steps of the nursing process; it must be complete, accurate, concise and in chronological order. Inaccurate or incomplete documentation will raise red flags and may indicate the nurse failed to meet the standards of care. The attorney will review the medical record with the nurse before giving a deposition (sworn pretrial testimony.) Above-average performance reviews could be considered supporting information. Certification is an "extra" based on the nurse's initiative; it is, however, unrelated to accurate charting.

front 101

The client had a colon resection two days ago. Which statement should the nurse use when assigning an unlicensed assistive person (UAP) to help ambulate this client?

"If the client is dizzy upon standing, ask the client to look up and hold onto you."

"When you help the client to walk, ask if the pain increases or decreases."

"Have the client sit on the side of the bed for three to five minutes before standing."

"Help the client to sit in a chair in the room as often as desired."

back 101

"Have the client sit on the side of the bed for three to five minutes before standing."

It is important to give clear and concise information when assigning a task or activity to the UAP. The nurse should also ask the UAP to report client concerns after completing the task but the UAP cannot assess the client; only nurses can assess, plan and evaluate client care.

front 102

A LPN complains to the charge nurse that an unlicensed assistive person (UAP) consistently leaves the work area untidy and does not restock supplies. What is the best initial response by the charge nurse?

Write down potential solutions to the problems today by shift's end

Add this concern to the agenda of the next unit meeting

Assure the staff nurse that the complaint will be investigated

Explore for further identification about the nature of the problem

back 102

Explore for further identification about the nature of the problem

Helping staff manage conflict is part of the charge nurse's role. It is appropriate to work with the LPN in order to work out problems with minimal intervention from administration when possible. Further definition of the problem and associated issues would be a first step. The nursing process can be used to collect more data before plans or interventions are made.

front 103

A newly licensed nurse is concerned about time management. Which action should be most effective in the initial development of a time management plan?

Ask for additional assistance when necessary to complete tasks

Keep a time log for what was done during the hours worked

Complete each task before beginning another activity

Set daily goals with the establishment of priorities

back 103

Keep a time log for what was done during the hours worked

The first step in planning for time management is to establish what tasks were done and when they were completed. This provides a baseline for needed changes in any activities and time use log. The key words in this question are “time management," “most effective," and “initial development.” Remember the first step in the nursing process is data collection - this applies to both caring for clients and developing management skills.

front 104

The nurse manager identifies that time spent charting is excessive. The nurse manager states that "staff will form a task force to investigate and develop potential solutions to the problem and then report on this at the next staff meeting." What is the nurse manager's leadership style?

Transformational

Autocratic

Dynamic

Affiliative

back 104

Transformational

A transformational style of management involves staff members in the decision-making processes. Staff members review current policies and provide feedback to their leader in the pursuit of the common good.

front 105

The health care provider has written an order for "morphine sulfate 2 mg IV push every 3 to 4 hours as needed for pain" for a 75 year-old client in an extended care facility. The licensed practical nurse (LPN) in charge has no other licensed persons working that shift. Which action should the LPN take first?

Hold the medication and contact the health care provider

Administer the prescribed dose as ordered

Give the medication orally and follow up with the health care provider

Check with the pharmacist

back 105

Hold the medication and contact the health care provider

LPNs do not give IV push medications. The LPN will need to contact the health care provider and ask to have the medication delivered by another route.

front 106

A client diagnosed with schizophrenia states, "I don't need medication. It makes me sleepy." The client insists that the nurse explain the use and side effects of the medication. What should the nurse understand before responding to the client?

A decision to reinforce or not reinforce information about medications should be made by the nurse

Clients have a right to know about any prescribed or over-the-counter medications

It is dangerous for clients who are diagnosed with schizophrenia to know about their medications

A referral needs to be sent to the psychiatrist with a request for discussion of the client’s medication

back 106

Clients have a right to know about any prescribed or over-the-counter medications

Clients diagnoses have no influence on their right to know about the medications that they are prescribed. Clients have a right to refuse treatment and to be informed about the use and side effects of their medications.

front 107

Information about case management and the role of the case management nurse is presented during an orientation session for new nurses. Which statement correctly describes an important fact about case management?

The interdisciplinary team makes all the decisions for the client and family
Case management is a collaborative process designed to meet complex client needs

Case management strategies focus on the client's needs during hospitalization

Physicians are responsible and accountable for client outcomes

back 107

Case management is a collaborative process designed to meet complex client needs

Case management is a collaborative process of organizing and coordinating resources and services within and across multiple settings. The focus is on cost-savings as well as quality and continuity of care. Case management nurses work closely with physicians, nurses, social workers to meet the complex health needs of the client, Case management is "client-centric" and all members of the team, including the client, work together to achieve desired outcomes. Cases that involve high-risk diagnoses (such as AIDs/HIV, cancer, people with cognitive deficits) or high-volume cases (such as total hip or total knee replacements) are often selected for case management.

front 108

A client refuses to take the medication prescribed because the client prefers to take an herbal preparation. What is the first action the nurse should take?

Report the behavior to the charge nurse

Discuss with the client to find out about the preferred herbal preparation

Explain the importance of the medication to the client

Contact the client's health care provider about the refusal

back 108

Discuss with the client to find out about the preferred herbal preparation

Remember, the collection of additional data is typically the initial approach when problems arise. Although the client has the right to refuse the medication, it's possible that the herbal preparation does not have the intended purpose of the prescribed medication or may even have unintended side effects

front 109

The licensed practical nurse (LPN) who is in charge hears a health care provider loudly criticizing one of the unlicensed assistive persons (UAP) within the earshot of others. The UAP does not react or respond to the health care provider's complaints. What should be the charge nurse's first action after hearing this?

Request an immediate private meeting with the health care provider and the UAP

Walk up to the health care provider and quietly state: “This unacceptable behavior has to stop.”

Allow the UAP to handle this situation without interference for the next few minutes

Notify the nursing administrator and chief of the medical staff within the hour about the breach of professional conduct

back 109

Request an immediate private meeting with the health care provider and the UAP

Assertive communication respects the needs of all parties to express themselves in a private location, but not at the expense of others. The PN charge nurse needs first to protect clients and other staff from this display of inappropriate behavior and come to the assistance or defense of the employee.

front 110

The nurse asks another staff nurse to sign for a wasted narcotic, which was not witnessed by anyone. This type of request seems to be a recent pattern of behavior for this nurse. What is the appropriate initial action of the second staff nurse?

Confront the nurse about suspected medication misuse

Sign the narcotic sheet but document the request by an incident report

Counsel the colleague about the risky behaviors

Report this immediately to the nurse manager

back 110

Report this immediately to the nurse manager

The incident must be reported to the appropriate supervisor, either the charge nurse or the nurse manager, for both ethical and legal reasons. This is not an incident that a coworker can resolve without referring to an appropriate authority. The key words here are “appropriate initial action” and “recent pattern of behavior” regarding wasted narcotics. Ask yourself about your legal responsibility in this situation.

front 111

The nurse, who is located in a large urban area, uses telecommunications to provide health care and education to clients in remote locations. What is the best reason for using telehealth?

Empowers clients to take a greater interest in their illness

Standardizes electronic data sharing of health information

Reduces health care costs

Removes time and distance barriers from the delivery of care

back 111

Removes time and distance barriers from the delivery of care

Telehealth is the use of technology to deliver health care, health information, or health education at a distance. People in rural areas or homebound clients can communicate with providers via telephone, email or video consultation, thereby removing the barriers of time and distance for access to care. Although increased access to information and collaboration between the client and provider can be empowering, this is not the primary reason for using telecommunications/telehealth.

front 112

The LPN/VN assists the RN in evaluating the plan of care for clients. What action does the LPN focus on during the evaluation phase?

Selection of interventions that are measurable and achievable

Achievement or status of progress related to prior goals

Establishment of goals to ensure continuity of care

Identification of any findings of physical and psychosocial stressors

back 112

Achievement or status of progress related to prior goals

Evaluation process of the clinical problem-solving process (the nursing process) should focus on the clients' status, progress toward goal achievement and ongoing re-evaluation of the plan of care. LPN/VN's gather, observe, record and communicate client responses to nursing interventions.

front 113

A home health nurse is providing care for a client. Which client statement should the nurse consider to be a priority and report immediately to the case manager?

"I really don't want the service of Meals on Wheels. I am just not hungry."

"My neighbors just don't get along with me since I refuse to let them walk across my lawn."

"I just didn't sleep well the last few nights. I have thoughts running through my mind."

"When I emptied my urine catheter bag it looked like rusty colored water."

back 113

"When I emptied my urine catheter bag it looked like rusty colored water."

Although nurses need to report diverse information to case managers through phone calls and documentation, they need to immediately report findings that suggest serious changes in a clients' condition. The change in the color of urine to "rusty" suggests blood, a potential danger sign. This requires immediate reporting, documentation and further assessment.

front 114

A Bosnian Muslim woman who does not speak English seeks care at a community center. Through physical gestures, the woman indicates that she has pain originating in either the pelvic or genital region. Assuming several people are available to interpret, who would be the most appropriate choice?

A female interpreter who does not know the client

A female neighbor of the client who is also from Bosnia

A Bosnian male, who is a certified medical interpreter

The client's adult daughter

back 114

A female interpreter who does not know the client

When the nurse and the client do not speak the same language, or have limited fluency, the services of an interpreter is needed. But, it may be inappropriate to have a male interpreter for a female client because the client may not be as forthcoming. The client may also feel it is inappropriate to have private matters interpreted by her daughter (especially if they are of a sexual nature or involve infidelity). To avoid a breach of confidentiality, the nurse should avoid using an interpreter from the same community as the client. The best response is to have a female interpreter who does not know the client.

front 115

The client has a musculoskeletal disorder and has been newly fitted for a lower limb orthotic. Which activity can be assigned to the unlicensed assistive personnel (UAP)?

Assist the client while transfering from the bed to a chair

Check the client's skin for any redness or irritation

Provide instruction for independent ambulation with the orthotic

Monitor the client's response to activity

back 115

Assist the client while transfering from the bed to a chair

The UAP can assist with routine activities of daily living, including transferring clients from a bed to a chair or wheelchair. When performed correctly, these routine tasks usually have a predictable outcome. The option about checking the client's skin involves assessment and monitoring the client's response is evaluation, both of which are nursing-only activities. A physical therapist would teach the client to ambulate with an orthotic.

front 116

During the management of a client's pain, a nurse should consider ethical practice. Which of these items best describes the ethical considerations made by a nurse?

The client's self-report of pain is the most important consideration

Cultural sensitivity is fundamental to pain management

Clients have the right to have their pain relieved

Nurses should not prejudge a client's pain based on the nurse's values

back 116

The client's self-report of pain is the most important consideration

Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is and when it is. To help answer this question, consider that the correct response is the only one that is client-centered.

front 117

Upon completing a review of the admission documents, a nurse identifies that an 87 year-old client does not have an advance directive. What action should the nurse take?

Record this information on the chart

Inform charge nurse and give information about advance directives

Assume that the client wishes a full code

Refer this issue to social services department

back 117

Inform charge nurse and give information about advance directives

For each admission, nurses should verify a copy of the current advance directive. If there is none, the practical nurse should inform the charge nurse and offer written information about advance directives to the client. It is then the client's choice to sign it. The witness of signature for an advanced directive must be someone not involved in direct care of the client. Social service staff are approved nationwide to witness signatures on advance directives. One option only deals with recording the information and is not sufficient. In another option the nurse should avoid making assumptions that the client has been informed of health care choices. Another option represents an action to be done after written information is given.

front 118

The home health nurse is visiting a client diagnosed with type 1 diabetes and osteoarthritis. The client has difficulty drawing up the insulin dosage. The nurse should refer the client to which community resource person?

Physical therapist

Occupational therapist

Home health aide

Social worker

back 118

Occupational therapist

An occupational therapist can assist a client to improve the fine motor skills needed to prepare an insulin injection. An occupational therapist works with the tasks that are needed for smaller movements to maintain activities of daily living or for work actions. A physical therapist works with general movement problems, mobility stability, range of motion or strength training exercises. The key terms in this question are "difficulty drawing up the insulin dosage" and "osteoarthritis." Combined, these terms should call to mind the need for fine motor skills.

front 119

The practical nurse (PN) is assigned to care for several clients on the 7:00 pm to 7:00 am shift. Which client should be checked immediately after getting shift report?

The client with pancreatitis who was admitted yesterday

The client diagnosed with chronic renal failure who returned from dialysis five hours ago

The client diagnosed with asthma who is scheduled for discharge

The client diagnosed with a peptic ulcer who has been vomiting most of the day

back 119

The client diagnosed with a peptic ulcer who has been vomiting most of the day

The client with the peptic ulcer should be checked immediately and findings reported to the charge nurse and/or health care provider. A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life-threatening situation.

front 120

Before the client signs a surgical consent form, the nurse must ensure the client has the ability to understand the information in the document.

T/F

back 120

True

The nurse reviews the information in the consent form with the client and witnesses the client's signature. The nurse verifies the client has the capacity to make choices and understands the consequences prior to the client signing the consent.

front 121

Nurses participate in quality improvement activities which are intended to promote safety and improve quality of care.

T/F

back 121

True

Quality improvement is essential for all health care providers. Nurses engage in quality improvement initiatives to facilitate collaborative practice, improve client outcomes, and enhance overall quality of care.

front 122

Negligence involves any action or inaction that results in unintended harm to a client.

T/F

back 122

True

Negligence means doing something that a "reasonably prudent" person, under similar circumstances, would not do. Negligent conduct can be an act, or a failure to act, that causes (unintended) harm to the client.

front 123

Nurses rarely participate in the organ donation process with clients' families.

T/F

back 123

False

Nurses serve an important role in the organ donation process through providing families with support and resources. Nurses are responsible for knowing their local laws and institutional policies about organ donation.

front 124

The nurse has a legal duty to abide by the scope of practice set forth in the nurse practice act/nursing act.

T/F

back 124

True

Each nurse practice act/nursing act defines the scope of activities that constitute the duty of a nurse licensed in that state/province /territory.

front 125

Nurses should only access client information for those clients directly under their care.

T/F

back 125

True

Nurses can legally access information that is required to provide nursing care for clients assigned to them. Accessing client information for purposes other than providing nursing care is a breach of confidentiality.

front 126

The nurse has a legal duty to provide nursing care to clients.

T/F

back 126

True

The care the nurse provides must be within the legally defined scope of practice, as well as the nurse's education and experience.

front 127

The nurse is responsible for reporting any breach of client privacy or confidentiality.

T/F

back 127

True

According to ethical principles, many laws (including most nurse practice acts), and agency policies, it is the legal duty of nurses to protect client confidentiality. Nurses should report violations of client confidentiality and/or privacy.

front 128

The nurse has an obligation to carry out the health care provider's written orders, whether the orders are appropriate for the client or not.

T/F

back 128

False

The nurse should never carry out a health care provider's order that is unclear or inappropriate. The nurse should contact the HCP immediately to clarify the order.

front 129

Advance directives are required for all clients.

back 129

False

An advance directive is a legal document that indicates client preferences for treatment or life-saving measures. Clients are encouraged, but not required, to have an advance directive.

front 130

Which situation requires handwashing? (Select all that apply.)

Before having direct contact with a client

After contact with inanimate objects in the immediate vicinity of the client

After making a chart entry

Prior to eating

After cleaning a wound

back 130

Before having direct contact with a client

Prior to eating

After cleaning a wound

After contact with inanimate objects in the immediate vicinity of the client

Handwashing is still the simplest and most effective strategy to prevent the spread of infection. It is necessary to wash one's hands to protect oneself prior to eating, after removing gloves following any client procedure, and even after having contact with intact skin or objects in the client's room. However, it is not necessary to wash hands after handling every chart (although using an alcohol-based hand rub would be advisable).

front 131

The client, who is diagnosed with dementia, wanders throughout the long-term care facility. How can the nurse best ensure the safety of a client who wanders?

Attach a monitoring band to the client's wrist

Apply a restraint to keep keep the client in a chair when awake

Explain the risk of walking with no purpose

Frequently reorient the client to time, person, place

back 131

Attach a monitoring band to the client's wrist

A wander management system is used to give people with dementia and other "at risk" clients the ability to move freely where they live. The sensor in the bracelet trips an alarm that's attached to exterior doors if the client attempts to leave the facility. It is inappropriate to use restraints or other restrictive devices to keep clients in chairs or beds (unless they are potentially harmful to themselves or others.) Reality orientation is inappropriate for someone with dementia.

front 132

A practical nurse (PN) is having difficulty reading a health care provider's written order from the prior shift. What action should the nurse take?

Leave the order for the oncoming staff to follow up or interpret

Call the pharmacy for assistance in the interpretation

Contact the manager to report the problem with the legibility of the order

Ask the registered nurse (RN) to notify the health care provider for clarification

back 132

Ask the registered nurse (RN) to notify the health care provider for clarification

The nurse should clarify the order with the person who wrote the illegible or confusing order. If the PN reports to an RN, then the RN should obtain written clarification. In some states PNs may write verbal or telephone orders and in other states this is not allowed by the state’s nurse practice act.

front 133

A 76 year-old client is admitted to the unit after reportedly falling at home. The client begins to seize and loses consciousness. What action by the nurse is appropriate to do next?

Place an oral airway in the mouth and suction the mouth

Stay with client and observe for airway obstruction

Collect pillows and pad the side rails of the bed

Announce a cardiac arrest and assist with intubation

.

back 133

Stay with client and observe for airway obstruction

For the client's safety, the client should not be left unattended. The nurse must remain at the bedside, observe respirations and type of seizure activity, and prepare to clear the airway if it's obstructed. The nurse should not not place anything in the client's mouth. A code is called only if pulse or respirations are absent after the seizure

front 134

During a 12-hour night shift, the nurse has a "near miss" and catches an error before giving a new medication. Which statement might explain the reason for the near miss? (Select all that apply.)

The nurse is sleep-deprived

The nurse is interrupted when preparing the medication

The unit is short-staffed

The nurse has worked on the same unit for 5 years

The nurse works in the intensive care unit (ICU)

back 134

The nurse is sleep-deprived

The nurse is interrupted when preparing the medication

The unit is short-staffed

The nurse works in the intensive care unit (ICU)

There are a number of reasons for near misses and making medication errors, including heavy workload and inadequate staffing, distractions, interruptions, and inexperience. Fatigue and sleep loss are also factors, especially for nurses working in units with high acuity clients.

front 135

The nurse listens to report about a newly admitted client who has a skin ulcer that's tested positive for MRSA (methicillin-resistant Staphylococcus aureus). What precautions must be taken for this hospitalized client? (Select all that apply.)

Perform hand hygiene after direct contact with the client and before leaving the room

Keep all equipment in the client's room for his/her sole use

Keep the door to the room closed, with a notice for visitors

Wear mask when providing routine care to the client

Place the client in a single room

back 135

Perform hand hygiene after direct contact with the client and before leaving the room

Keep all equipment in the client's room for his/her sole use

Keep the door to the room closed, with a notice for visitors

Place the client in a single room

Contact precautions are recommended in acute care settings for MRSA when there's a risk for transmission or wounds that cannot be contained by dressings. The client should be in a single room, with the door closed; the sign on the door instructs visitors to report to the nurse before entering the room. All equipment, such as stethoscopes and blood pressure devices, should be for the client's sole use and kept in the room. Health care workers must perform hand hygiene (wash hands with soap and water) after direct contact with the client and his/her environment and before leaving the isolation room. Contact precautions require

front 136

The mother of an infant who is being treated for pesticide poisoning asks, "Why is activated charcoal used?" What is an appropriate response by the nurse?

"Activated charcoal binds with the poison to limit absorption from the digestive tract."

"When it is absorbed into the blood stream, activated charcoal neutralizes the poison."

"Activated charcoal stimulates bowel evacuation."

"This liquid causes vomiting, which eliminates the poison from the body."

back 136

"Activated charcoal binds with the poison to limit absorption from the digestive tract."

Activated charcoal binds to the poison through the entire GI tract; it is estimated that it reduces absorption by almost 60%. Activated charcoal is a fine, black powder that is odorless, tasteless, and nontoxic. It is often used after gastric lavage in the emergency treatment of certain kinds of poisoning.

front 137

The nurse is discussing safety precautions with the parents of a child. Which activity would be most hazardous to an 18 month-old child?

Riding in a car

Jumping on a bed

Eating whole peanuts

Playing around electrical outlets

back 137

Riding in a car

Car accidents are a leading cause of death in infants and children, as well as a major cause of permanent brain damage and spinal cord injury. Although all the other options pose a danger to young children, drowning is actually the second most common cause of accidental death among children.

front 138

A client is admitted to an inpatient crisis unit with the diagnosis of acute mania and has been placed in seclusion. The nurse is assigned to observe the client at all times. It is now time for the client's dinner. What action should the nurse take next?

Accompany the client to the dining area and maintain observation

Hold the meal until after the seclusion order has been discontinued

Obtain a contract for safe behavior before accompanying the client to the dining area

Serve the dinner in the seclusion room, maintaining observation

back 138

Serve the dinner in the seclusion room, maintaining observation

Seclusion is ordered by a physician and requires continuous observation, unless the order is discontinued or amended. It is incorrect to amend the seclusion or mealtime. Meals can be eaten in the seclusion room with the nurse continuing the 1:1 observation. Meals must be offered on time and should not be withheld. Contracts for safe behavior are meaningless in the presence of psychotic behavior (mania).

front 139

A child is admitted with a diagnosis of suspected meningococcal meningitis. Which admission orders should the nurse implement first?

Monitor and record vital signs every 30 minutes

Seizure precautions

Droplet precautions

Notify of changes in neurologic status

back 139

Droplet precautions

Meningococcal meningitis is an infection caused by the bacteria Neisseria meningitis. The first action for nurses to take is to initiate droplet precautions. The initial therapeutic management of acute bacterial meningitis includes droplet precautions, anti-infective therapy (a cephalosporin or penicillin), monitor neurological status along with vital signs, institute seizure precautions, and maintain optimum hydration.

front 140

A school nurse plans to reinforce information about the most effective methods to prevent the spread of head lice in school-age children when speaking at a teacher's conference. The nurse should plan to include which information?

The classroom should be sprayed with an insecticide before winter and spring vacations

The heads of children should be checked monthly for nits (lice eggs)

Each child should wash his or her hands after recess break

Children should not share or wear other children's coats, hats and scarves

back 140

Children should not share or wear other children's coats, hats and scarves

Lice can be spread easily by sharing hats, combs, scarves, coats and other items of clothing that touch the hair on the head. Insecticide spraying will not affect head lice and checking their heads monthly is not necessary. Washing hands after recess is a good idea, but will have no impact on the spread of head lice.

front 141

Parents of a 7 year-old child call a clinic nurse because their child was sent home from school due to a rash. The child, seen the day before by the health care provider, was diagnosed with fifth disease (erythema infectiosum) and is otherwise in good health. What would be the appropriate action by the nurse?

Refer the school officials to printed materials about this viral illness

Inform the school that the child is receiving antibiotics for the rash

Explain that this rash is no longer contagious and does not require isolation

Tell the parents to bring the child to the clinic for further evaluation

back 141

Explain that this rash is no longer contagious and does not require isolation

Fifth disease is a viral illness with an uncertain period of communicability (perhaps one week prior to and one week after the onset). Children are not contagious after the appearance of the rash, which gives a "slapped cheek" appearance. Isolation of the child with fifth disease is not necessary except in cases of hospitalized children who are immunosuppressed or having aplastic crises. The parents may need written confirmation of this from the health care provider to give to the school. Notice that two of the options focus on the content of this question (a rash); the other options do not. Note the word “antibiotics” in one option, but there is nothing in the question to indicate there's an “infection.”

front 142

The nurse is caring for a client diagnosed with hepatitis C. When reviewing the client's health history, which of the following findings does the nurse recognize as the most likely cause for developing hepatitis C?

Eating raw shellfish last week

Receiving blood product transfusions prior to 1992

Getting a tattoo three months ago at a licensed tattoo parlor

Recent travel to Central America

back 142

Receiving blood product transfusions prior to 1992

The client who was transfused prior to blood screening for hepatitis C (1992) may show findings of hepatitis C many years later. Raw shellfish ingestion and travel to foreign countries with poor sewage control can increase the risk of developing hepatitis A, but not hepatitis C. Most commercial tattoo parlors are licensed and follow standard safety precautions, so the likely cause of developing hepatitis B or C after a tattoo or a piercing is very low.

front 143

The parents of a toddler ask, "How long will our child have to sit in a car seat when riding in a car?” What would be the best response by the nurse?

"Until the child is about 2 years-old."

"When the child is 50 inches tall."

"Whenever the child is content to sit in a booster seat."

"When the child weighs 40 pounds."

back 143

"Until the child is about 2 years-old."

The American Academy of Pediatrics now recommends that infants and toddlers remain in rear-facing car safety seats until age 2 years (or when they physically outgrow the limits of the seat.) They can then transition to sitting in belt-positioning booster seats when they have reached about 4 feet 9 inches tall and are between 8 to 12 years-old. Children under age 13 years should ride in the back seat of the car.

front 144

The nurse is setting up a client's dinner tray. When the nurse turns her back to the client, the client grabs the nurse's buttocks and states he is hungry for much more than dinner. Which of the following responses by the nurse is indicated?

Call the health care provider

Complete an incident report

Quickly leave the room and ask the UAP to assist the client

Ignore the behavior

back 144

Complete an incident report

To keep the therapeutic relationship intact, a nurse needs to set limits on appropriate behavior and not ignore bad behavior. Sexual harassment is a form of violence and is never part of the job. The nurse should report the incident to her supervisor and complete an incident report. The nurse has the right to ask not to be assigned to this client.

front 145

The nurse observes a nursing assistant using antiseptic hand rub and rubbing the hands vigorously after leaving the room of a client diagnosed with Clostridium difficile. Which action is most appropriate by the nurse?

Tell the client to ask caregivers if they have washed their hands

Require the nursing assistant to wash hands again with soap and water

Ensure that visitors wash hands thoroughly before and after visiting

Praise the nursing assistant for proper use of antiseptic hand rub

back 145

Require the nursing assistant to wash hands again with soap and water

Anyone who is hospitalized should be encouraged to ask caregivers if they washed their hands and to remind visitors to wash their hands. However, it is the nurse's responsibility to supervise the nurse assistant and to correct practice errors as needed. Clostridium difficile (C. diff) is one of the few pathogens that require soap and water for cleansing the hands. Since antiseptic hand rub is ineffective against the hardy spores produced by this bacterium, the nurse should require the nursing assistant to wash his/her hands with soap and water, especially after providing care for this client.

front 146

The health care team is planning discharge for a 90 year-old client diagnosed with musculoskeletal weakness. Which intervention would be the priority to help prevent falls in the home?

Take calcium and vitamin D supplements

Wear eyeglasses and hearing aid

Begin therapy for muscle strengthening and balance

Place night lights in the bedroom and bathroom

back 146

Place night lights in the bedroom and bathroom

Family members and the client should understand the simple actions they can take to help prevent falls in the home. More falls occur in the bedroom than in any other location; a simple environmental change would be to add night lights in the bedroom and bathroom. Muscle strengthening and balance exercises, taking calcium and wearing glasses may be all indicated for this client, but using night lights is an immediate and effective action to help prevent falls.

front 147

The 4 year-old needs to have several vaccines prior to starting kindergarten. However, the nurse determines that the MMR vaccine should not be given. What is the best reason why the MMR should not be given to this child?

Low-grade temperature and a runny nose

The child is too old for the second dose of the MMR

Previous life-threatening allergic reaction to the antibiotic neomycin

Known allergy to peanuts

back 147

Previous life-threatening allergic reaction to the antibiotic neomycin

According to the CDC, if a person has experienced a life-threatening reaction to the antibiotic neomycin or gelatin s/he should not get the MMR. Vaccines can be given to children with mild cold symptoms, but it might be better to wait until they feel better. There is no relationship between the MMR and an allergy to peanuts. The CDC recommends administering the first MMR between 12 and 15 months and the second dose between 4 to 6 years of age.

front 148

The nurse is attending an in-service about healthcare-associated infections (HAIs). Which factor is identified as the most common cause of HAIs in the acute care setting?

Presence of an indwelling urinary catheter

Decreased mobility for a week or longer

Existence of an intravenous access device

Inadequate fluid intake over 72 hours

back 148

Presence of an indwelling urinary catheter

Catheter-associated urinary tract infections is the most common HAI in the acute care hospital setting. Surgical site infections, bloodstream infections and pneumonia are the other categories of infections.

front 149

Four clients are admitted to an adult medical unit on the same shift. The nurse should expect to implement airborne precautions for the client with which of the following diagnoses?

Confirmed AIDS with cytomegalovirus (CMV)

Suspected viral pneumonia

Positive Mantoux test with an abnormal chest x-ray

Advanced carcinoma of the lung

back 149

Positive Mantoux test with an abnormal chest x-ray

The client who must be placed in airborne precautions is the client with a positive Mantoux test (also called PPD) and an abnormal chest film because these could be suspicious tuberculin lesions. The client would be placed in a private room. Health care workers would have to use a HEPA filter respirator when in the room providing care for the client. Although the CMV virus is not highly communicable, it can be spread from person to person by direct contact; the virus is shed in the urine, saliva, semen and to other body fluids.

front 150

Standard precautions also includes respiratory hygiene/cough etiquette.

T/F

back 150

True

Standard precautions are used to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. Respiratory hygiene/cough etiquette is now considered part of standard precautions.

front 151

You should quickly remove contaminated clothing by pulling it over your head.

T/F

back 151

False

Contaminated clothing should be removed quickly, but it should be cut off instead of pulled over your head. Place contaminated clothing inside a plastic bag, seal the bag and then place inside another plastic bag.

front 152

The three elements of radiation protection are time, distance and shielding.

T/F

back 152

True

The farther away people are from a radiation source, the less their exposure; as a rule, if you double the distance, you reduce the exposure by a factor of four. The amount of radiation exposure typically increases with the time people spend near the source of radiation.

front 153

Sensor pads may be used on the beds of individuals who are a fall risk.

T/F

back 153

True

Bed alarms and sensor pads can be used to alert caregivers when a client is attempting to get up from a bed or chair, especially clients who are at risk for falls. This is an effective alternative to the use of restraints.

front 154

Restraints can be ordered “as needed” (PRN) by health care providers.

T/F

back 154

False

Health care providers are required to specify the duration and circumstances for which restraints are required and for how they should be used. Nurses and HCP’s must frequently monitor clients to reassess for the continued need for restraints.

front 155

Newborns are fitted with tamper-proof security sensors during their stay in the hospital.

T/F

back 155

True

Wearing a tamper-proof safety device reduces the risk of abduction. The sensor shows the location of the infant and the security system can activate other devices (such as cameras, door locks, public address systems, sirens, and other alarms) in the event of an attempted abduction.

front 156

Disaster triage differs from routine emergency department triage.

T/F

back 156

True

Disaster triage categories range from most urgent (first priority), urgent, nonurgent (the walking wounded), and dead/catastrophic.

front 157

Hands can be cleaned with an alcohol-based hand rub after caring for a client with Clostridium difficile (CDI).

T/F

back 157

False

Normally, hands can be decontaminated with an alcohol-based hand rub when they are not visibly soiled. However, alcohol does not kill C. difficile spores. Using soap and water for hand hygiene is recommended after caring for a client with CDI.

front 158

If a draining wound tests positive for Staphylococcus aureus (MRSA), the client is placed on contact precautions.

T/F

back 158

True

Clients with an abscess or draining wounds who test positive for Staphylococcus aureus (MRSA), group A streptococcus, are placed on contact precautions.

front 159

Assistive devices are used when a caregiver is required to lift more than 35 lbs (15.9 kg).

T/F

back 159

True

During any client-transferring task, if any caregiver is required to lift a client who weighs more than 35 lbs (15.9 kg), then the client should be considered to be fully dependent, and assistive devices should be used for the transfer.

front 160

The school nurse is observing a group of children. The nurse should be aware that which of these psychosocial needs are more commonly found in adolescents?

Attention, competition, being right

Social competencies, respect, sense of humor

Privacy, autonomy, peer interaction

Independence, confidence, narcissism

back 160

Privacy, autonomy, peer interaction

Adolescents display the need for privacy, autonomy, and peer interaction concurrent with an evolving sense of identity.

front 161

A nurse is observing children playing in the hospital playroom. The nurse should expect to see 4 year-old children playing in which manner?

Alone with hand-held computer games

Competitive board games with older children

Cooperatively with other preschoolers

With their own toys alongside with other children

back 161

Cooperatively with other preschoolers

Cooperative or associative play is typical of the preschool period. School-age children would play board games, toddlers engage in side-by-side or parellel play, and adolescents would be more likely to play the hand-held computer games.

front 162

The nurse is asked about chiropractic treatment for illnesses. The nurse should know that it focuses on which approach?

Electrical energy fields

Mind-body balance

Spinal column manipulation

Exercise of joints

back 162

Spinal column manipulation

The underlying theory of chiropractic medicine is that interference with transmission of mental or electrical impulses between the brain and the body organs produces diseases. Such interference is caused by misalignment of the vertebrae. Manipulation reduces the subluxation or misalignment. Notice that this is a specific question, which means it requires a specific response. Eliminate the two general options (electrical energy fields and mind-body balance). Now pay attention to the word “manipulation” in one option and the word "exercise" in the other remaining option. Return to the question to look for a clue to help with the choices. Focus on the words "treatment for illness" rather than "chiropractic" and go with what is known. An educated guess for "treatment of illness" is more likely to be "manipulation."

front 163

The clinic nurse is performing the intake assessment for a 74 year-old male. The client has a history of benign prostatic hypertrophy (BPH) and reports having trouble voiding. After the client uses the bathroom to void, how would the nurse best assess the bladder for retention?

Check for rebound tenderness

Palpate for rounded swelling above the symphysis pubis

Scan the bladder using a portable ultrasound scanner

Insert an intermittent urinary catheter

back 163

Scan the bladder using a portable ultrasound scanner

Urinary retention and incomplete bladder emptying can result from urethral obstruction, as seen in BPH. The nurse can palpate the area from the umbilicus towards the symphysis pubis; an empty bladder rests behind the symphysis pubis and should not be palpable. The nurse can also percuss this area; a urine-filled bladder produces a dull sound. But a bladder ultrasound the most effective technique since it will digitally register bladder volume. Routine catheterization to check for post void residual is not recommended; but if bladder distention is greater than 200 mL, the client may need to be catheterized.

front 164

The geriatric social worker is working with the nurse to assess the client's ability to perform instrumental activities of daily living (IADL). Which of the following skills are considered instrumental activities of daily living? (Select all that apply.)

Ability to bathe self

Ability to cook meals

Ability to write checks

Ability to eat independently/feed self

Ability to take medications

back 164

Ability to cook meals

Ability to write checks

Ability to take medications

Activities of daily living (ADLs) are basic self-care tasks, such as feeding, toileting, grooming, bathing, putting on clothes. Instrumental activities of daily living (IADLs) are slightly more complex skills and include a series of life functions necessary for living independently, such as the ability to use a telephone, shopping, doing housework, preparing meals, handling finances, and being responsible to take medications. ADLs and IADLs are part of an older adult's functional assessment.

front 165

While performing an initial assessment on a newborn following a breech delivery, the nurse suspects hip dislocation. Which of these findings is most suggestive of this abnormality?

Negative Ortolani response

Lengthened leg of affected side

Flexion of lower extremities

Irregular hip symmetry

back 165

Irregular hip symmetry

Early assessment of irregular hip symmetry alerts the nurse and the provider to a correctable congenital hip dislocation. The leg is shortened on the affected side. One check for hip dislocation is the Ortolani click; if it is found, it is called a positive response.

front 166

A nurse who works in a high school is reinforcing information to a group of unwed pregnant students. What is the most important action the nurse should stress so that each girl can deliver a healthy child?

Get adequate sleep and frequent rest

Stay in school to keep normal activities

Maintain good nutrition

Keep in contact with the child's father

back 166

Maintain good nutrition

Nurses can play a pivotal role in reinforcing nutritional education. Weight gain during pregnancy is one of the strongest predictors of infant birth weight. Pregnant teens who gain between 26 and 35 pounds have the lowest incidence of low birth-weight babies. Specifically, teens need to increase their intake of protein, vitamins and minerals (including iron.)

front 167

A 38 year-old female client is admitted to the hospital with an acute exacerbation of asthma. This is her third admission for asthma in seven months. She describes how she doesn't really like having to use her medications all the time. Which of the following long-term consequence of uncontrolled airway inflammation should the nurse reinforce?

Lung remodeling and permanent changes in lung function

Frequent pneumonia

Degeneration of the alveoli

Chronic bronchoconstriction of the large airways

back 167

Lung remodeling and permanent changes in lung function

While an asthma attack is an acute event from which lung function essentially returns to normal, chronic under-treated asthma can lead to lung remodeling and permanent changes in lung function. Increased bronchial vascular permeability leads to chronic airway edema which leads to mucosal thickening and swelling of the airway. Increased mucous secretion and viscosity may plug airways, leading to airway obstruction. Changes in the extracellular matrix in the airway wall may also lead to airway obstruction. These long-term consequences should help the nurse when reinforcing the need for daily management of the disease, regardless if the client "feels better" or not.

front 168

The nurse is giving the pneumovax vaccination to clients in a community health clinic. The nurse should not administer the vaccine to which of the following clients?

The client who received a flu shot the week before

The client who reports feeling achy all over about two days ago

The client with a temperature of 99 F (37.2 C)

The client who had chemotherapy for cancer four days ago

back 168

The client who had chemotherapy for cancer four days ago

Immunization with this vaccine is contraindicated with clients that are immunosuppressed. The pneumovax vaccine is to be given at least a week apart from other vaccines. The other two options do not warrant suspicion of immunological problems.

front 169

A newly pregnant woman asks the nurse what to expect in the early stages of pregnancy. The major developmental task that a woman must accomplish during the first trimester of pregnancy is the acceptance of which issue?

The potential risk for a termination of the pregnancy

The fetus as a separate and unique being

The satisfactory resolution of fears related to giving birth

The pregnancy and the physical changes that are involved

back 169

The pregnancy and the physical changes that are involved

During the first trimester the maternal focus is directed toward acceptance of the pregnancy and adjustment to the minor discomforts. Ambivalence is a normal, expected emotion. You should be able to determine that two of the options occur later in the pregnancy. The option about the potential risk for termination of the pregnancy is unrelated to the question being asked

front 170

A newborn born prematurely is to be fed breast milk through a nasogastric tube. Why is breast milk preferred over formula for premature infants?

Has less fatty acids

Is higher in calories/ounce

Contains less lactose

Provides antibodies

back 170

Provides antibodies

Breast milk is ideal for the preterm baby who needs additional protection against infection through maternal antibodies. It is also much easier to digest. Therefore, less residual is left in the infant's stomach.

front 171

A 75 year-old client is admitted with the diagnosis of possible dehydration. The nurse should understand that older adults are at risk for dehydration due to which of the following factors?

Reduced gastric emptying

Weakened urinary sphincter

Decreased sensation of thirst

Reduction in lean body mass

back 171

Decreased sensation of thirst

Older adults do not drink because they do not feel as thirsty as younger people. Other risk factors for minimal ingestion of fluids in older adults may include fear of incontinence, inability to drink fluids independently or it's simply too painful to get up from a chair.

front 172

A healthy 18 year-old is entering college in the fall. Which immunization would the health care provider recommend prior to college? (Select all that apply.)

Meningococcal conjugate vaccine (MCV4)

Tetanus, Diphtheria, Pertussis vaccine (Tdap)

Pneumococcal polysaccharide vaccine (PPSV23)

Seasonal influenza vaccine

Shingles vaccine

back 172

Meningococcal conjugate vaccine (MCV4)

Tetanus, Diphtheria, Pertussis vaccine (Tdap)

Seasonal influenza vaccine

Human papillomavirus (HPV) vaccine

Adults older than age 50 should get the shingles vaccine. The PPSV23 is given to adults older than age 65. (The pneumococcal vaccine PCV13 is routinely given to infants/children.) An 18 year-old who is going to college should receive the TDAP, MCV4 and seasonal influenza vaccine. He or she should also receive the HPV vaccine if s/he has not already received it.

front 173

A client is in the third month of her first pregnancy. During the interview, she tells a nurse that she has several sex partners and is unsure of the identity of the baby's father. Which of these nursing interventions is best at this time?

Request the RN to counsel the woman to consent to HIV screening

Refer the client to a family planning clinic

Refer her for testing for sexually transmitted infections

Discuss the risk for cervical cancer

back 173

Request the RN to counsel the woman to consent to HIV screening

The client's behavior places her at high risk for HIV. While it would be a good idea to draw blood to test for STDs, this can't be done without informed consent of the client. Since the woman is already at a clinic seeking health care, it would be best to provide information (and possibly begin treatment) now, instead of simply referring her to another health care facility. The best response is for the RN to provide information and counsel the woman to consent to HIV screening.

front 174

According to Piaget, which finding indicates that a child has attained the stage of concrete operations?

Makes the moral judgment that "stealing is wrong"

Explores the environment with the use of sight and movement

Reasons that homework is time-consuming yet necessary

Thinks in mental images or word pictures

back 174

Makes the moral judgment that "stealing is wrong"

The stage of concrete operations is depicted by logical thinking and moral judgments. This stage is associated with school-aged children from ages 7 to about 11. It is a time when children develop transitive thinking and reversibility concepts. They do well with inductive logic, which involves going from a specific experience to a general principle. They do not do well with deductive logic, or the use of a general principle to determine an outcome of a specific event.

front 175

A client referred for a mammography asks the nurse about the cancer risks from radiation exposure. What is an appropriate response by the nurse?

"A chest x-ray gives you more radiation exposure."

"The radiation from a mammography is equivalent to one hour of sun exposure."

"Exposure to mammography every two years is not dangerous."

"You have nothing to worry about; it is less than tanning in the nude."

back 175

"The radiation from a mammography is equivalent to one hour of sun exposure."

A client would have to have numerous procedures during the course of a year to be at risk for cancer. The correct response is concise and gives the client a point of reference. The other options are either judgmental and nontherapeutic ("tanning in the nude"), inaccurate and having the potential for causing more concern (getting more radiation from a chest x-ray), or do not address the client's concern (it's "not dangerous").

front 176

The client is an adult who was recently diagnosed with type 1 diabetes. Which action would be the best strategy for a nurse to use when reinforcing insulin injection techniques?

Ask the client questions during practice sessions

Listen to client's verbalized understanding

Observe a return demonstration

Ask the client questions after practice sessions

back 176

Observe a return demonstration

Because injecting insulin is a psychomotor skill, observing a return demonstration is the best strategy to know or evaluate whether the client has learned the proper technique.

front 177

During the physical inspection of a client, the nurse notes a pulsating mass in the client's periumbilical area. Which action is appropriate for the nurse to take to gather more data about the mass?

Auscultate the area

Percuss the area

Measure the length of the mass

Palpate the area

back 177

Auscultate the area

Auscultation of the abdomen will find a bruit, which will confirm the presence of an abdominal aneurysm. The other actions would be contraindicated because placing pressure on the area might cause the aneurysm to leak or rupture.

front 178

A nurse is working with family members of an 80 year-old client newly diagnosed with Alzheimer's disease. Which intervention would be helpful?

Have the family feed the client

Role play communication strategies

Demonstrate an active-passive exercise routine

Assist the family to bathe the client

back 178

Role play communication strategies

Because Alzheimer's disease is a progressive chronic illness that challenges caregivers, the nurse can be of great assistance in helping the family to identify changes in language, as well as ways to communicate with their loved one that will help avoid or minimize difficult behaviors. The client should feed and bathe him or herself as long as physically possible. Exercise is important for Alzheimer's victims, but walking or enjoying other physical activities are more important than specific exercise routines.

front 179

Parents are asking for information about how they will know if their toddler is ready for toilet training. What should the nurse understand before reinforcing information about toilet training?

Neuronal impulses are interrupted at the base of the ganglia

The child learns voluntary sphincter control through repetition

Myelination of the spinal cord is completed during the toddler years

The toddler can understand cause and effect

back 179

Myelination of the spinal cord is completed during the toddler years

Voluntary control of the sphincter muscles can be gradually achieved due to the complete myelination of the spinal cord, which occurs sometime between the ages of 18 to 24 months. The other options are incorrect. Notice that both the question and the correct option has the word “toddler” in them.

front 180

The adolescent's spine is straight and posterior ribs are symmetrical when the client bends forward.

Abnormal finding(s)

or

Expected finding(s)

back 180

Expected finding(s)

The adolescent client should be assessed for scoliosis by asking the client to bend forward and touch his or her toes. The client's spine should be straight and without curvature or asymmetry.

front 181

An 84-year-old has decreased muscle strength in his bilateral upper extremities.

Abnormal finding(s)

or

Expected finding(s)

back 181

Expected finding(s)

A common age-associated change with the musculoskeletal system is the decline in muscle mass and strength.

front 182

A 5-month-old has a sunken anterior fontanel.
Abnormal finding(s)
or

Expected finding(s)

back 182

Abnormal finding(s)

The fontanel should be flat; a sunken fontanel indicates possible dehydration

front 183

A client can tell you her name, but does not know the day of the week.
Abnormal finding(s)

or

Expected finding(s)

back 183

Abnormal finding(s)

Normal mental function includes orientation to person, place and time.

front 184

A 60-year-old male has a left scrotal sac that is slightly lower than the right.

Abnormal finding(s)

or

Expected finding(s)

back 184

Expected finding(s)

Asymmetry in the scrotum is normal, with the left usually larger or hanging lower than the right.

front 185

Auscultation reveals bowel sounds in two of the four abdominal quadrants.
Abnormal finding(s)
or
Expected finding(s)

back 185

Abnormal finding(s)

Normally, you should hear bowel sounds in all four quadrants in a healthy client.

front 186

During a female client's breast exam, you see a cluster of very tiny dimples near one nipple.
Abnormal finding(s)

or

Expected finding(s)

back 186

Abnormal finding(s)

There should be no dimples; in fact "orange peel" skin is a late sign of breast cancer.

front 187

A 42-year-old breathes 30 times per minute.
Abnormal finding(s)

or
Expected finding(s)

back 187

Abnormal finding(s)

Normal respiratory rate in adolescents and adults is 12-20 breaths per minute.

front 188

The client is able to stand on one foot, with eyes shut, for five seconds.

Abnormal finding(s)

or
Expected finding(s)

back 188

Expected finding(s)

Balancing on one foot, with eyes shut, is one sign of normal cerebellar function.

front 189

When you examine the mouth, you see that the soft palate is moist and pink with whitish spots.
Abnormal finding(s)
or
Expected finding(s)

back 189

Abnormal finding(s)
The soft palate should be reddish pink; spots are a sign of possible infection.

front 190

Reflecting back on life

back 190

Older Adult

Integrity vs. Despair (approximately age 65 years & older)

front 191

Exploring independence; developing a sense of self

back 191

Adolescence

Identity vs. Role Confusion (approximately age 12-18 years)

front 192

Exploring and developing close, committed relationships

back 192

Early Adulthood

Intimacy vs. Isolation (approximately age 18-40 years)

front 193

Developing a greater sense of personal control.

back 193

Early Childhood

Autonomy vs. Shame & Doubt (approximately 18 months to 3 years)

front 194

Building career and family.

back 194

Adulthood

Generativity vs. Stagnation (approximately age 40-64 years)

front 195

Developing trust.

back 195

Infant

Trust vs. Mistrust (approximately birth to 18 months)

front 196

Developing a sense of pride in accomplishments.

back 196

School Age

Industry vs. Inferiority (approximately age 6-11 years)

front 197

Play, imagination and initiating activities with others.

back 197

Preschool

Initiative vs. Guilt (approximately age 3-5 years)

front 198

The safest time for the fetus is to give the mother analgesia when her cervix is dilated 8 to 10 centimeters.

T/F

back 198

False

The safest time to offer analgesia is when dilation is between 4 to 7 centimeters.

front 199

A woman cannot become pregnant when she is breastfeeding.

T/F

back 199

False

Pregnancy can occur with unprotected intercourse at or before the first menstrual cycle after birth. Nurses should caution women to avoid pregnancy for the first three months after delivery to allow the body time to heal.

front 200

Common issues on the first postpartum day include afterpains and episiotomy discomfort and swelling.

T/F

back 200

True

The nurse should provide information about interventions that will help the new mother cope with the common physical and emotional changes she is experiencing. For example, the client can apply ice or a cold pack to the perineum and use a gentle squeeze of warm water for cleansing after voiding.

front 201

About 5 days after delivery, lochia is pink-brown in color.

T/F

back 201

True

Normal bleeding and discharge should be more watery and pink-brown colored (lochia serosa) about 3 to 5 days after delivery. It may take up to 2 to 4 weeks for discharge to taper off completely.

front 202

A baby tapped briskly on the bridge of the nose will close both eyes.

T/F

back 202

True

Tapping on the glabella (flat bone between the eyebrows) causes a neurologically healthy baby to close both eyes. This is referred to as the glabellar reflex.

front 203

An APGAR score of 2 for appearance means the newborn's fingers and toes are bluish in color.

T/F

back 203

False

The normal color all over for the newborn is pink; a pink baby earns a score of 2. A baby who is pink with pale blue toes/feet and fingers/hands will receive a score of 1 on the APGAR test.

front 204

A gravida 3, para 3 woman should be rushed to the delivery room once engagement has occurred.

T/F

back 204

False

Engagement means that the baby's head no longer floats freely, but has dropped down into the pelvis. In a multipara, engagement normally occurs about two weeks before birth.

front 205

The fetus receives more oxygenated blood when the laboring mother lies on her side.

T/F

back 205

True

Positioning the laboring mother on her (left) side usually results in a higher fetal oxygen saturation. Other measures to increase fetal oxygenation (and placental perfusion) include administering oxygen to the laboring woman.

front 206

Chloasma is the first milk the new mother produces.

T/F

back 206

False

Chloasma is a skin discoloration of pregnancy. The first breast milk is called colostrum. Colostrum is low in fat, high in carbohydrates, protein and antibodies and is easy for the newborn to digest.

front 207

The nurse will give Rh immune globulin (RhoGAM®) to a Rh negative women after a miscarriage (spontaneous abortion).

T/F

back 207

True

RhoGAM® is administered to Rh negative women after any possible exposure to fetal blood, such as after each ectopic pregnancy, miscarriage, abortion or amniocentesis. RhoGAM® will be given to help prevent problems associated with incompatible blood types in future pregnancies.

front 208

One of the first signs of pregnancy is Chadwick's sign, which is the softening of the cervix.

T/F

back 208

False

There are several findings of pregnancy during the first trimester. Increased vascularity in the vagina is called Chadwick's sign; the increased vascularization and softness of the uterine isthmus is Hegar's sign; and the softening of the cervix is Goodell's sign.

front 209

Most pregnancy tests measure the level of estrogen in the woman's blood.

T/F

back 209

False

Pregnancy tests measure the hormone human chorionic gonadotropin (hCG) in the urine or in the blood. Levels can be first detected about 12 to 14 days after conception and peak in the first 8 to 11 weeks of pregnancy.

front 210

When the fetus is active, its heart rate should increase by about 15 beats per minute.

T/F

back 210

True

When the fetus is active, its heart rate will accelerate by about 15 beats per minute above the baseline. Average fetal heart rate is about 130 BPM when near term.

front 211

The fourth stage of labor is placental separation and expulsion.

T/F

back 211

False

The third stage of labor is placental separation and expulsion and lasts about 5 to 30 minutes. The fourth stage of labor is maternal adaptation, occurring 1 to 2 hours after birth.

front 212

Fetal movement count during the third trimester should be at least 5 movements per day.

T/F

back 212

False

In the third trimester, an awake, healthy fetus should move at least 3 times per hour. If the baby does not move, the mother should drink a glass of juice and then start a new count.

front 213

While interviewing a client, the nurse notices that the client is shifting positions, wringing the hands, and avoiding eye contact. What initial action should the nurse take?

Change the focus of the discussion to a less anxiety-provoking topic

Recognize the behavior as a side effect of medications

Ask the client about current feelings or thoughts

Check the client for the possibility of auditory hallucinations

back 213

Ask the client about current feelings or thoughts

The initial step in anxiety intervention is observing, identifying and validating anxiety. The behaviors suggest that the client may be anxious or nervous about the topic being asked about in the interview.

front 214

The nurse is assisting a client who has a substance use disorder. Which response by the nurse would best help the client to deal with issues of guilt?

"You've caused a great deal of pain to yourself, the family and close friends. It will take time to undo anything you've done."

"Let's not focus on your guilty feelings. These feelings will only lead you to more drug and alcohol use."

"Addiction usually causes people to feel guilty. It is a typical response due to your drinking behavior."

"What have you done that you feel most guilty about? What steps can you begin to take to help you deal with your feelings of guilt?"

back 214

"What have you done that you feel most guilty about? What steps can you begin to take to help you deal with your feelings of guilt?"

The best response is the one that encourages the client to get in touch with his or her feelings and to utilize problem-solving steps to reduce the feelings of guilt. If you are not sure about the correct response, you'll notice that two of the options focus on "drinking," which is not discussed in the question. These two answers can be eliminated. One other option is a guilt-provoking statement and this would never be considered appropriate; this, too, can be eliminated

front 215

A nurse is collecting data on a client suspected of being in an abusive relationship. Which statement by the client is most indicative that this individual is in an abusive relationship?

"I am determined to leave my house in a week."

"I have only been in this relationship for two months."

"No one else in the family has been treated like this."

"I have tried leaving in the past, but have always gone back."

back 215

"I have tried leaving in the past, but have always gone back."

Battered individuals stay in abusive relationships for a variety of reasons. They may blame themselves for being abused and often believe they can keep the peace if they stay. There is a fear of danger if they try to leave, including threats made by the batterer to hurt the children. All members in the family suffer from the effects of abuse, even if they are not battered themselves.

front 216

A client who lives in an assisted living facility tells the nurse, "I am so depressed. Life isn't worth living anymore." What is the best response by the nurse to this statement?

"Think of the many positive things in life today."

"Did you tell any of this to your family?"

"Have you thought about hurting yourself?"

"Come on, it is not that bad."

back 216

"Have you thought about hurting yourself?"

It's important to determine if someone, who has voiced thoughts about death, is considering a suicidal act. This response is most therapeutic under the circumstances. To respond by saying things are not so bad, denies the validity of the client's statement. To ask if the family or anyone knows of these feelings lacks focus on the client and would also be in violation of the rights of the client. Many times, when there doesn't seem to be an urgent physiologic need, look for a response that focuses on the safety of the client.

front 217

Stages of the grieving process

back 217

The phases of loss or the grief process according to Dr. Kubler-Ross are: denial, anger, negotiation, depression and acceptance.

front 218

The nurse is caring for a client who has a history of heavy alcohol use. Which behaviors would indicate the client is experiencing delirium tremens (DTs)?

An excited state accompanied by disorientation, hallucinations and tachycardia

Disorganized thinking and feelings of terror with nonpurposeful behaviors

Tremors or jerking movements caused by rapidly contracting muscles or tremors

A generalized shaking of the body accompanied by repetitive thoughts and movements

back 218

An excited state accompanied by disorientation, hallucinations and tachycardia

Delirium tremens (DTs) is a severe form of alcohol withdrawal that usually occurs within 72 hours after the last drink. During DTs, the person experiences both physical and mental hyperexcitability. Common findings include agitation, confusion, disorientation and hallucinations. The physical component of DTs includes diaphoresis, tachycardia, hypertension, tremors, fever, and eventually, if not treated, grand mal seizures, severe dehydration and death.

front 219

The nurse works with clients diagnosed with dementia and recognizes that this disorder involves impairment and loss. What type of impairments are expected for clients with dementia?

Learning, creativity and judgment

Endurance, strength and mobility

Hearing, speech and sight

Balance, flexibility and coordination

back 219

Learning, creativity and judgment

Dementia is not a single disease but a general term used to describe symptoms such as impairments to memory, communication and thinking. There are many causes of dementia and although we generally associate dementia with aging, we know that it is due to degenerative changes to the brain. The other options include expected changes due to aging but are not necessarily due to cognitive impairment related to dementia.

front 220

A client diagnosed with schizophrenia first speaks animatedly, with clarity of pronunciation. The client is then observed mumbling to self and speaking to the radio. A desirable outcome for this client's care should include which action by the client?

Demonstrate improved social relationships

Accurately interpret events and behaviors of others

Express feelings appropriately through verbal interactions

Engage in meaningful and understandable verbal communication

back 220

Engage in meaningful and understandable verbal communication

The data supports impaired verbal communication. The outcome must be related to the diagnosis and supporting data. So the most appropriate outcome would be for the client to engage in meaningful and understandable verbal communication. When trying to narrow the options down, look at the two similar but dissimilar answers. That would lead to options that both focus on "verbal" communication and interaction. Notice the word "feelings" in one option and ask: Are feelings in the stem of this question? Because no data is presented about feelings or to thinking processes, the option about expressing feelings would not be an appropriate outcome. Remember, content cannot be in your answer that is not in the question.

front 221

The client is an 80 year-old diagnosed with a neurocognitve disorder. The nurse is discussing with family members the best type of care for their mother. To assist the family with decision-making, what question should the nurse ask first?

"Are you able to assist with the care of your mother in any manner?"

"What type of assistance does your mother require?"

"What is your opinion of nursing homes or assisted living facilities?"

"Is your mother taking any over-the-counter or prescription medications at the present time?"

back 221

"What type of assistance does your mother require?"

The initial question should focus on the client's needs, as the family sees them. Because the client is cognitively impaired, the client is not a reliable source of information for decision making. The sequence of questioning after this would be to ask if the family is able to care for the client, to determine what medications the client is taking, and then to ask the family's opinion of other living arrangements, such as assisted living facilities or nursing homes.

front 222

The nurse works in an inpatient psychiatric setting. What would be the best reason why the nurse should limit touch to a handshake with a client?

Clients may misconstrue touch as an invitation to more intimate behavior

Refusing to touch a client indicates a lack of concern

Touching a client can set off a violent episode

Shaking hands allows the use of touch in a professional manner

back 222

Shaking hands allows the use of touch in a professional manner

The therapeutic use of touch is a basic part of the nurse-client relationship. However, in a psychiatric setting, the extent of physical contact should be limited to handshakes. Some facilities may even have a no-touch policy, especially when working with clients who have a history of sexual trauma. Even reassuring touching can be misinterpreted by the client

front 223

A nurse is caring for a client diagnosed with end-stage heart failure. The family members are distressed about the client's impending death. Which action should the nurse do first?

Ask about the family's religious affiliation and practices

Recommend an easy-to-read book on grief

Explore the family's past patterns for dealing with death

Explain the stages of death and dying to the family

back 223

Explore the family's past patterns for dealing with death

When a problem is identified, it is important for the nurse to collect accurate data. This is crucial to ensure that the client and the family's needs are addressed. But because the question is addressing the family's distress, the initial action should be directed at the family, and not the client. You should also notice that the word “death,” which is used in the question, only appears in the correct response ("exploring the family's past patterns for dealing with death.")

front 224

The client reports seeing spiders crawling on the walls, over the bed, and on the food tray, but denies feeling spiders crawling on the skin. The nurse determines that there are no spiders in the room. Which of the following assessments should the nurse use to document these findings? (Select all that apply.)

Spiders reported to be crawling on client

Delusional thinking

Visual hallucinations

Spiders reported to be crawling on surfaces

Incoherent speech

Tactile hallucinations

Spiders not found in the room

back 224

Visual hallucinations

Spiders reported to be crawling on surfaces

Spiders not found in the room

Charting should be factual and not judgmental. It is important to evaluate the client's statements. The nurse looks to see if there are indeed spiders in the room surfaces. When the client sees something that is not present, this is called a visual hallucination. Because this client did not feel crawling spiders, tactile hallucinations is not an acceptable answer.

front 225

A nursing assistant asks the nurse to explain the beliefs of a client who is a Christian Scientist and refuses admission to the hospital after being involved in a motor vehicle accident. The best response by the nurse should emphasize that the "believer" has which guiding principle?

Dietary practices

Spiritual healing

Meditation

Fasting with prayer

back 225

Spiritual healing

For many Christian Scientists, they may decide to pray first about a challenge, including health issues. For the believer, medical treatments may interfere with drawing closer to God. Notice that two of the options are both associated with religion. The word “healing” in one option is a hint if it is associated with the words in the stem “motor vehicle accident.”

front 226

The nurse is caring for a mother who has just delivered a stillborn baby. What would be the most therapeutic comment by the nurse to this grieving mother?

"Tell me about your pregnancy experience."

"You are young and will have other children."

"You have an angel in heaven watching over you now."

"Nature has a way of getting rid of the imperfect."

back 226

"Tell me about your pregnancy experience."

The nurse must help the mother actualize the loss by encouraging her to talk about it. Advice and clichés are inappropriate and not comforting.

front 227

A client of Chinese descent is admitted with the diagnosis of generalized anxiety disorder. The client is unable to provide self-care. Based on the cultural belief of yin and yang, to what should the nurse expect the client’s family to attribute this illness?

Yin, the negative force that represents darkness, cold, and emptiness

Yang, the positive force that represents light, warmth and fullness

A failure to use homeopathy correctly

Too many hot spicy foods and herbs

back 227

Yin, the negative force that represents darkness, cold, and emptiness

According to Chinese folk medicine, health is represented as a balance of yin and yang. Yin is the negative female force characterized by darkness, cold and emptiness; excessive yin predisposes one to nervousness. Notice that the content of this question “yin and yang” appears in two of the options. Because the client is experiencing more negative items (“anxiety” and “cannot care for self”), eliminate the “positive force” in the one option and select the "negative force" option as the correct answer.

front 228

A client talks about being upset after electroconvulsive therapy (ECT) because of the side effect of confusion. In the post ECT phase, the client reports losing money and an inability to remember telephone numbers. What would be the most therapeutic response by the nurse?

"The confusion will clear up within 48 to 72 hours each time."

"I can understand that the confusion is upsetting to you."

"Your illness indicates that you needed the treatments."

"We will develop a plan to prevent money and memory loss."

back 228

"I can understand that the confusion is upsetting to you."

Communicating caring and empathy while acknowledging the client's feelings is the most appropriate and therapeutic response. Developing a plan for dealing with the effects of memory loss can be done later if it is agreed upon by the client.

front 229

An Hispanic couple confides in the nurse about their concern with staff giving their newborn the "evil eye." What should the nurse communicate to the other personnel who are involved in the care of this family?

Bless the newborn while speaking to the child

Avoid touching the newborn

Touch the newborn after looking at the child

Look only at the parents and not the newborn

back 229

Touch the newborn after looking at the child

In many cultures, an "evil eye" is cast when looking at a person without touching. Thus, the spell is broken by touching while looking or assessing. Remember that quotations in the stem of the question are often the most important content in the question (evil eye). You should make the association between the words “looking” and “seeing” (eye). Also note that the answer needs to refer to the newborn, not the parents (“give the newborn the evil eye”).

front 230

The nurse is caring for a client who is being treated for major depressive disorder. During which period of time would the nurse expect the client to be at the highest risk for attempting suicide?

Within 72 hours after admission, while in one-to-one observation

When the client refuses to participate in group therapy sessions while hospitalized

After an angry outburst with family members over some insignificant issue

Within one to two weeks after initiation of antidepressant medication and psychotherapy

back 230

Within one to two weeks after initiation of antidepressant medication and psychotherapy

As the findings of depression decrease due to treatment, the client may acquire the energy to develop a plan and follow through with a suicide attempt. Sudden changes in behavior, such as excessive happiness, are indicators that a client may have decided on a suicide plan.

front 231

The nurse observes a client with a diagnosis of obsessive-compulsive disorder on an inpatient unit. Which behavior is consistent with this medical diagnosis?

Repetitive, involuntary movements

Verbalized suspicions about thefts on the unit

Preference for consistent caregivers

Repeatedly checking that a door is locked

back 231

Repeatedly checking that a door is locked

Obsessive-compulsive disorder is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to perform certain actions (compulsions.) People know their thoughts and behaviors don't make sense, but they are often unable to stop them. Verbalized suspicions reflect a paranoid thought process. Repetitive, involuntary movements are characteristic of some antipsychotic medication side effects.

front 232

The child with this disorder has difficulties with social interaction and verbal and nonverbal communication and also exhibits repetitive behaviors.

back 232

A child with autism spectrum disorder (ASD) has difficulty with social interactions and verbal and nonverbal communication; the child also exhibits repetitive behaviors. ASD is considered a neurodevelopmental disorder.

front 233

This disorder includes Alzheimer’s disease, traumatic brain injury and Huntington’s disease.

back 233

This group of disorders was formerly referred to as “dementia, delirium, amnestic and other cognitive disorders."

front 234

Malabsorption syndrome and Wernicke-Korsakoff syndrome are associated with this disorder.

back 234

Nutritional deficiencies are common among clients who suffer from chronic alcohol abuse and are related to malabsorption of fat, nitrogen, sodium, water, thiamine, folic acid and vitamin B12. Wernicke-Korsakoff syndrome (also called Wernicke encephalopathy) is caused by a lack of thiamine (vitamin B1).

front 235

A client with this disorder experiences hallucinations and delusional thoughts.

back 235

A client with schizophrenia experiences hallucinations and delusional thoughts. There are different types of schizophrenia, but often the client is unable to think rationally, communicate properly, make decisions or remember information.

front 236

A client with this disorder recognizes their behavior is excessive and unreasonable but cannot stop the behavior.

back 236

Clients with obsessive compulsive disorder (OCD) cannot control their obsessions and/or compulsions, even though they recognize that they are unreasonable or excessive.

front 237

“Drug holidays” are sometimes used in the management of this disorder.

back 237

A drug holiday refers to the deliberate interruption of pharmacotherapy for a defined period and for a specific clinical purpose. Sometimes a clinician will give a child with attention deficit hyperactivity disorder (ADHD) a "vacation" from medications on weekends or during summer break from school.

front 238

A client with this disorder may experience drastic changes in mood accompanied by extreme changes in energy, activity, sleep and behavior.

back 238

Clients with bipolar disorder may experience mood swings ranging from mania to depression, with periods of normal mood and activity in between. Sometimes the mood swings can be unusually intense or extreme; at other times, they are less extreme.

front 239

Russell’s sign is observed with this disorder.

back 239

A person who repeatedly self-induces vomiting will have scraped or raw areas on the knuckles. Bulimia nervosa is a type of eating disorder that involves binging (eating large amounts of food) and purging (vomiting).

front 240

Electroconvulsive therapy (ECT) is used to treat a severe form of this disorder.

back 240

ECT can be used as a treatment for severe depression when medication does not ease the symptoms of clinical depression. ECT is not a cure for depression. ECT can also be used to treat clients with symptoms of delusions, hallucinations or suicidal thoughts.

front 241

The only FDA-approved type of medications used to treat this disorder are selective serotonin reuptake inhibitors (SSRIs.)

back 241

Sertraline (Zoloft) and paroxetine (Paxil) are FDA-approved to treat PTSD. Other medications may be used off-label or as adjunct treatment. For example, prazosin (Minipress) may be used to decrease nightmares.

front 242

Religious beliefs influence decisions about health.

T/F

back 242

True

Religious beliefs impact all aspects of a client's life, including health and illness. Research supports that worship and prayer contribute to positive emotions, including hope and spiritual contentment.

front 243

Nurses must be aware of their own cultural values and beliefs to avoid biases when providing care to clients.

T/F

back 243

True

Nurses must be aware of and sensitive to the cultural needs and beliefs of their clients and their families, as well as themselves. Nurses must engage in self-awareness and critical reflection of their own beliefs to provide culturally sensitive care to all clients. This is especially true when caring for clients with mental health disorders because biases can hinder the therapeutic relationship.

front 244

The nurse should write everything down for the client with Wernicke's aphasia.

T/F

back 244

False

Clients with Wernicke's aphasia may have no understanding of language in any modality – spoken or written. They can speak, but what they say makes no sense. Communication may be more effective using non-verbal techniques, such as actions, movements, props and gestures.

front 245

Mental health disorders and substance use disorder rarely occurs together.

T/F

back 245

False

Mental health problems can often lead to alcohol or drug use and abuse. Many clients who suffer from substance use disorder are also diagnosed with mental health disorders (and vice versa). Mental and substance use disorders share some underlying causes, including changes in brain composition, genetics and early exposure to stress and trauma.

front 246

Liquid medications are best for clients who are on suicide precautions.

T/F

back 246

True

Although the nurse can inspect the client's mouth after giving oral medications in tablet form, medications given in oral liquid form can prevent the client from hiding and hoarding medications.

front 247

Stress activates the parasympathetic nervous system.

T/F

back 247

False

Stress activates the sympathetic nervous system (norepinephrine and epinephrine) and the endocrine system (especially the pituitary gland). The sympathetic nervous system is responsible for stimulating the "fight-or-flight" response often associated with stress. The process under which the body confronts stress is the General Adaptation Syndrome.

front 248

Primitive defense mechanisms are very effective for long-term use.

T/F

back 248

False

People use defense mechanisms to protect themselves from things they don't want to think about or deal with. Primitive defense mechanisms, such as denial, regression, acting out and projection, are often used by children and can have short-term advantages, but become less effective when used long term.

front 249

The grieving process lasts for approximately one year.

T/F

back 249

False

The time span of the grieving process varies and there is no set time limit for how long an individual grieves. Also, the stages of grieving are not linear; they may pass and later return.

front 250

Only young clients suffer from abuse.

T/F

back 250

False

Abuse can affect clients across the lifespan, from children to older adults. Abuse can be physical, emotional or sexual. Depending on the jurisdiction, nurses may be mandated to report elder abuse; all U.S. states have enacted laws and policies related to child abuse and neglect.

front 251

The nurse-client relationship is a mutually defined, social relationship.
T/F

back 251

False

Although mutually defined, the nurse-client relationship is time-limited, goal-directed and bounded by standards of care and of professional practice. It is not a social relationship. In fact, one of the blocks to therapeutic communication is the social response.

front 252

The client had a long leg hinged cast applied following surgery to realign a fractured tibia. When the client returns from surgery, what initial intervention to increase mobility will be reinforced?

Full active range of motion of the knee

Muscle-setting exercises

Partial weight-bearing exercises with crutches

Call for assistance before transferring to the wheelchair

back 252

Muscle-setting exercises

The client will use crutches (or a walker) and will be non-weight bearing for up to 12 weeks or until the tibia fracture has healed. Active and passive range of motion exercises will be prescribed, but initially, the nurse should encourage the client to perform basic isometric exercises like quadriceps setting, wiggling the toes and ankle exercises. When the cast is dry, the client can be allowed up in a chair or wheelchair with the leg elevated.

front 253

The nurse is caring for a client who is paralyzed. What observation of the client would indicate the probable presence of a fecal impaction?

Semisoft to liquid stools

Oozing liquid stool

Continuous rumbling flatulence

Absence of bowel movements

back 253

Oozing liquid stool

When the bowel is impacted with hardened feces, there is often a frequent seepage of brownish liquid around the obstruction. This is often mistaken for uncontrolled diarrhea. Be careful to report only the objective facts; for example, the the client is oozing brownish liquid from the rectum.

front 254

The nurse is caring for an infant with six teeth. What is the best way for the nurse to give mouth care to this infant?

Brush with a little toothpaste and floss each tooth

Offer a bottle of water for the infant to drink

Swab the teeth and gums with a flavored mouthwash

Use a moistened soft brush or cloth to clean the teeth and gums

back 254

Use a moistened soft brush or cloth to clean the teeth and gums

The nurse should use a soft cloth or soft brush to perform mouth care so that the infant can adjust to the routine of cleaning the mouth and teeth. You will note that two of the options refer to "brush" the teeth, but that the word "soft" is used in the correct option (which would make sense because the client is an infant). Based on the number of teeth, this infant is most likely between 8 and 12 months of age.

front 255

A 69 year-old client states that he experiences the passage of hard dry stools at least twice a week. To improve bowel function, the nurse should suggest that the client take which of these actions first?

Use a chemical laxative occasionally

Increase fiber intake to include 20 to 30 grams daily

Avoid binding foods such as cheese and chocolate

Monitor the balance between activity and rest

back 255

Increase fiber intake to include 20 to 30 grams daily

Incorporating high-fiber foods, especially whole grains, fruits and vegetables, into the diet is the first step in improving bowel function. For someone eating 2000 calories a day, this would work out to be about 25 grams of fiber. The client should also increase fluid intake. Changing a person's diet should reduce the need for chemical laxatives.

front 256

A nurse is providing care to a 75 year-old adult client diagnosed with bilateral pneumonia. Which intervention will best promote the client’s comfort?

Increase oral fluid intake

Keep conversations short

Monitor vital signs frequently

Encourage visits from family and friends

back 256

Keep conversations short

Keeping conversations short will promote the older adult client’s comfort by decreasing the demands on the client’s breathing and energy. Increased intake of fluids is not related to comfort. While the presence of family is supportive, demands on the client to interact with the visitors may interfere with the client’s rest. Monitoring vital signs is an important assessment but not related to promoting the client’s comfort.

front 257

A 2 year-old child is brought to the pediatrician's office with a report of mild diarrhea for two days. Nutritional counseling by the nurse would reinforce which information?

Place the child on clear liquids and gelatin for 24 hours

Place NPO for 24 hours, then rehydrate with liquids

Give bananas, apples, rice and toast as tolerated

Continue with a regular diet and include oral electrolyte replacement drinks

back 257

Continue with a regular diet and include oral electrolyte replacement drinks

Current recommendations for mild to moderate diarrhea are to maintain an age-appropriate diet and include rehydration fluids. Some doctors now recommend the CRAM diet (cereal, rice and milk) because milk provides fat and protein and the CRAM foods are shown to ease diarrhea faster. The BRAT diet, consisting of bananas, rice, applesauce, and toast or tea, should be avoided for children with acute gastroenteritis because it is low in energy foods, protein and fat. Both the CRAM and BRAT diets require oral hydration therapy.

front 258

The client is grimacing, crying and reports having pain. What is the first step the nurse should take when collecting data about the client's pain?

Ask the client to indicate the location of the pain

Accept the client’s report of pain

Have the client identify coping methods

Determine the severity and duration of pain

back 258

Accept the client’s report of pain

Although all of the actions are correct, the first and most important piece of information for data collection is to accept what the client is telling about the pain, i.e., “the client’s report.”

front 259

During a 12-hour shift, a client who underwent a transurethral resection of the prostate (TURP), had an IV intake of 1200 mL, oral intake of 400 mL, continuous bladder irrigation of 2400 mL, 2 syringe flushes of 50 mL each, and indwelling urinary catheter output of 3000 mL.
What is the end of shift fluid intake? (Write the answer using a whole number.)

back 259

4100mL.

(1200 mL + 400 mL + 2400 mL + 100 mL) = 4100 mL. The amount of irrigation fluid must be included in intake; only the urine collected from the indwelling urinary catheter is considered output.

front 260

The client is diagnosed with Ménière's disease. The nurse should reinforce that the client modify the diet by avoiding foods high in which substance?

Carbohydrates

Fiber

Calcium

Sodium

back 260

Sodium

The client with Meniere's disease has an excess accumulation of fluid in the inner ear. A low sodium diet will aid in reduction of the fluid. If you are not sure about which answer to select, look at the "similar/dissimilar" options; in this case, it's the two minerals: calcium and sodium. Then you should consider which mineral is typically restricted in diets: calcium or sodium?

front 261

A client diagnosed with heart failure has been instructed about proper nutrition associated with the disease process. The selection of which lunch items by the client indicates that the client has learned about sodium restriction?

Leftover turkey on a sandwich and fresh pineapple

Mushroom pizza and ice cream

Grilled cheese sandwich with a glass of 2% milk

Cheeseburger and baked potato chips

back 261

Leftover turkey on a sandwich and fresh pineapple

A turkey sandwich using leftover turkey (as opposed to sliced lunch meat) is appropriate because it is not a highly processed food and fresh pineapple has low sodium. Any food with more than 480 mg of sodium per serving should be considered a high-sodium food. A sodium restricted diet should consist of less than 2 grams of sodium per day. A regular diet should include 4 to 6 grams of sodium per day. All the other choices contain one or more high-sodium foods.

front 262

The nurse is reviewing proper nutrition with a client who has a history of emphysema. Which action should the clinic nurse emphasize to the client?

Cleanse the mouth of dried secretions to reduce the risk of infection

Perform exercises after respiratory treatments to enhance appetite

Eat foods high in sodium to increase sputum liquefaction

Use oxygen during meals to minimize oxygen deficits

back 262

Use oxygen during meals to minimize oxygen deficits

Clients with emphysema breathe easier with the use of oxygen during eating. This allows adequate oxygen for digestion as well as general cellular needs. Clients with emphysema should also limit salt intake; too much sodium can cause fluid retention that may interfere with breathing.

front 263

The nurse is reinforcing foot care instructions to a client with a history of arterial insufficiency of the legs. The nurse should identify which client's statement as incorrect?

"I will trim corns and calluses regularly."

"I will ask a family member to help inspect my feet."

"I can only wear cotton socks."

"I should not go barefoot around my house."

back 263

"I will trim corns and calluses regularly."

Clients who have diabetes mellitus, and/or have arterial peripheral vascular disease, often have decreased circulation and sensation in one or both feet. With older adults vision may also be impaired. Therefore, these clients need to be taught to examine their feet daily or have someone else do so. They should wear cotton socks that have not been mended and always wear shoes or slippers when out of bed. They should not cut their toenails, corns and calluses by themselves; they should have them trimmed by providers who specialize in foot care.

front 264

The client is diagnosed with type 2 diabetes. What information about diet should the nurse reinforce with the client?

Keep a candy bar available for hypoglycemic episodes

Continue the same caloric intake but cut down on complex carbohydrates

Reduce intake of carbohydrates to 30% and intake of protein to 15%

Improve food choices but continue a regular schedule of meals and snacks

back 264

Improve food choices but continue a regular schedule of meals and snacks

Currently, calorie-controlled diets with strict meal plans are rarely suggested for clients who are diagnosed with diabetes mellitus. Plan to incorporate food changes into the client's existing dietary patterns. Clients need to learn how to read labels and identify specific canned foods, frozen entrees, or other foods that are acceptable and those that should be avoided because of additives. No specific percentage of fats, protein or carbohydrates is generally recommended.

front 265

An 82 year-old client reports being unable to completely empty the bladder and feeling bloated and uncomfortable. What additional finding does the nurse expect and need to report to the health care provider right away?

Inadequate fiber in the diet

Excess abdominal fat

Acid reflux and indigestion

Fecal impaction

back 265

Fecal impaction

Obstruction of the urethra causes urinary retention by blocking the normal flow of urine out of the body. Elderly clients with acute urinary retention often have severe constipation or fecal impaction. The combination of a full bladder and constipation will cause abdominal bloating and discomfort. Many other conditions can cause urinary obstruction, including benign prostatic hyperplasia in men, organ prolapse in women, urinary tract stones, and tumors. The bloating could be attributed to extra tummy fat and indigestion, but these would not cause urinary retention. Although inadequate fiber intake can cause constipation, the greater priority is treating the fecal impaction.

front 266

The client is diagnosed with cystic fibrosis (CF). The nurse would expect the client to be treated with oral pancreatic enzymes and which type of diet?

Dairy-free

Gluten-free, low fiber

Sodium-restricted

High fat, high-calorie

back 266

High fat, high-calorie

CF affects the cells that produce mucus, sweat and digestive juices. Someone with CF needs a high-energy diet that includes high-fat and high-calorie foods, extra fiber to prevent intestinal blockage and extra salt (especially during hot weather.) People with CF are at risk for osteoporosis and need calcium and dairy products. Someone with celiac disease or with a gluten intolerance, not CF, needs a gluten-free diet.

front 267

The mother of a 3 month-old infant tells the nurse, “I want to change from formula to whole milk and add cereal and meats to my infant’s diet.” What should be emphasized as the nurse reinforces information about correct infant nutrition?

Solid foods should be introduced at three to four months

Tap water with fluoride should be used to dilute the milk

Supplemental apple juice can be used between feedings

Whole milk is difficult for a younger infant to digest

back 267

Whole milk is difficult for a younger infant to digest

Cow's milk is generally not given to children less than one year old because it is difficult to digest. Also, it contains little iron and creates a high renal solute load. Solid food introduction varies by health care provider, but it is usually started between 4 and 6 months of age. Water with fluoride is recommended for the prevention of dental caries. Apple juice is not considered a supplement, but rather a clear liquid with little nutritional value other than being a liquid with sugars.

front 268

A 14 month-old child had cleft palate surgical repair several days ago. Which lunch selected by the parents is the best example of an appropriate meal?

Baked chicken, applesauce, cookie, milk

Peanut butter and jelly sandwich, chips, pudding, milk

Soup, blenderized soft foods, ice cream, milk

Hot dog, carrot sticks, gelatin, milk

back 268

Soup, blenderized soft foods, ice cream, milk

In a child with cleft palate repair, the parents should prepare soft foods and avoid those foods with particles that might traumatize the surgical site. The key to answering this question is to pay attention to the age of the child. Also, focus on the words "best" and "cleft palate repair several days ago." Only the correct answer has all "soft" foods in the response.

front 269

An obese client tells the nurse: "I just started a diet and I am eating no more than 800 calories a day." What information is most important for the nurse to know in order to therapeutically respond to this statement?

This diet is classified as low calorie and adequate if balanced with 1 meat, 1 fruit, and 2 fat exchanges

Very low-calorie diets often have severe and irreversible side effects

A very low-calorie diet is never a successful weight loss program and should be discouraged

Individuals following a very low-calorie diet need professional monitoring

back 269

Individuals following a very low-calorie diet need professional monitoring

A very low-calorie diet (VLCD) is a short-term weight loss method for obese people (BMI greater than 30) and can result in a loss of about 3 to 5 pounds per week. Anyone considering this type of diet should be under the care of health professionals. VLCDs are generally considered safe and common side effects (such as fatigue, constipation or diarrhea) are usually minor and improve within a few weeks. Of course, the best way to maintain weight loss is through a combination of behavioral therapy, exercise and more modest dietary restrictions. The exchange diet, which groups food together by nutritional content, is typically reserved for individuals with diabetes.

front 270

The nurse is caring for a preschooler who has the left leg in balanced skeletal traction. Which activity would be an appropriate diversional activity?

Play electronic hand-held games

Play "Simon Says"

Kick balloons with right leg

Throw bean bags

back 270

Play electronic hand-held games

Immobilization with traction must be maintained until bone ends are in satisfactory alignment. Activities that increase mobility interfere with the goals of treatment.

front 271

The nurse documents “effective use of guided imagery to change report of pain from a 4 to a 1.” Which definition best describes this technique?

Closing the eyes to focus on the back of the eyelids or a blank screen

Inhalation to a count of four and exhalation to a count of four

Focusing on pleasant mental pictures of a relaxing scene

Repetition of a word to oneself while thinking of only the word

back 271

Focusing on pleasant mental pictures of a relaxing scene

Guided imagery is a technique that uses pleasant mental visuals of a relaxing scene that can be recalled by the client to reduce stress, anxiety or pain. Repeating a word to oneself describes meditation. Closing the eyes and focusing on a blank screen is also a form of meditation; a person uses a mental picture of a blank black screen and attempts to think of nothing. Counting while breathing is considered slow deep breathing.

front 272

Neuropathic pain is also called musculoskeletal pain.

T/F

back 272

False

Somatic pain is also known as musculoskeletal pain because it originates in tissues such as the skin, muscle, joints, bones and ligaments. Neuropathic pain originates from the nervous system.

front 273

The client with a sigmoid colectomy will have semi-liquid stool collect in a colostomy bag.

T/F

back 273

False

A colectomy is the primary treatment for colon cancer. The cancerous part of the large intestine is removed and the remaining bowel is joined together (anastomosis). The client will not need a colostomy. Bowel movements may be more frequent after a colectomy.

front 274

A 7-year-old child can be taught to self-catheterize him or herself.

T/F

back 274

True

Children with neurogenic bladder complications or spina bifida may successfully learn self-catheterization as young as 6 or 7. Training initially starts with performing the procedure using a doll.

front 275

Urinary incontinence is a normal part of aging.

T/F

back 275

False

Urinary incontinence is not normal, regardless of the client's age. Kegel exercises, medications (anticholinergics, topical estrogen), medical devices (pessary), or surgery (sling procedures, bladder neck suspension) can help to counteract incontinence.

front 276

The nurse will hold a tube feeding when the gastric residual is greater than 100-150 mL.

T/F

back 276

False

If the residual volume exceeds the amount of formula given in the previous 2 hours, it may be necessary to consider reducing the rate of the feeding. Current protocols state not to stop feedings unless there are other signs of intolerance (such as bloating, abdominal pain, emesis or nausea).

front 277

A client with gout is prescribed a pureed diet.

T/F

back 277

False

Clients with gout should eat a low-purine diet because purines are turned into uric acid, which aggravates the symptoms of gout. Almost any food contains purines: organ meats, anchovies and sardines in oil, mushrooms, spinach, dried beans and peas contain higher levels. The pureed diet is indicated when chewing or swallowing is difficult or causes discomfort.

front 278

The thirst center is located in the parathyroid gland.

T/F

back 278

False

A dry mouth and dehydration will activate the thirst center, which is located in the hypothalamus. As a result, there will be a conscious desire to drink. There will also be a series of subconscious steps to correct the dehydration, including vasopressin secretion by the pituitary gland.

front 279

Complementary & integrated health therapies replace the need for pharmacologic interventions.

T/F

back 279

False

Complementary & integrated health therapies are widely used among clients for various disorders and are often used in conjunction with medical treatment. Pain management may consist of pain medication, as well as relaxation or acupuncture. Complementary & integrated health therapies may also be effective at reducing anxiety, improving mood and increasing a client's sense of control over the environment.

front 280

Iron is one of the macrominerals found in a healthy human body.

T/F

back 280

False

Iron is considered a trace mineral. The seven major minerals are: calcium, magnesium, sodium, potassium, phosphorus, sulfur and chlorine.

front 281

The client using a cane should hold it on his strong side and move the cane at the same time as the weaker leg.

T/F

back 281

True

A cane can provide stability when walking. The standard cane is fine if it's only needed for balance but if the client needs the cane to bear weight, an offset cane with four tips might be best.

front 282

Clients with insomnia either have difficulty falling asleep or staying asleep.

T/F

back 282

True

Insomnia is a sleep disorder. There are 2 types of insomnia: primary and secondary.

front 283

Glucose is the only fuel used by brain cells.

T/F

back 283

True

Although most energy needs could be met by fats and proteins, the brain requires carbohydrates, specifically glucose. Neurons need a constant supply of glucose since they cannot store it.

front 284

Less than 4 to 8 wet diapers a day may be a sign of dehydration in a baby.

T/F

back 284

True

Babies should have a minimum of 4 to 8 wet diapers a day. Babies can become quickly dehydrated. Other signs of dehydration in infants include sunken fontanels, decrease or absence of tears, dry mouth and irritability.

front 285

Women who are planning on becoming pregnant need about 200 ug/day of folic acid.

T/F

back 285

False

Prior to conception and during early pregnancy, women need to add 400 ug of folic acid (vitamin B9) each day. Research has demonstrated this significantly reduces the risk of neural tube defects.

front 286

Protein is the body's only source of nitrogen.

T/F

back 286

True

In a healthy client, a nitrogen balance is achieved when dietary intake is balanced by excretion of urea wastes. A negative nitrogen balance occurs if excretion is greater than the nitrogen content of the diet, as seen in burns, infections, injuries, fever or starvation.

front 287

The nurse can use the deltoid muscle, vastus lateralis muscle, ventrogluteal muscle and dorsogluteal muscle to administer an intramuscular injection.

T/F

back 287

False

The accepted sites for intramuscular injections include the deltoid muscle, vastus lateralis muscle and ventrogluteal muscle. The dorsogluteal muscle should not be used for IM injections due to the risk of sciatic nerve damage.

front 288

Hypovolemia is a risk for the client receiving whole blood products.

T/F

back 288

False

Hypervolemia (circulatory or fluid overload) develops when too large a volume of blood is given too quickly. To avoid hypervolemia, blood products should be infused at a rate no faster than 2 to 4 mL/kg/hour (but not to exceed a 4 hour hang time).

front 289

The nurse can crush the oral medication disopyramide CR and mix it with applesauce.

T/F

back 289

False

CR means 'controlled release' and this medication must not be crushed. Do not crush any oral medication that ends in the following abbreviations: CR (controlled release), CD (controlled delivery), LA (long acting), SR (sustained release), XL (extended release), XR (extended release) or XT (extended release).

front 290

Clients increase their risk of adverse effects if they use herbal supplements along with prescription medications.

T/F

back 290

True

There is an inherent risk of adverse effects when a client combines herbal agents with prescription drugs. Because herbal remedies have drug actions of their own, the client taking prescription drugs should not take herbal supplements or over-the-counter drugs until they have discussed these with their health care providers.

front 291

Lactated Ringer's (LR) solution is a hypotonic fluid.

T/F

back 291

False

Lactated Ringer's is an isotonic fluid solution used in many different clinical situations, including fluid resuscitation. An example of a hypotonic fluid is 0.45% sodium chloride.

front 292

An elderly client is more sensitive to the active substance in a transdermal patch than a younger adult.

T/F

back 292

True

Transdermal medication application requires adequate tissue perfusion to absorb and distribute the medication. Skin permeability varies based on hydration, temperature, age (the skin of babies and the elderly is more permeable than that of other age groups) and ethnicity (the skin of Caucasians is more permeable than that of African Americans). Therefore an older client would be more sensitive to medication administered this way than a younger adult.

front 293

A nurse should ask a client with emphysema to bear down during the insertion of a non-tunneled central venous catheter (CVC).

T/F

back 293

True

Intravenous pressure must exceed atmospheric pressure during CVC insertion to prevent air from entering the catheter and traveling to the heart and lungs. Any client, regardless of his or her diagnosis, should be asked to bear down during CVC insertion.

front 294

Examples of Schedule I medications include morphine and secobarbital.

T/F

back 294

False

Schedule I drugs have no medical use and there is a high potential for abuse. Examples of Schedule I drugs include heroin and LSD. While morphine and short-acting barbiturates like secobarbital also have a high risk for abuse, they also have safe and accepted uses; they are examples of Schedule II drugs.

front 295

Sublingual medications avoid the first-pass effect.

T/F

back 295

True

Medications given sublingually and rectally bypass metabolism by gastrointestinal and hepatic enzymes. When a medication is given orally, the amount of available medication is reduced before it reaches the general circulation due to the first-pass effect.

front 296

The nurse applies mild pressure to the inner canthus of the eye after instilling eye drop medication.

T/F

back 296

True

Applying pressure to the inner aspect of the eye for about a minute or so helps decrease systemic absorption of the medication.

front 297

Furosemide is a potassium-sparing diuretic.

T/F

back 297

False

Furosemide is a loop diuretic. It inhibits absorption from the ascending loop of Henle in the renal tubule. It is used to treat pulmonary edema, chronic heart failure, hypertension and other conditions of the liver and kidneys.

front 298

Ondansetron is given to prevent nausea and vomiting caused by cancer chemotherapy.

T/F

back 298

True

Ondansetron is in a class of medications called serotonin 5-HT3 receptor antagonists. It blocks the action of serotonin, a substance that may cause nausea and vomiting.

front 299

Propofol is a long-acting sedative used for many surgical procedures.

T/F

back 299

False

Propofol is a short-acting sedative. It takes effect very quickly and provides sedation for less than 10 minutes in most clients. It is often used for conscious sedation for outpatient procedures.

front 300

For clients at risk for cardiovascular disease, the usual oral daily dose of aspirin is 2 tablets (650 mg total).

T/F

back 300

False

Aspirin is a potent antiplatelet medication but it can cause significant side effects when taken in large amounts. Most health care providers will order a daily dose of 81 mg (the amount in a baby aspirin) to 325 mg.

front 301

Calcium channel blockers can cause severe constipation in older adults.

T/F

back 301

True

Calcium channel blockers include amlodipine, diltiazem and verapamil and are used to treat hypertension. Other antihypertensives that do not cause severe constipation should be considered for older adults.

front 302

Regular insulin intravenous infusions are mixed in 5% dextrose in water.

T/F

back 302

False

Normal saline is used to infuse IV insulin. Regular insulin is the only insulin that can be given intravenously.

front 303

The client should use a dry-powder inhaler as rescue therapy during acute asthma attacks.

T/F

back 303

False

Dry-powder inhalers are contraindicated for acute asthma attacks because they do not deliver rapidly acting medication for bronchodilation. Rescue therapy may include albuterol (salbutamol-Canada) or epinephrine.

front 304

To help reduce stomach upset, a client can take an antacid at the same time as almost any other oral medication.

T/F

back 304

False

Antacids can reduce the absorption of many medications. It is recommended to take an antacid at least 1 hour before or 2 hours after taking other medications.

front 305

The client taking chlorpromazine should avoid saunas and temperature extremes.

T/F

back 305

True

Chlorpromazine impairs body temperature regulation, so the client should avoid temperature extremes (e.g., exercise, hot weather, hot baths, showers, or saunas).

front 306

Clients receiving organ transplants are often started on cyclosporine after surgery.

T/F

back 306

True
t
Cyclosporine is an immunosuppressant; it is commonly used, along with other medications, to prevent transplant rejection. It may also be used to treat clients with rheumatoid arthritis and psoriasis.

front 307

The nurse instructs the client to take no more than 2 extra-strength acetaminophen tablets (1000 mg) 4 times a day.

T/F

back 307

True

The maximum dose of acetaminophen is 4 grams (4000 mg) in 24 hours. Hepatotoxicity can occur when the client exceeds the maximum dose.

front 308

The client should take levothyroxine immediately after breakfast.

T/F

back 308

False

Levothyroxine is a thyroid hormone used to treat hypothyroidism. This medication should be taken on an empty stomach, 30 to 60 minutes before breakfast.

front 309

The nurse should check the international normalization ratio (INR) lab results prior to hanging intravenous heparin.

T/F

back 309

False

The INR or prothrombin time (PT) is performed to monitor therapeutic warfarin levels. The nurse should check the partial thromboplastin time (PTT) and/or the plasma heparin concentration (anti-factor Xa assay) lab results for the client receiving IV heparin.

front 310

Extended-release oral potassium chloride (KCl) should be taken with meals and a full 8-ounce (236 mL) glass of water.

T/F

back 310

True

Oral potassium chloride (KCl) should be taken with meals and a full 8-ounce (236 mL) glass of water or juice to reduce its possible stomach-irritating or laxative effects. The client should not chew or suck the extended-release tablet.

front 311

Naloxone is used to counteract the respiratory depression associated with barbiturate overdose.

T/F

back 311

False

Naloxone is used to reverse the effects of narcotic (opioid) depression. It is not effective in counteracting depression due to barbiturates, tranquilizers or other non-narcotic anesthetics or sedatives.

front 312

What is the drug classification for: risedronate

back 312

Bone Resorption Inhibitors bind to hydroxyapatite in bone and inhibit bone resorption by decreasing the number and activity of osteoclasts.

They are primarily used in the prevention and treatment osteoporosis in postmenopausal women; they are also used to treat osteoporosis due to other causes, e.g., Paget's disease of the bone and corticosteroid therapy.

front 313

What is the drug classification for: infliximab

back 313

Some Antirheumatics relieve pain (analgesics), some reduce inflammation (NSAIDs & steroids), while others control the underlying disease (disease modifying rheumatoid arthritis drugs or DMARDs & biologic drugs, like infliximab).

DMARDs are used as long-term solutions to control symptoms of rheumatoid arthritis by slowing down joint destruction and preserving joint function. Biologic agents (IM or IV only) target specific components of the immune system; biologic agents may be used alone, but are often given with other DMARDs to increase the benefits and limit potential side effects.

front 314

What is the drug classification for: benazepril

back 314

ACE Inhibitors slow the activity of the enzyme angiotensin converting enzyme (ACE), which decreases the production of angiotensin II. As a result, blood vessels relax and dilate, blood pressure is lowered, and more oxygen-rich blood can reach the heart.

They are primarily used to control blood pressure, treat heart failure, and to help prevent strokes.

front 315

What is the drug classification for: isoniazid (INH)

back 315

Antituberculars have various actions that affect mycobacteria, with most having bactericidal (for example, rifampin) and/or bacteriostatic (for example, isoniazid) actions.

They used in the treatment and prevention of tuberculosis (TB).

front 316

What is the drug classification for: mannitol

back 316

Osmotic Diuretics are low-molecular-weight substances that produce a rapid loss of sodium and water by inhibiting their reabsorption in the kidney tubules and the loop of Henle. They also increase the osmolality of plasma, which increases diffusion of water from the intraocular and cerebrospinal fluids.

They are mainly used in the management of cerebral edema to decrease intracranial pressure.

front 317

What is the drug classification for: nifedipine

back 317

Calcium Channel Blockers (CCBs) slow the rate at which calcium passes into the heart muscle and into the vessel walls; this relaxes the vessels and allows blood to flow more easily through them, thereby lowering blood pressure.

They are used to treat hypertension, angina, and abnormal heart rhythms (atrial fibrillation, paroxysmal supraventricular tachycardia). They are also used for client post-MI who cannot tolerate beta-blockers.

front 318

What is the drug classification for: metoprolol

back 318

Beta Blockers block norepinephrine and epinephrine from binding to beta receptors on nerves. By blocking the effects of these neurotransmitters, they reduce heart rate and reduce blood pressure by dilating blood vessels.

They are used to treat hypertension; heart failure; arrhythmias; angina (but not for immediate relief); glaucoma (ophthalmic); sometimes used in heart attack patients to prevent future heart attacks; also used prophylactically for migraine headaches.

front 319

What is the drug classification for: potassium bicarbonate & potassium citrate

back 319

Minerals/electrolytes/pH modifiers are taken to correct imbalances of substances in the blood (minerals and electrolytes) or to make the urine more alkaline (pH modifiers).

They are used in the prevention and treatment of any deficiencies or excesses of electrolytes. Acidifiers and alkalinizers are also used to prevent crystals from forming in the urine and inhibit the formation of kidney stones. Magnesium sulfate is used for pre-eclampsia and eclampsia. Some of these meds are used to neutralize gastric acid.

front 320

What is the drug classification for: celecoxib

back 320

Non-steroidal Anti-inflammatory Drugs (NSAIDs) block the cyclooxygenase (COX-1 & COX-2) enzymes and reduce prostaglandins throughout the body, thereby reducing inflammation, pain, and fever.

They are used to control mild-to-moderate pain, reduce fever, and to treat various inflammatory conditions, such as osteoarthritis.

front 321

What is the drug classification for: fentanyl

back 321

Opioid Analgesics interact with opioid receptors in the central nervous system, acting as agonists of endogenously occurring opioid peptides (eukephalins and endorphins); this action alters perception and response to pain. They can be categorized as long-acting, short-acting, or rapid-onset agents. Fentanyl is a rapid-acting and long-acting Opioid Analgesic approved for cancer breakthrough pain. They are all Schedule II drugs.

They are used in the management of moderate-to-severe pain.

front 322

What is the drug classification for: acyclovir

back 322

Antivirals are designed to work in one of two ways - they either inhibit the ability to multiply or they mimic the virus attachment protein, disrupting the replication process.

They are commonly used in the management, prevention, and/or treatment of viral infections, such as HIV, herpes simplex and cytomegalovirus, pneumonia, measles and mumps, and influenza strains (including swine flu).

front 323

What is the drug classification for: glimepiride

back 323

Some Oral Antidiabetic Agents (sulfonylureas and meglitinides) work by stimulating insulin release from the beta cells of the pancreas - glipizide is a sulfonylurea. Other (biguanides) improve insulin's ability to move glucose into cells, especially muscle cells. Some (thiazolidinediones) enhance insulin effectiveness in both muscle and adipose tissue. Others (alpha-glucosidase inhibitors) block enzymes that help digest starches, slowing the rise in blood sugar.

These medications are used to treat type 2 diabetes mellitus.

front 324

What is the drug classification for: clopidogrel

back 324

Antiplatelet Agents block the formation of blood clots by preventing the clumping of platelets.

They are used to treat and prevent thromboembolic events, e.g., stroke, myocardial infarction, peripheral vascular disease. They are used after stent, artificial heart values, and other devices that are placed inside the heart or blood vessels.

front 325

What is the drug classification for: lispro

back 325

Rapid-acting insulin, such as insulin lispro, covers insulin needs for meals eaten at the same time as the injection. Short-acting insulin covers insulin needs for meals eaten within 30 to 60 minutes. Intermediate-acting insulin covers insulin needs for about half of the day or overnight (and is often combined with rapid- or short-acting insulin). Long-acting insulin covers insulin needs for about one full day.

Insulin is used in the treatment of type 1 diabetes mellitus and may be used to treat type 2 diabetes mellitus.

front 326

What is the drug classification for: streptokinase

back 326

Thrombolytics convert plasminogen to plasmin, which then degrades fibrin in clots.

They are used for the acute management of coronary thrombosis (MI), massive pulmonary emboli, deep vein thrombosis, and arterial thromboembolism.

front 327

What is the drug classification for: sertraline

back 327

Selective Serotonin Reuptake Inhibitors (SSRIs) block the reabsorption (reuptake) of serotonin.

They are used primarily to treat moderate-to-severe depression and chronic fatigue syndrome; they may also be used to treat premenstrual dysphoric disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and generalized anxiety disorder.

front 328

What is the drug classification for: ampicillin

back 328

Penicillins belong to a group of antibiotics called beta-lactams, which exert bactericidal action by inhibiting bacterial cell wall production. Currently the group includes more than 20 antibiotics.

Used in the treatment and prophylaxis of wide range of bacterial infections including streptococcal infections, syphilis and Lyme disease.

front 329

What is the drug classification for: phenelzine

back 329

Monoamine oxidase inhibitors (MAOIs) prevent the enzyme monamine oxidase from breaking down the neurotransmitters norepinephrine and serotonin (also known as monoamines) in the brain.

They are typically used to treat depression.

front 330

What is the drug classification for: azathioprine

back 330

Immunosuppressants inhibit cell-mediated immune responses. Azathioprine can also be categorized as an Antirheumatic.

Most of these drugs are used in the prevention of transplantation rejection reactions; others are used in the management of selected autoimmune diseases (for example, nephritic syndrome of childhood and severe rheumatoid arthritis).

front 331

What is the drug classification for: cephalexin

back 331

Cephalosporins belong to a group of broad spectrum, semi-synthetic beta-lactam antibiotics derived from the mold Cephalosporium. The mechanism of action is the same as penicillins (they interfere with bacterial cell wall synthesis). An example of a 1st generation Cephalosporin is cephalexin.

They are mainly used in the treatment and prophylaxis of a wide variety of bacterial infections, such as respiratory tract infections, skin and soft-tissue infections, and urinary tract infections.

front 332

What is the drug classification for: sumatriptan

back 332

Some Vascular Headache Suppressants(ergot derivatives) directly stimulate alpha-adrenergic and serotonergic receptors, producing vascular smooth muscle vasoconstriction. Others (5-HT1 or selective serotonin receptor agonists, such as sumatriptan) work by narrowing dilated blood vessels and blocking nerves from transmitting signals of pain to the brain.

They are used for the treatment of vascular headaches (migraines and cluster headaches).

front 333

What is the drug classification for: cyclobenzaprine

back 333

Skeletal Muscle Relaxants act centrally on the spinal cord or brain stem and inhibit neuronal transmission; dantrolene is the only one that acts directly on skeletal muscle. These medications are typically classified by their pharmacologic properties as either antispasticity (baclofen & tizanidine) or antispasmodic (cyclobenzaprine & carisoprodol) agents.

These drugs are used to treat spasticity associated with spinal cord diseases (such as cerebral palsy, multiple sclerosis) or lesions; they may also be used as adjunctive therapy in the symptomatic relief of acute painful musculoskeletal conditions

front 334

What is the drug classification for: ketorolac

back 334

Non-steroidal Anti-inflammatory Drugs (NSAIDs) block the cyclooxygenase (COX-1 & COX-2) enzymes and reduce prostaglandins throughout the body, thereby reducing inflammation, pain, and fever.

They are used to control mild-to-moderate pain, reduce fever, and to treat various inflammatory conditions, such as osteoarthritis.

front 335

What is the drug classification for: enoxaparin

back 335

Anticoagulants work by inhibiting clotting factor synthesis, inhibiting thrombin, or by interfering with blood platelet formation. Enoxaparin is classified as a low-molecular-weight heparin (LMWH).

They are used to prevent or treat blood clots associated with stroke, heart attack, heart valve disease, coronary artery disease, heart failure, arrhythmia, atrial fibrillation, deep vein thrombosis, and pulmonary embolism.

front 336

What is the drug classification for: meloxicam

back 336

Nonopioid Analgesics target and block the chemical substances released by the brain in response to injury (particularly prostaglandin) that facilitate the transmission of the pain stimuli to the brain.

These drugs are used to control mild-to-moderate pain and/or fever.

front 337

What is the drug classification for: methotrexate

back 337

Antineoplastics inhibit or prevent the development, maturation or spread of neoplastic cells by various different mechanisms of action. Many damage the DNA of cancer cells; others interfere with the cancer cell's metabolism or affect cell division (methotrexate is classified as an antimetabolite); still others create an unfavorable environment for cancer cell growth (hormones). Methotrexate is also listed in the drug category: Antirheumatic.

They are used in the treatment of various solid tumors, lymphomas, and leukemias. They may also be used in some autoimmune disorders (such as rheumatoid arthritis).

front 338

What is the drug classification for: montelukast

back 338

Antiasthmatics either relax the smooth muscles that line the airway (bronchodilators), block the inflammation that narrows the airways (corticosteroids), counteract substances that cause the air passages to constrict and secrete mucus (leukotriene modifiers), or prevent allergic reactions or asthma symptoms. Montelukastis aleukotriene antagonist; it can also be categorized as a Bronchodilator.

They are used in the management of acute and chronic episodes of reversible bronchoconstriction associated with asthma. The goal of therapy is to treat acute attacks (short-term control) and to decrease incidence and intensity of future attacks (long-term control).

front 339

What is the drug classification for: doxycycline

back 339

Tetracyclines exert their bacteriostatic effect by inhibiting protein synthesis in bacteria. They are broad spectrum anti-infectives.

They are typically used in the treatment of respiratory tract infections, acne and skin infections, genital infections (syphilis, Chlamydia), urinary tract infections, Lyme disease, mycoplasmal infections and rickettsial infections and the infection that causes stomach ulcers (helicobacter pylori).

front 340

What is the drug classification for: clonazepam

back 340

Some Anticonvulsants are thought to generally depress central nervous system function. Others (such as GABA inhibitors) are thought to target specific neurochemical processes, suppress excess neuron function, and regulate electrochemical signals in the brain. Clonazepam is also categorized as a Benzodiazepine.

They are primarily used to help control epileptic seizures; they are also used to treat neuropathic pain (associated with diabetes, shingles, and fibromyalgia), migraine headaches, and bipolar disorder.

front 341

What is the drug classification for: trimethoprim-sulfamethoxazole

back 341

Sulfonamides are bacteriostatic and have a broad spectrum of activity against both gram-positive and gram-negative bacteria.

They are typically used in the treatment of urinary tract infections and also some types of bacterial pneumonia (Pneumocystis Carinii), shigellosis, as well as some protozoal infections.

front 342

What is the drug classification for: nitroglycerin

back 342

Antianginals are vasodilators - they dilate the blood vessels, improving blood flow and allowing more oxygen-rich blood to reach the heart muscle and they also relax the veins.

They are used to treat and prevent attacks of (acute) angina.

front 343

What is the drug classification for: midazolam

back 343

Benzodiazepinesde press the CNS, probably by potentiating GABA, which is an inhibitory neurotransmitter. Midazolamcan also be categorized as a Sedative/Hypnotic. These are all Schedule IV drugs.

They are primarily used to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. Midazolam is used as an agent for sedation/anxiolysis/amnesia

front 344

What is the drug classification for: flecainide

back 344

Some Antiarrhythmics slow down the heart (the calcium channel blockers, digoxin, and beta-blockers); other slow the heart's electrical impulses by blocking the heart's potassium channels (amiodarone, sotalol, dofetilide). They are generally classified by their effects on cardiac conduction tissue (Class IA, IB, IC, II, III, IV). Flecainide is in Class IC.

They are used in the suppression of (potentially lethal) cardiac arrhythmias.

front 345

What is the drug classification for: clarithromycin

back 345

The action of Macrolides is mainly bacteriostatic.

They are used in the treatment of various systemic and local bacterial infections of the respiratory tract, gastrointestinal tract, and soft tissues; they are also effective in treating severe acne and sexually transmitted infections. They are used prophylactically in the prevention of whopping cough and the prevention of endocarditis in dentistry.

front 346

What is the drug classification for: lorsartan

back 346

Angiotensin Receptor Blockers block the action of angiotensin II by preventing angiotensin II from binding to angiotensin II receptors on blood vessels. As a result, blood vessels enlarge (dilate) and blood pressure is reduced.

They are primarily used to control high blood pressure and treat heart failure. In addition, they slow the progression of kidney disease due to high blood pressure or diabetes.

front 347

What is the drug classification for: promethazine

back 347

Some Antiemetics may inhibit the chemoreceptor trigger zone in the medulla by blocking dopamine receptors; others act by decreasing the sensitivity of the vestibular apparatus. Phenergan has different effects on the brain - both antihistamine and anticholinergic activity.

They are used to manage the various causes of nausea and vomiting, including surgery, anesthesia, antineoplastic and radiation therapy, and motion sickness.

front 348

What is the drug classification for: gentamicin

back 348

Aminoglycosides are bactericidal; they primarily act by inhibiting protein synthesis in bacteria and compromising the structure of the bacterial cell wall.

They are used in the treatment and prophylaxis of severe infections, such as septicemia, severe urinary tract infections, and hospital-acquired respiratory infections, caused by aerobic, gram-negative bacteria, e.g., as Escherichia coli and Klebsiella species.

front 349

What is the drug classification for: bisacodyl

back 349

Laxatives are typically classified as either bulk-forming agents, osmotics, salines, stimulants (such as bisacodyl) or stool softeners.

They are used to treat or prevent constipation or to prepare the bowel for radiologic or endoscopic procedures.

front 350

What is the drug classification for: loperamide

back 350

Antidiarrheals work in a variety of ways. Some slow the passage of stools through the intestines (like loperamide). Others decrease the secretion of fluid into the intestine and inhibit the activity of bacteria (bismuth subsalicylate).

They are used to control and to provide symptomatic relief of acute and chronic nonspecific diarrhea.

front 351

What is the drug classification for: rosiglitazone

back 351

Some of these Oral Antidiabetics (sulfonylureas and meglitinides) work by stimulating insulin release from the beta cells of the pancreas. Other (biguanides) improve insulin's ability to move glucose into cells, especially muscle cells. Some (thiazolidinediones - like rosiglitazone) enhance insulin effectiveness in both muscle and adipose tissue. Others (alpha-glucosidase inhibitors) block enzymes that help digest starches, slowing the rise in blood sugar.

These medications are used to treat type 2 diabetes mellitus.

front 352

What is the drug classification for: fluticasone

back 352

Corticosteroids mimic the effect of hormones produced naturally by the adrenal glands. When the dose exceeds the body's usual hormone levels, they will suppress inflammation, as well as the immune system; they are also used for their antineoplastic activity.

Oral forms are used to treat inflammation and pain associated with arthritis and autoimmune diseases (such as lupus, Crohn's). Inhaled medications are used to treat asthma and allergies. Topical applications help heal skin conditions. The injected forms are used treat the pain and inflammation of arthritis, gout and other inflammatory diseases.

front 353

What is the drug classification for: albuterol

back 353

Bronchodilators relax bronchial smooth muscle. Relaxing these muscles makes the airways larger and allows air to pass through the lungs. Some also increase mucociliary clearance (beta agonists). Albuterol (Proventil) is a short-acting (or rescue) medication and can also be categorized as an Antiasthmatic.

Short-acting medications are used as needed as asthma "rescue" medications. Long-acting medications are used every day to control asthma in conjunction with an inhaled steroid.

front 354

What is the drug classification for: atenolol

back 354

Beta Blockers block norepinephrine and epinephrine from binding to beta receptors on nerves. By blocking the effects of these neurotransmitters, they reduce heart rate and reduce blood pressure by dilating blood vessels. The spelling of many beta blockers often end with “lol.”

They are used to treat hypertension; heart failure; arrhythmias; angina; glaucoma (ophthalmic); sometimes used in heart attack patients to prevent future heart attacks; also used prophylactically for migraine headaches.

front 355

What is the drug classification for: risperidone

back 355

Antipsychotics work by blocking a specific subtype of the dopamine receptor (the D2 receptor). The 2nd generation of these medications not only block D2 receptors but also a specific subtype of serotonin receptor (5HR2A receptor). Risperidone (Risperdal) is a 2nd generation antipsychotic.

They are used in the treatment of acute and chronic psychosis, especially when accompanied by increased psychomotor activity. Off-label uses include Tourette’s syndrome, substance abuse, stuttering, obsessive-compulsive disorder, post-traumatic stress disorder, depression, bipolar disorder and personality disorders.

front 356

What is the drug classification for: fexofenadine

back 356

Antihistamines compete with histamine for histamine receptor sites and when they occupy the histamine receptor sites, they prevent histamine from causing allergic symptoms.

They are used for relief of symptoms associated with allergies (including rhinitis, urticaria and angioedema) and as adjunctive therapy in anaphylactic reactions. Some are used to treat insomnia (diphenhydramine), motion sickness (dimenhydrinate and meclizine), Parkinson-like reactions (diphenhydramine), and other nonallergic conditions.

front 357

What is the drug classification for: clotrimazole

back 357

Antifungal agents are also called antimycotic agents; they kill or inactivate fungi.

They are used to treat systemic, localized, or topical fungal infections (including yeast infections).

front 358

What is the drug classification for: amitriptyline

back 358

Tricyclic Antidepressants inhibit the nerve cell's ability to reuptake serotonin and norepinephrine, resulting in increased levels of these neurotransmitters in the brain. They also block the action of acetylcholine and histamine (which causes many of the side effects of these meds).

They are used to relieve depression and may also be used to treat obsessive compulsive disorder and bedwetting. Off-label uses include panic disorder, bulimia, and chronic pain (migraine, diabetic neuropathy & post herpetic neuralgia).

front 359

What is the drug classification for: duloxetine

back 359

Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) block or delay the reuptake of serotonin and norepinephrine by the presynaptic nerves. The increased levels of these neurotransmitters elevates mood.

They are primarily used to treat depression, but are also used to treat anxiety disorder, panic disorder and other mood disorders.

front 360

What is the drug classification for: ropinirole

back 360

Some of these Antiparkinson Agents replenish dopamine, while others mimic the role of dopamine or block the effects of other chemicals that cause problems in the brain when dopamine levels drop. Ropinirole (Requip) is a dopamine agonist.

They are used to help relieve the symptoms of parkinsonism (such as tremor or trembling in the hands, arms, legs, jaw, and face; stiffness or rigidity of the arms, legs, and trunk; bradykinesia; poor balance and coordination).

front 361	back 361
What is the drug classification for: donepezil	Some of these Anti-Alzheimer's Agents (cholinesterase inhibitors, like donepezil) are thought to prevent the breakdown of acetylcholine by blocking the activity of acetylcholinesterase. Others (NMDA receptor antagonists) helps regulate the activity of glutamate, a chemical involved in the processing, storage and retrieval of information. They are used to treat Alzheimer's disease.
front 362	back 362
What is the drug classification for: chlorothiazide	Thiazide Diuretics are derived from a chemical called benzothiadi(A)zene. They work in the distal convoluted tubule by decreasing the kidney's reabsorption of sodium and chloride (which results in increased urine production) and they also help dilate blood vessels. They are used alone or in combination with loop diuretics in the treatment of hypertension or edema due to heart failure or other causes.
front 363	back 363
What is the drug classification for: verapamil	Calcium Channel Blockers slow the rate at which calcium passes into the heart muscle and into the vessel walls; this relaxes the vessels and allows blood to flow more easily through them, thereby lowering blood pressure. They are used to treat hypertension, angina, and abnormal heart rhythms (atrial fibrillation, paroxysmal supraventricular tachycardia). They are also used for client post-MI who cannot tolerate beta-blockers.
front 364	back 364
What is the drug classification for: spironolactone	Potassium-sparing Diuretics are used to conserve potassium in clients receiving thiazide or loop diuretics; they decrease sodium reabsorption in the collecting tubules of the kidneys. They are often used in clients with heart failure; they do not significantly lower blood pressure.

front 365

What is the drug classification for: pantoprazole

back 365

Some of the Antiulcer Agents (PPIs) block the secretion of gastric acid by the gastric parietal cells (one example is pantoprazole). Others (H-2 receptor blockers) stop the action of histamine on the gastric parietal cells, which inhibits the secretion of gastric acid. Remember, the spelling of PPIs often end with "prazole."

These drugs are used in the treatment and prophylaxis of peptic ulcer and gastric hypersecretory conditions, e.g., Zollinger-Ellison syndrome and also to manage the symptoms of gastroesophageal reflux disease (GERD).

front 366

What is the drug classification for: temazepam

back 366

Sedatives/Hypnotics are substances that moderate activity and excitement while inducing a calming effect (and may be anxiolytic) or substances that may induce drowsiness and sleep. Most all are Schedule IV drugs. Temazepamis a intermediate-acting benzodiazepine.

They are used to provide sedation, usually prior to procedures. Selected agents are useful as anticonvulsants, skeletal muscle relaxants, adjuncts in general surgery and adjuncts for the treatment of alcohol withdrawal syndrome.

front 367

What is the drug classification for: epinephrine

back 367

Vasopressors are potent vasoconstrictors, producing a rise in blood pressure (increase in mean arterial pressure).

They are used to control blood pressure in hypotensive states, such as (cardiogenic, septic) shock, drug reactions, spinal anesthesia. They can also be used to prolong anesthesia and to treat certain heart rhythm problems, including cardiac arrest.

front 368

What is the drug classification for: furosemide

back 368

Loop Diuretics work in the ascending limb of the loop of Henle (where magnesium & calcium are reabsorbed). Disrupting the reabsorption of these 2 ions brings about increased urine production (which lowers blood volume) and results in lowered blood pressure. They also cause the veins to dilate, which lowers blood pressure mechanically.

They are used to treat acute pulmonary edema and manage edema; they can also be used to reduce intracranial pressure and to treat hyperkalemia.

front 369

What is the drug classification for: lorazepam

back 369

Antianxiety Agents act at many levels in the CNS to produce anxiolytic effect. They may produce CNS depression and the effects may be mediated by GABA (an inhibitory neurotransmitter).

They are used in the treatment of Generalized Anxiety Disorder (GAD) and Panic Disorder; they are also used in the management of anxiety associated with depression.

front 370

What is the drug classification for: benazepril

back 370

ACE Inhibitors slow the activity of the enzyme angiotensin converting enzyme (ACE), which decreases the production of angiotensin II. As a result, blood vessels relax and dilate, blood pressure is lowered, and more oxygen-rich blood can reach the heart. The spelling of many angiotensin-converting enzyme (ACE) inhibitors end with "pril".

They are primarily used to control blood pressure, treat heart failure, help prevent strokes.

front 371

What is the drug classification for: atorvastatin

back 371

Lipid-lowering Agents reduce LDL (“bad”) cholesterol by inhibiting the enzyme in the liver (HMG-CoA reductase) responsible for making cholesterol. Along with diet and exercise, they are used to reduce blood lipids in an effort to reduce the morbidity and mortality of atherosclerotic cardiovascular disease and its sequelae.

front 372

A nurse is talking to a client diagnosed with chronic renal failure about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in the medication regimen. What is the best explanation for the nurse to give the client for the use of this medication?

Reduce serum calcium

Control gastric acid secretions

Increase urine output

Decrease serum phosphate

back 372

Decrease serum phosphate

Aluminum binds phosphates in the gastrointestinal tract. Phosphates tend to accumulate in the client with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphojel and Basaljel are commonly used to lower phosphate levels

front 373

A client is newly diagnosed with hypothyroidism and takes levothyroxine 50 mcg/day by mouth. What information should the nurse understand about this medication?

May decrease the client's energy level

Must be stored in a dark container

Will decrease the client's heart rate

Should be taken in the morning

back 373

Should be taken in the morning

A thyroid supplement, such as levothyroxine (Levothroid, Levoxyl, Synthroid), should be taken on an empty stomach, in the morning. Morning dosing minimizes the side effects of insomnia and an empty stomach facilitates absorption.

front 374

A terminally ill client is receiving high doses of an opioid analgesic to manage pain. As death approaches and the client becomes unresponsive to verbal stimuli, what approach to pain management should the nurse now anticipate?

A nonopioid analgesic will be prescribed

The analgesic will be discontinue

The same analgesic dosage will be continued

The dosage of the analgesic will be decreased by half

back 374

The same analgesic dosage will be continued

Dying clients who have been in chronic pain will probably continue to experience pain even though they are unresponsive. Pain medication should be continued at the same dosage that was considered effective when the client was more alert and responsive.

front 375

The nurse is discussing medication with a client. Which information should be reinforced by the nurse about captopril (Capoten)?

Avoid green leafy vegetables

Avoid the use of salt substitutes

Take the medication with meals

Restrict fluids to 1000 mL/day

back 375

Avoid the use of salt substitutes

Captopril is an angiotensin converting enzyme (ACE) inhibitor. Captopril is used to control blood pressure, treat heart failure, and help prevent strokes. Because it can cause an accumulation of potassium (or hyperkalemia), clients should avoid the use of salt substitutes, which are generally potassium-based. The generic names of ACE inhibitors often end with "pril."

front 376

A clinic nurse assists with a toddler who is diagnosed with a first episode of otitis media. Which reinforcement of information should the nurse include in instructions to the child's parents?

Emphasize the importance of a return visit after completing antibiotic therapy

Describe the tympanocentesis used to detect persistent infections

Demonstrate how the toddler should learn to swallow tablets

Provide the parents with a handout describing the purpose of myringotomy tubes

back 376

Emphasize the importance of a return visit after completing antibiotic therapy

A liquid suspension, not tablets, will be prescribed for the toddler and the nurse should reinforce how to store and measure the liquid. The child should be examined again after completion of the full course of antibiotics to assess hearing or to check for findings of a persistent infection and/or middle ear effusion. There is no need to discuss surgery or any other treatment at this time.

front 377

A nurse administers cimetidine to a 75 year-old client diagnosed with a gastric ulcer. Which function may be affected by this medication and should be closely monitored by the nurse?

Blood pressure

Mental status

Liver function

Hearing

back 377

Mental status

Cimetidine (Tagamet) is a histamine H2-receptor antagonist, used to treat gastric ulcers. Clients over age 50 or who are severely ill may become temporarily confused while taking H2 blockers, especially cimetidine.

front 378

A postoperative client has a prescription for acetaminophen with codeine. A nurse should recognize that a primary effect of this combination is what action?

Prevents tolerance

Enhanced pain relief

Minimized side effects

Faster onset of action

back 378

Enhanced pain relief

Combination of analgesics with different mechanisms of action can afford greater pain relief.

front 379

The client is discharged from the hospital with a new prescription for furosemide. One week later, during a follow-up visit with the health care provider, the client reports experiencing the following findings. Which finding is most important to report to the health care provider?

Constipation

Muscle cramps

Increased urine production

Occasional lightheadedness

back 379

Muscle cramps

Furosemide (Lasix) is a loop diuretic used to treat edema and hypertension. It can cause dehydration and electrolyte imbalances (hypokalemia and hypomagnesemia), which can result in muscle cramps. This is the most important finding. Dizziness, lightheadedness, or headache may occur as the client adjusts to the medication. The nurse should reinforce that the client should get up slowly when rising from a sitting or lying position but to tell the health care provider if these findings persist or become worse. Increased urine production is an expected action of the medication. Some people experience constipation when taking this medication.

front 380

The provider ordered 500 mg erythromycin oral suspension every six hours for a client diagnosed with pneumonia. The client has a gastrostomy tube. The pharmacy sends up the medication in a liquid suspension of 250 mg/5 mL.
How much medication will the nurse administer every six hours?

back 380

10mL.

250 mg/5 mL = 500 mg/X mL 250x = 2500 x = 2500/250 = 10 mL

front 381

A client has been given a prescription for alendronate. Which of the following statements indicate the client understands how to safely take this medication? (Select all that apply.)

"I will notify the health care provider if I have any difficulty swallowing."

"I will take the pill immediately preceding weight-bearing exercise."

"I will always eat breakfast before taking it."

"I will swallow it with 8 ounces of water."

"I will stand or sit quietly for 30 minutes after taking it."

back 381

"I will notify the health care provider if I have any difficulty swallowing."

"I will swallow it with 8 ounces of water."

"I will stand or sit quietly for 30 minutes after taking it."

Alendronate (Fosamax) can cause esophagitis or esophageal ulcers unless precautions are followed. The client must be able to sit upright or stand for at least 30 minutes after taking the tablet. The client should take the tablet first thing in the morning, with a full glass of water, at least 30 minutes before eating or drinking anything or taking any other medication.

front 382

A client diagnosed with tuberculosis is to begin taking rifampin and isoniazid. Which statement by a nurse is most appropriate to include when reinforcing information about these medications?

"You may have occasional problems sleeping."

"You may experience an increase in appetite."

"You may notice an orange-red color to your urine."

"You can take the medication with food."

back 382

"You may notice an orange-red color to your urine."

Rifampin can cause reddish-orange discoloration of the urine and other body fluids. It is harmless, but the client needs to be aware of it. The nurse should caution the client not to wear soft contacts while taking this medication.

front 383

An antibiotic is ordered to be given intramuscularly (IM) to a toddler. The total volume of the injection equals 2 mL. What is the correct nursing intervention?

Check with pharmacy to substitute a liquid form of the medication

Administer the medication in two separate injections

Call the health care provider and request a smaller dosage

Give the medication in the dorsal gluteal site

back 383

Administer the medication in two separate injections

Intramuscular injections should not exceed a volume of 1 mL for small children. Medication doses exceeding this volume should be split into two separate injections of 1 mL each. In adults the maximum intramuscular injection volume is commonly 5 mL depending on the characteristics of the site. The vastus lateralis of the thigh should be used to administer IM medications to a toddler (12 to 36 months of age).

front 384

The client is prescribed digoxin as a treatment for heart failure. What side effect can occur if the client develops hypokalemia when taking digoxin?

Dyshrythmias

Altered level of consciousness (LOC)

Oliguria

Tingling sensation

back 384

Dyshrythmias

Conditions that increase the risk of digoxin-induced dysrhythmias include hypokalemia and increased serum digoxin levels. The nurse should reinforce the importance of eating high-potassium foods (spinach, bananas, potatoes) and report signs of hypokalemia, such as nausea, general muscle weakness and irregular pulse. Tingling or other unusual sensations are associated with hyperkalemia. Altered LOC is not associated with hypokalemia. Persistent hypokalemia can cause polyuria, not oliguria.

front 385

The order is for ibuprofen oral drops 10 mg/kg of body weight. The client weighs 62 lbs. Motrin oral drops are supplied in bottles containing 40 mg/mL. How many milliliters will the nurse administer? (Report to the nearest whole number.)

back 385

7mL.
Dimensional analysis:

X mL = 1 mL/40 mg X 10 mg/kg X 1 kg/2.2 lbs X 62 lbs = 620/88 = 7.05 or 7 mL

Ratio :
62 lbs/x = 1 kg/2.2 lbs = 28.19 kg
10 mg/x = 1 mL/40 mg = 10/40 = 0.25
0.25 X 28.19 = 7.05 or 7 mL

front 386

A nurse is reinforcing how to use the metered-dose inhaler (MDI) to a client newly diagnosed with asthma. The client asks, “How will I know the canister is empty?” What is the best response by the nurse?

“Estimate how many doses are usually in the canister.”

“Shake the canister to detect any fluid movement.”

“Count the number of doses as the inhaler is used.”

“Drop the canister in water to observe floating.”

back 386

“Count the number of doses as the inhaler is used.”

Dropping the canister into a bowl of water assesses the amount of medications remaining in a metered-dose inhaler is the old way of checking how much was left in the canister. Now clients should be instructed to calculate how many doses are in each canister and keep track of the number of doses used. Some of the newer canisters have counters.

front 387

The nurse observes a family member administering a rectal suppository. With the client lying on the left side, the family member pushes the suppository in the rectum, up to the second knuckle. After 10 minutes, the family member helps the client turn to the right side. What is the appropriate comment for the nurse to make?

“Did you feel any stool in the intestinal tract?”

"Why don’t we now have the client turn back to the left side.”

“Let’s check to see if the suppository is in far enough.”

“That was done correctly. Did you have any problems with the insertion?”

back 387

“That was done correctly. Did you have any problems with the insertion?”

Left side-lying position is the optimal position for the client receiving rectal medications. Due to the position of the descending colon, left side-lying allows the medication to be inserted and move along the natural curve of the intestine and facilitates retention of the medication. The suppository should be somewhat melted after 10 to 15 minutes. The other responses are incorrect because there is no data in the stem to support these comments.

front 388

A client at risk for developing a deep vein thrombosis is being discharged home on enoxaparin. Which information would be appropriate for the nurse to reinforce before the client leaves the hospital?

"You must have your lab tests checked daily."

"You will have a special type of temporary IV inserted before discharge."

"Massage the injection site after the medication is given."

"Notify the health care provider if you notice any unusual bruising on your skin."

back 388

"Notify the health care provider if you notice any unusual bruising on your skin."

Enoxaparin (Lovenox) is a low molecular weight heparin and can result in the complication of bleeding. The client should monitor for any indication of unusual bleeding in the skin, mucous membranes or urine. The medication will be given subcutaneously, not by the IV route. Unlike heparin, enoxaparin does not require routine laboratory monitoring.

front 389

The home care nurse is admitting a new client with a diagnosis of COPD, atrial fibrillation and gout. After reviewing the client's medication list, the nurse would arrange for periodic monitoring of blood drug levels for which of the following medications? (Select all that apply.)

Beclomethasone inhaled (Qvar)

Theophylline (Elixophyllin, Theo-24, Uniphyl)

Allopurinol (Aloprim, Zyloprim)

Glipizide (Glucotrol)

Digoxin (Lanoxin)

back 389

Theophylline (Elixophyllin, Theo-24, Uniphyl)

Digoxin (Lanoxin)

It is necessary to monitor blood levels for the client taking theophylline and digoxin to prevent the client from developing toxicity.

front 390

The nurse is discussing with a client some of the necessary precautions when taking warfarin. The nurse should remind the client to avoid which over-the-counter (OTC) medication?

Nonsteroidal anti-inflammatory medications

Laxatives containing magnesium salts

Cough medicines with guaifenesin

Histamine blockers

back 390

Nonsteroidal anti-inflammatory medications

Warfarin is indicated in the prophylaxis and treatment of blood clots, atrial fibrillation and cardiac valve replacements. Taking warfarin and a nonsteroidal anti-inflammatory medication, such as ibuprofen, or an antiplatelet medication, such as aspirin, may increase the risk for bleeding. Garlic and ginkgo biloba can also increase the risk of bleeding if taken with warfarin.

front 391

A client has a new prescription for a selective serotonin reuptake inhibitor (SSRI) antidepressant. Which information would prompt the nurse to contact the health care provider after reviewing the client's admission history and physical?

Frequent use of antacids

Recent prescribed use of an MAO inhibitor

Diagnosis of vascular disease

History of obesity

back 391

Recent prescribed use of an MAO inhibitor

SSRIs should not be taken concurrently with MAO inhibitors due to serious, life-threatening medical condition called serotonin syndrome. Serotonin syndrome symptoms may occur within several hours of taking a new drug. It may be necessary to allow two to five weeks (or more) between stopping a MAOI and starting the SSRI (or vice versa).

front 392

There is an order to insert a urinary catheter. The client is an adult female. The nurse slips the catheter approximately 4-5 inches (10-12 cm) into an opening, but no urine is obtained. What is the most probable reason for this outcome?

The bladder is overdistended without the ability to empty

No urine is present in the bladder

The catheter is not inserted far enough into the canal

The catheter is located in the vaginal canal

back 392

The catheter is located in the vaginal canal

For an adult female, a urinary catheter is inserted about 2-3 inches (5-7 cm) in the urinary meatus until the urine flow begins. If urine does not flow, the catheter can be rotated gently and carefully inserted a bit further. When a catheter is inserted 4-5 inches (10-12 cm) with no urine return, the catheter is probably in the vaginal canal.

front 393

When assessing a client who has just undergone a cardioversion, the nurse finds the respirations are 12 per minute. Which action should the nurse take first?

Ask the registered nurse (RN) to assess the vital signs

Continue to monitor the respirations

Measure the pulse oximetry

Try to vigorously stimulate normal breathing

back 393

Continue to monitor the respirations

Normal respirations range 12 to 20 BPM; respirations 8 or less are a cause for concern. Vigorous stimulation is not indicated. It is also not necessary to ask the RN to check findings.

front 394

A client is being prepared for electroconvulsive therapy (ECT). Which x-ray should the nurse anticipate for the client prior to having this procedure?

Chest

Pelvic

Jaw

Spinal

back 394

Spinal

Spinal x-rays must be obtained to identify any abnormalities, especially in the neck area. In addition, blood and urine samples must be obtained, along with a signed consent form. To help answer this question, you should remember that the person experiences grand mal seizure activity during ECT. In reading the options, you'll notice that three options are assessing a very small area of the body. Finally, consider which area of the body would potentially have severe consequences if not evaluated before the procedure.

front 395

The nurse is preparing the client for an intravenous pyelogram (IVP) test. Which intervention would the nurse perform?

Restrict the client's fluid intake four hours prior to the examination

Inform the client that only one x-ray of the abdomen is necessary

Administer a laxative to the client the evening before the test

Instruct the client to maintain a regular diet 24 hours before the scheduled time

back 395

Administer a laxative to the client the evening before the test

Bowel preparation is important to clean out the large intestine to allow for the visualization of the kidney, bladder and ureters. Clients are often given the osmotic bowel preps the night before, such as Colyte, and an enema in the morning of the test. Beginning the day before the test, a clear liquid diet is prescribed and the client is NPO after midnight.

front 396

A nurse is caring for a client who had a closed reduction of a fractured right wrist, followed by the application of a fiberglass cast about 12 hours ago. Which finding requires the nurse’s immediate attention?

Client reports prickling sensation in the right hand

Slight swelling of fingers of right hand

Skin warm to touch and normally colored

Capillary refill of fingers on right hand is three seconds

back 396

Client reports prickling sensation in the right hand

A prickling sensation, or paresthesia, may be an indication of compartment syndrome and requires immediate action by the nurse. The client may also report extreme pain, there may be pallor and an absent or diminished pulse on the affected extremity. The nurse should report the findings to the RN charge nurse, who will then split the cast to help relieve the pressure and contact the health care provider. The other findings are normal for a client in this situation.

front 397

A client is two days postoperative. The vital signs are: BP 120/70, heart rate 100, respiratory rate 30, and temperature 100.4 F (38 C). The client suddenly becomes profoundly short of breath and the skin color is gray. Which vital sign should have alerted the nurse initially to the client's change in condition?

Respiratory rate

Heart rate

Temperature

Blood pressure

back 397

Respiratory rate

Tachypnea is one of the first clues that the client is not being adequately oxygenated. The compensatory mechanism for decreased oxygenation is increased respiratory rate. To help answer this question, you will notice that the problem in the question is respiratory (short of breath), so you should look for a response with this focus.

front 398

The client is diagnosed with a tension pneumothorax and has a chest tube inserted. What is the purpose of the chest tube for this client?

Increase the intrathoracic pressure to restore it back to normal

Remove air out of the pleural space to restore normal intrathoracic pressure

Provide the appropriate postoperative treatment for a pneumothorax

Drain the purulent drainage from the empyema that caused it

back 398

Remove air out of the pleural space to restore normal intrathoracic pressure

With a tension pneumothorax, the lung is collapsed due to air in the pleural space and this trapped air continues to build up; the pressure of this air pushes on and displaces the mediastinum. The classic sign of a tension pneumothorax is a deviation of the trachea away from the side of the tension. This is an emergency situation and is not the result of a surgical procedure. Insertion of a chest tube will remove the air, which will reduce the intrathoracic pressure, and allow the lung to re-inflate.

front 399

A nurse is preparing a client diagnosed with a deep vein thrombosis (DVT) for a venous doppler evaluation. Which nursing intervention is necessary to prepare the client for this test?

Have ready a sedative medication prior to the test

No special preparation is necessary for the client

Keep the client NPO after midnight

Discontinue anticoagulant therapy just before to the test

back 399

No special preparation is necessary for the client

This is a noninvasive procedure. Because this is an ultrasound test for the venous circulation, it does not require any special preparation (as compared to an ultrasound of the uterus that requires a full bladder).

front 400

A nurse is caring for a client who had surgery to remove the gallbladder as well as a common bile duct exploration with the placement of a T-tube. The nurse observes copious amounts of drainage through the T-tube the day after surgery. Which action should the nurse take next?

Continue to monitor the drainage

Clamp the T-tube for two hours

Lower the head of the bed

Notify the registered nurse (RN) charge nurse immediately

back 400

Continue to monitor the drainage

Several hundred milliliters of drainage can be expected from the T-tube in the initial 24 to 48 hours after a duct exploration. The nurse's responsibility is to continue to monitor the drainage and notify the health care provider if the findings indicate leakage of bile into the peritoneum or a blocked duct. The tube should not be clamped unless there is a specific order to do so (tube is clamped 3 to 4 days postop) while client is eating and for a few hours afterwards to test for duct patency. If nausea and vomiting occur when the tube is clamped, this indicates the duct is not patent and the nurse should remove the clamp. Keeping the head of the bed elevated will help to facilitate drainage.

front 401

A nurse is caring for an unconscious client. To prevent keratitis, moisturizing ointment should be applied to which site?

Perianal area

Lower eyelid

Tips of fingernails and toenails

External ear canal

back 401

Lower eyelid

Keratitis is a corneal ulcer or abrasion caused by exposure to the air from lack of or minimal blink reflex. Treatment involves the application of moisturizing ointment to the exposed cornea and a plastic bubble shield or eye patch.

front 402

A 78 year-old male client had a hernia repair in an outpatient surgery clinic. He is awake and alert, but has not been able to void since he returned from surgery six hours ago. He received 1000 mL of IV fluids. Which action would most likely help this client to void?

Wait two hours and have him try to void again

Apply Crede's method to the bladder from the bottom to the top

Assist him to stand by the side of the bed to void

Have him drink several glasses of water

back 402

Assist him to stand by the side of the bed to void

When a male is not able to use a urinal unassisted, the client should stand by the side of the bed to void. This is the most desirable position for normal voiding for male clients. Given the client's age, he most likely also has some degree of prostate enlargement, which may also interfere with voiding.

front 403

A client is being treated for diabetic ketoacidosis (DKA). A basic metabolic panel (BMP) was drawn and the nurse notes the client's serum glucose is 650 mg/dL (36.08 mmol/dL). Which other serum lab result should the nurse check?

Magnesium

Calcium

Creatinine

Potassium

back 403

Potassium

Hyperglycemia induces osmotic diuresis, causing water and electrolyte loss, especially potassium. Most clients with DKA have moderate to severe dehydration and will be initially treated in an intensive care unit. The client is given IV fluids with potassium to replace the fluid loss. The other electrolytes listed (magnesium and calcium) are not on a BMP. Creatinine is part of the BMP but it measures kidney function.

front 404

The child diagnosed with thalassemia major has received several blood transfusions during the past three days. What lab value should be monitored closely during this therapy?

Red blood cell indices

Neutrophil percent

Hemoglobin

Platelet count

back 404

Hemoglobin

Hemoglobin is the oxygen-carrying protein component of the red blood cell. Normal hemoglobin range for children is approximately 11-13 gm/dL. Beta thalassemia, also called Cooley's anemia, is a genetic defect that causes anemia. The only treatment is blood transfusions (every month) or a bone marrow transplant. With frequent blood transfusions, the body is unable to eliminate the excess iron contained in the transfused blood; over time this can result in tissue and organ damage.

front 405

A client is in the physical therapy room and tells the LPN/VN, "I feel like I'm going to have a seizure." Which intervention is most appropriate for the nurse to implement first?

Assist the client to a safe position away from hazards

Reduce the noise and dim the lights in the room

Instruct a coworker to notify the registered nurse (RN)

Stay with the client and document observations

back 405

Assist the client to a safe position away from hazards

Clients with seizure disorders (or epilepsy) often experience symptoms that warn them that a seizure is going to happen, called an aura. The most important action to implement in this situation is to place the client in a safe position so that if a seizure occurs, the client will not be injured. The LPN/VN should stay with the client and send someone to notify the RN (who can bring medication to prevent seizure activity). Noise reduction and light dimming may be beneficial in preventing an impending seizure, but they are not the priority. Remember to consider safety first when there isn't an immediate physical need.

front 406

The cardiac monitor displays a rhythm that appears to be ventricular fibrillation. Which initial nursing action is appropriate?

Initiate cardiopulmonary resuscitation

Notify the health care provider

Prepare to administer IV epinephrine

Determine responsiveness of the client

back 406

Determine responsiveness of the client

Electrical interference can be mistaken for ventricular fibrillation, in which case the client would respond when checked. Therefore, the most important initial action would be to check to see if the client is responsive or not. It would be inappropriate to initiate CPR or prepare to administer emergency drugs without first determining that the client is unresponsive.

front 407

A pregnant woman in the third trimester is admitted with a report of painless vaginal bleeding over the last several hours. A nurse should prepare this client for what procedure?

Pelvic exam

C-section

Nonstress test

Abdominal ultrasound

back 407

Abdominal ultrasound

Third-semester painless vaginal bleeding suggests placenta previa. Placenta previa is diagnosed through an abdominal ultrasound. This may be followed up with a transvaginal ultrasound. The health care provider would not perform a vaginal exam; vaginal exams may increase the risk of heavy bleeding. If the bleeding is unusually heavy and cannot be controlled and/or the baby is in distress, an emergency c-section may be necessary.

front 408

Following surgery for the placement of a ventriculoperitoneal (VP) shunt as treatment for hydrocephalus of their infant, the parents ask the licensed practice nurse (LPN) to reinforce the registered nurse's (RN) explanation as to why the infant has a small abdominal incision. What is the best response by the LPN about the abdominal incision?

The incision was made in order to insert the catheter into the abdominal cavity

The incision was made in order to insert the tubing into the urinary bladder

The incision was made in order to insert the catheter into the stomach

The incision was made in order to insert the camera for catheter placement

back 408

The incision was made in order to insert the catheter into the abdominal cavity

The preferred procedure in the surgical treatment of hydrocephalus is placement of a ventriculoperitoneal (VP) shunt. This shunt procedure provides primary drainage of the cerebrospinal fluid from the ventricles to an extracranial compartment, usually the peritoneum. A small incision is made in the upper quadrant of the abdomen so the shunt can be guided into the peritoneal cavity.

front 409

The licensed practical nurse (LPN) assists the registered nurse (RN) with suctioning a tracheostomy. What action is taken to prevent hypoxia during the procedure?

Apply suction for no more than 10 seconds

Lubricate three to four inches of the catheter tip

Withdraw catheter in a circular motion

Maintain sterile technique

back 409

Apply suction for no more than 10 seconds

Applying suction for more than 10 seconds may result in hypoxia, by suctioning oxygenated air out of the airway. The clue was to read the question correctly - it asked about prevention of hypoxia associated with suctioning. Although the other responses are important and correct actions, hypoxia results from actions that decrease the oxygen supply.

front 410

The client has been taking isoniazid (INH) and rifampin for several months to treat pulmonary tuberculosis. Which laboratory tests does the nurse anticipate will be ordered for this client.

Pancreatic enzymes

Kidney function

Liver enzymes

Cardiac enzymes

back 410

Liver enzymes

INH, as well as other long-term by-mouth medications, can cause hepatocellular injury. The nurse anticipates monitoring liver enzymes (ALT, AST and alkaline phosphatase) because these are released into the blood when the liver is damaged.

front 411

The nurse begins the enteral tube feeding at 8 am at a continuous rate of 40 mL/hour. It is now noon. What action is needed by the nurse?

Measure, record and then discard gastric residual (GRV)

Flush the feeding tube with 30 mL of warm water

Assess bowel sounds and gastric pH

Check gastric residual and stop the feeding if the volume is greater than 150 mL

back 411

Flush the feeding tube with 30 mL of warm water

The nurse will flush the tube with approximately 30 mL of warm water every 4 hours to maintain patency and check GRV every 4-6 hours (it's best to do both at the same time.) Residuals should be returned to the stomach because they contain electrolytes, nutrients, and digestive enzymes. Current evidence shows that acceptable GRVs range can from 150-500 mL and that a single elevated GRV simply requires ongoing monitoring. Although the nurse will monitor the client's response during the tube feeding, the nurse should have assessed bowel sounds and measured gastric pH (as well as GRV) before starting the feeding.

front 412

Many clients experience some soreness and shoulder pain following a diagnostic laparoscopy.

T/F

back 412

True

A laparoscopy involves injecting carbon dioxide or nitrous oxide gas into the abdominal cavity to expand the area for better viewing. Many people experience shoulder pain for a few days after the procedure because the gas irritates the diaphragm, which shares some of the same nerves as the shoulder.

front 413

Pulse oximetry replaces the need to obtain arterial blood gases (ABGs).

T/F

back 413

False

Pulse oximetry estimates oxygen (O2) saturation (SpO2) of capillary blood and these estimates typically correlate to arterial O2 saturation measurements (SaO2) when used correctly. But, pulse oximetry cannot detect hypercapnia or acidosis. An ABG is needed for accurate measurements of PaO2, PaCO2 and blood pH.

front 414

The nonrebreather mask with reservoir bag can deliver oxygen concentrations near 100%.

T/F

back 414

True

The nonrebreather mask delivers the highest percentage of oxygen of any of the high flow systems. It should be used only in medical emergencies, for a relatively short time (6 to 8 hours); any longer and the client risks pulmonary oxygen toxicity.

front 415

A client's hemodynamic status (blood pressure) is continuously monitored during hemodialysis.

T/F

back 415

True

During hemodialysis, blood is diverted from the body; if it is not replaced at the proper rate and osmolality, complications such as shock could develop.

front 416

The nurse should inject approximately 30 mL of air through the nasogstric (NG) tube while auscultating the abdomen to confirm placement of a NG tube.

T/F

back 416

False

Evidence-based practice recommends aspirating gastric contents to test the pH (which should be below 5) and/or obtaining an x-ray if there are concerns about the placement (and before instilling any feedings or medications).

front 417

Foam dressings are ideal for draining full-thickness wounds.

T/F

back 417

True

A foam dressing with a fluid-proof backing is a good choice for treating full thickness wounds. This dressing will absorb moderate amounts of drainage and cushion the wound site. A secondary dressing, such as Kerlix, may be needed to secure the primary dressing in place.

front 418

15 to 30 pounds (6.8 to 13.6 kg) of traction is recommended for Buck's skin traction.
T/F

back 418

False

5 to 7 pounds (2.3 to 3.2 kg) of traction is recommended for Buck's skin traction – any more weight and the boot will be pulled off the leg! Buck's traction is used to immobilize, position and align the lower extremity. It is one of the most commonly used types of traction.

front 419

Pacemakers use high-energy electrical pulses to treat life-threatening arrhythmias.

T/F

back 419

False

Pacemakers use low-energy electrical pulses to speed up a slow heart rhythm, help control abnormal or fast rhythms, and coordinate electrical signaling between the chambers of the heart. Implantable cardioverter defibrillators (ICD) use both low-energy and high-energy electrical pulses (these high-energy pulses treat the life-threatening arrhythmias).

front 420

The nurse should frequently suction the airway of clients with pneumonia and bronchitis.

T/F

back 420

False

Suctioning should only be done when clinically necessary and when the client is physically unable to cough up secretions on his or her own. Clinical indicators for suctioning include coarse breath sounds, noisy breathing, increased or decreased pulse, increased or decreased respiration, and prolonged expiratory breath sounds.

front 421

The nurse should expect to hear bowel sounds when assessing the client who is one day post-op following colostomy surgery.

T/F

back 421

False

It may take three or four days for the bowel to return to normal function after a colostomy.

front 422

Clients should remove all metal objects, including any and all piercings, prior to a magnetic resonance imaging (MRI) scan.

T/F

back 422

True

An MRI uses powerful, magnetic fields and radiofrequency energy to create clear pictures of internal body structures. Because of these magnetic fields, clients must remove all metal objects. Clients with shrapnel, a pacemaker or any surgically implanted joints may not be able to have this test.

front 423

Clients should fast 8 to 12 hours before having blood drawn for lipid blood tests.

T/F

back 423

True

The client should fast for at least 8 to 12 hours before a lipid panel blood draw; the client can drink clear liquids. Lipids include cholesterol, triglycerides, high-density lipoprotein (HDL) and low-density lipoprotein (LDL).

front 424

An esophageal manometry may be ordered to confirm dysphagia or gastroesophageal reflux (GERD).

T/F

back 424

True

During an esophageal manometry a thin, pressure-sensitive tube is passed into the esophagus. As the client swallows, the tube measures the pressure of the muscle contractions. This test is used to determine the cause of dysphagia, to evaluate for signs of GERD or to evaluate chest pain that may be coming from the esophagus.

front 425

The ELISA test is used to detect antibodies in the blood.

T/F

back 425

True

ELISA stands for enzyme-linked immunosorbent assay (it is also known as EIA, or enzyme immunoassay). This laboratory test is used to detect antibodies in the blood. It is used for clinical diagnosis, screening blood products and testing individuals who believe they may have been exposed to other infectious substances or viruses, such as HIV.

front 426

A myelogram is a painless test that measures the electrical activity in muscles.

T/F

back 426

False

A myelogram uses a special dye (oil-based, water-soluble and even air-contrast) and an x-ray (fluoroscopy) to make pictures of the bones and the subarachnoid space between the bones in the spine. Electrical activity in muscles is measured by an electromyogram (EMG); this may be a painful test.

front 427

A barium study and a computerized tomography (CT) scan can be completed within 24 to 48 hours of each other.

T/F

back 427

False

Barium takes up to four days to be completely excreted so that its radio occlusive properties do not interfere with the CT scan.

front 428

An intravenous cholangiogram (IVC) is an iodine-based contrast study designed to visually study the function of the kidneys.

T/F

back 428

False

An IVC shows the bile ducts. It is the intravenous pyelogram (IVP) that visualizes the kidneys and urinary system.

front 429

The Schick test is used to test for allergies.

T/F

back 429

False

A variety of different allergy tests can be used. One or more allergen-specific IgE antibody tests may be performed by either intradermal injection or by scratching the skin. Alternately, a radioallergosorbent test (RAST) can measure antibodies in the blood. A Schick test detects the presence of diphtheria toxin.

front 430

Serum bilirubin and urobilinogen measure how well the liver and gallbladder are functioning.

T/F

back 430

True

The prefix “bil-“ refers to bile, a product of the liver that is stored in the gallbladder and excreted into the small intestine. Testing for bilirubin in the blood helps identify liver disease and any obstruction of the gallbladder or bile ducts. Urobilinogen is a breakdown product of bilirubin and can be detected with a urinalysis.

front 431

The basic metabolic panel (BMP) is a group of 8 specific tests used to determine the status of the kidneys, blood sugar, electrolyte and acid/base balance.

back 431

True
This commonly-ordered test includes: glucose, calcium, sodium, potassium, carbon dioxide (CO2), chloride, blood urea nitrogen (BUN) and creatinine. A related test is the comprehensive metabolic panel (CMP), which consists of 14 specific tests.

front 432

The QRS complex of the ECG is when the atria depolarize.

T/F

back 432

False

The QRS complex of the ECG represents the time it takes for depolarization of the ventricles. The duration of the QRS complex is normally 0.06 to 0.12 seconds. The P wave represents depolarization of the atria.

front 433

A clean catch urine specimen can be used to detect the presence of blood cells, protein and bacteria.

T/F

back 433

True

The urine obtained from a clean catch urine specimen can be used for a variety of tests, including urinalysis, cytology and urine culture. The nurse will need to instruct (or reinforce teaching to) the client about the correct procedure to obtain a clean catch specimen.

front 434

Excessive bruising, swollen and painful joints and lengthy bleeding.

back 434

There are several types of hemophilia. All types can cause abnormal or exaggerated bleeding and poor blood clotting. Common sites for bleeding are the joints, muscles and gastrointestinal tract.

front 435

Hypotension and tachycardia, with muffled heart sounds and jugular vein distention.

back 435

Beck’s triad (hypotension; jugular vein distention; and distant/muffled heart sounds) are the classic symptoms of cardiac tamponade. Cardiac tamponade is where blood or fluid accumulates in the pericardial space and acts to compress and constrict the heart.

front 436

Fluttering or "thumping" sensation in the chest.

back 436

Atrial fibrillation (AFib) is the most common type of irregular heartbeat. Many clients have no symptoms. A client with AFib is five times more likely to have a stroke than someone without AFib.

front 437

Anemia, episodes of pain and frequent infections.

back 437

The most common finding of sickle cell disease is pain (sickle cell crisis). This is caused by the characteristic crescent-shaped red blood cells getting stuck and blocking blood vessels. Clients with sickle cell disease often also have anemia and are more prone to infections.

front 438

Pain, pallor, paresthesia, pulselessness, paralysis or poikilothermia.

back 438

Occlusive arterial disease (also known as peripheral artery disease) is caused by arteriosclerosis. The classic symptoms appear during walking or exercise and are relieved with rest.

front 439

Sequence of color changes in skin in response to cold or stress.

back 439

Raynaud’s phenomenon is a condition where cold temperatures or strong emotions cause blood vessel spasms, which block blood flow to the fingers, toes, ears and nose.

front 440

Dyspnea, fatigue and weakness, and edema in legs, ankles and feet.

back 440

Systolic heart failure is when the heart muscle cannot pump/eject the blood out of the heart. Diastolic heart failure is when the heart muscles are stiff and do not fill up with blood easily. As the heart’s pumping action becomes less effective, blood backs up in other areas of the body (congestive heart failure).

front 441

Bleeding, blood clots, bruising and drop in blood pressure.

back 441

In disseminated intravascular coagulation (DIC), the proteins that control blood clotting become overactive, increasing a client's risk for serious bleeding. This can be due to inflammation, infection or cancer.

front 442

Skin redness, swelling, warmth and tenderness over a vein.

back 442

Thrombophlebitis is a swollen or inflamed vein due to a blood clot.

front 443

ST elevation on ECG.

back 443

STEMI is a type of heart attack when the coronary artery is completely blocked off by an occlusion. The client will experience crushing, non-remitting retrosternal pain, diaphoresis, nausea/vomiting and dyspnea.

front 444

Cardiomyopathy related to myocarditis.
Etiology
or
Finding

back 444

Finding

After the initial infection subsides, the body's immune system continues to damage the heart muscle, weakening the heart. Myocarditis is a common cause of dilated cardiomyopathy.

front 445

Mononucleosis related to myocarditis.

Etiology
or

Finding

back 445

Etiology

Myocarditis is an inflammation of the myocardium (the middle layer of the heart wall) and it is usually caused by a viral infection (it can also be caused by bacteria, parasites and fungi). Other viruses associated with myocarditis include the common cold (adenovirus), rubella, parvovirus B19 (which causes fifth disease) and HIV.

front 446

Marfan syndrome related to aortic valve insufficiency.

Etiology

or
Finding

back 446

Etiology

Causes of aortic insufficiency include ankylosing spondylitis, endocarditis, hypertension, Marfan syndrome, syphilis and systemic lupus erythematosus. Marfan syndrome is an inherited disease of connective tissues. In the past, the main cause of aortic insufficiency was rheumatic fever.

front 447

Congenital disorder related to pulmonary stenosis.

Etiology
or

Finding

back 447

Etiology

Pulmonary stenosis is a congenital defect affecting the pulmonary valve. It is the second more common congenital heart defect.

front 448

Aging heart related to aortic stenosis.

Etiology
or

Finding

back 448

Etiology

Aortic stenosis can be a congenital disorder, but it is more commonly caused by the buildup of calcium deposits that narrow the valve, which is seen in older adults. Another cause of aortic stenosis is rheumatic fever.

front 449

Dyspnea, syncope and angina related to aortic stenosis.

Etiology
or
Correct!

back 449

Finding

In aortic stenosis, the aortic valves do not open fully, causing decreased blood flow from the heart. Dyspnea, syncope and angina are the three classic findings of aortic stenosis.

front 450

Narrow or obstructed valve related to pulmonary stenosis.

Etiology
or

Finding

back 450

Etiology

Pulmonary stenosis is, by definition, a narrowing of the pulmonary valve

front 451

Peripheral edema related to pulmonary stenosis.

Etiology
or
Finding

back 451

Finding

The most common symptoms of pulmonary stenosis are rapid or heavy breathing, dyspnea, tachycardia and peripheral edema (swelling in the feet, ankles, face, eyelids and/or abdomen).

front 452

Dyspnea, chest pain, and syncope related to pulmonary stenosis.

Etiology

or
Finding

back 452

Finding

Dyspnea, chest pain, and syncope are the three classic findings of pulmonary stenosis.

front 453

Dyspnea related to mitral valve regurgitation.

Etiology

or
Finding

back 453

Finding

Findings of mitral valve regurgitation depend on the severity and how quickly the condition develops. Common findings include heart murmurs, shortness of breath, fatigue and paroxysmal nocturnal dyspnea.

front 454

Mitral valve prolapse related to mitral valve regurgitation.

Etiology
or
Finding

back 454

Etiology

Any disease or problem that weakens or damages the valve or heart tissue around the valve can cause mitral valve regurgitation (also called mitral valve insufficiency).

front 455

Sharp, stabbing chest pain related to pericarditis.

Etiology

or
Finding

back 455

Finding

The main finding of pericarditis is a sharp, stabbing pain in the center or left side of the chest. By definition, chest pain is a finding.

front 456

Upper respiratory infection related to pericarditis.

Etiology
or

Finding

back 456

Etiology

Pericarditis is inflammation of the pericardium (the thin, sac-like covering of the heart). A common cause of pericarditis includes viral infections, including pneumonia and influenza; other causes include bacterial or fungal infections.

front 457

Rheumatic fever related to endocarditis.

Etiology
or

Finding

back 457

Etiology

Rheumatic fever is usually caused by an untreated streptococcal infection. The risk for developing endocarditis increases if a person had rheumatic fever or rheumatic heart disease (usually as a child).

front 458

Cardiac murmurs related to endocarditis.

Etiology

or
Finding

back 458

Finding

Endocarditis is inflammation of the inside lining of the heart chambers (endocardium) and heart valves. Heart murmurs are heard in a majority of clients with endocarditis.

front 459

There is a valve between the portal vein and the left atrium.

T/F

back 459

False

The portal vein has no direct connection to the left atrium, which receives blood from the pulmonary vein.

front 460

During systole, the pulmonic valve is open but the tricuspid valve is closed.

T/F

back 460

True

In systole, the ventricles contract. So the right ventricle should be pushing blood through the pulmonic valve, not backward through the tricuspid.

front 461

The mitral valve should open during diastole.
T/F

back 461

True

During diastole (ventricular filling), the mitral valve is open to allow blood to flow from the atria to the ventricles.

front 462

The aorta is a vein.

T/F

back 462

False

The aorta is the largest artery of the body. It exits the left ventricle to distribute oxygenated blood to the body.

front 463

The septum is a valve between the two ventricles.

T/F

back 463

False

The septum is a wall; normally there should be no opening between the ventricles.

front 464

The arteries stay open when cut.

T/F

back 464

True

The arteries contain a fibrous outer layer (tunica adventitia) that is stiff enough to hold them open when cut. The veins collapse when cut.

front 465

The pulmonary vein takes blood away from the heart to the lungs.

T/F

back 465

False

All veins lead to the heart; it is arteries that lead away from it. The pulmonary vein returns oxygenated blood from the lungs to the left atrium.

front 466

Peripheral veins contain valves that keep the blood flowing back to the heart.

T/F

back 466

True

Unlike arteries, veins do not contain an elastic membrane lining; they instead rely on valves to keep blood flowing in a single direction, back to the heart.

front 467

There are two veins called venae cavae.

T/F

back 467

True

There is an anterior (superior) vena cava and a posterior (inferior) vena cava; both bring blood from the body back to the heart.

front 468

Blood flows from the ventricles to the atria.

T/F

back 468

False

Blood flows from the atria (sometimes incorrectly called "auricles") to the ventricles.

front 469

The heart muscle (myocardium) gets oxygenated blood via the aorta.

T/F

back 469

True

The aorta's first two branches are the right and left coronary arteries, which bring blood to the myocardium.

front 470

The endocardium is a sac that surrounds and supports the heart.

T/F

back 470

False

The "endo (inside) cardium (heart)" is the layer inside the myocardium.

front 471

The mitral (bicuspid) valve is an atrioventricular valve.

T/F

back 471

The mitral valve controls flow between the left atrium and left ventricle.

front 472

The aorta carries oxygenated blood.

T/F

back 472

True

The aorta leaves the left ventricle, which contains oxygen-rich blood from the lungs.

front 473

Normally, the blood pressure is lower in systole than in diastole.

T/F

back 473

False

In systole the heart muscle squeezes or contracts; in diastole, it relaxes.

front 474

Cough; exertional dyspnea; fatigue; fainting; swelling of feet or ankles

back 474

Cor pulmonale

Cor pulmonale is an alteration in the structure and function of the right ventricle caused by a primary disorder of the respiratory system.

front 475

Barrel chest; chronic cough, shortness of breath, wheezing; weight loss

back 475

Emphysema

Emphysema is a chronic and progressive disease of the lungs that causes shortness of breath due to over-inflation of the alveoli.

front 476

Chest pain; muffled heart and lung sounds; mediastinal shift; respiratory distress

back 476

Tension Pneumothorax

A tension pneumothorax occurs when air gets trapped in the pleural cavity and as the pressure increases, it pushes the mediastinum to the other side of the chest, which compresses the other lung. This is a life-threatening condition.

front 477

Difficulty swallowing; ear pain; fever & chills; headache; sore throat

back 477

Tonsillitis

Tonsillitis is an inflammation of the tonsils, due to either viral or bacterial infections or immunologic factors. Findings are similar to pharyngitis (sore throat).

front 478

Ptosis; difficulty chewing & swallowing; weakness in arms & legs; shortness of breath

back 478

Myasthenia Gravis

Myasthenia gravis is a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal muscles. It is caused by a defect in the transmission of nerve impulses to muscles. Muscles that control eye and eyelid movement, facial expression, chewing, talking, swallowing, and breathing are often affected.

front 479

Cough; difficulty breathing; fatigue; fever greater than 100.4 F (38 C); headache; myalgia

back 479

Severe Acute Respiratory Syndrome (SARS)

SARS is a viral infection causing acute respiratory distress and sometimes death.

front 480

Fever, chills, productive cough, dyspnea, pleuritic pain, use of accessory muscles

back 480

Pneumonia

Pneumonia is an inflammatory process that results in edema of the lung tissues. Fluid moves into the alveoli and this can cause hypoxia. Pneumonia is caused by bacteria, viruses, fungi or chemicals.

front 481

Thick, sticky mucus, wheezing, exercise intolerance, repeated lung infections

back 481

Cystic Fibrosis

Cystic fibrosis is a hereditary disorder that causes severe damage to the lungs and digestive systems. It is a disorder that affects the exocrine glands, causing them to produce thick and sticky mucus.

front 482

Attacks include vertigo, tinnitus, hearing loss

back 482

Ménière's Disease

A chronic disorder of the inner ear that usually affects only one ear. It usually develops between the ages of 40-60 years.

front 483

Blurred vision without pain

back 483

Cataract

A clouding of the lens in the eye that affects vision. Most cataracts are related to aging.

front 484

Loss of (bilateral) peripheral vision, cupping of the optic disk, elevated intraocular pressure.

back 484

Chronic Open-angle Glaucoma

The most common type of glaucoma. The increase in pressure is often small and develops slowly.

front 485

Sudden onset of blurred vision and severe eye pain

back 485

Acute Closed-angle Glaucoma

Occurs when fluid is suddenly blocked and can't flow out of the eye, resulting in a quick, severe rise in eye pressure. This is a medical emergency.

front 486

Bright flashes of light, blurred vision, "floaters" in the eye

back 486

Retinal Detachment

Separation of the light-sensitive membrane (retina) from its supporting layers.

front 487

Guillain-Barré results from an acute infection and inflammation of the peripheral nerves.
T/F

back 487

False

Guillain-Barré is a progressive, inflammatory autoimmune response occurring in the peripheral nervous system. The autoimmune response results in damage to myelin sheath and slows or alters nerve conduction. It is not caused by an acute infection.

front 488

Ischemic strokes are the most common type of stroke.

T/F

back 488

True

Ischemic strokes account for about 87% of all stroke cases and are caused by an obstruction within a blood vessel supplying blood to the brain (either a thrombosis or embolism).

front 489

A person who has migraine headaches should avoid foods containing monosodium glutamate, tyramine and caffeine.

T/F

back 489

True

Many things can trigger migraine headaches, including hormonal changes, stress, sensory stimuli and sleep (too much or too little). Common food triggers include alcohol, aged cheeses (which contain tyramine), chocolate, overuse of caffeine and MSG.

front 490

The tonic component of the generalized seizure lasts longer than the clonic component.

T/F

back 490

False

Rigid contracture of muscles (the tonic phase) is usually brief. The clonic component is the rhythmic shaking that occurs during the seizure; it lasts longer than the tonic component. A generalized tonic-clonic seizure is also known as a grand mal seizure.

front 491

Sudden onset of fever, headache, photosensitivity and stiff neck are common findings of meningitis.

T/F

back 491

True

These are some of the classic findings of meningitis, which can occur quickly or over several days after exposure. However, infants may present with high fever, constant crying, excessive sleepiness or irritability and poor feeding.

front 492

Anticonvulsants and skeletal muscle relaxants are used in the management and treatment of trigeminal neuralgia.

T/F

back 492

True

Trigeminal neuralgia is one of more common causes of chronic and excruciating facial pain. Anticonvulsants help to decrease pain impulses and produce pain relief. The muscle relaxant baclofen may be used as an adjunct to anticonvulsants.

front 493

Delirium is a chronic condition affecting brain function.

T/F

back 493

False

Delirium, or acute confusional state, is not a disease but a transient and potentially reversible disorder of cognition. It is often mistaken for a neurocognitive disorder (formerly referred to as dementia) or even an acute schizophrenic reaction.

front 494

The nurse should use open-ended questions during admission of cognitively impaired clients.

T/F

back 494

False

Questions requiring a simple yes or no response are used if thinking abilities are impaired.

front 495

The pain of cluster headaches comes on slowly and takes days to resolve.
T/F

back 495

False

The pain of a cluster headache comes on suddenly and usually subsides quickly, before even over-the-counter pain relievers such as ibuprofen or acetaminophen can start working. Triptans can provide effective acute treatment for cluster headaches.

front 496

Anticholinesterase inhibitor medications should be given 30 to 60 minutes before a meal for clients diagnosed with myasthenia gravis.
T/F

back 496

True

Clients diagnosed with myasthenia gravis experience progressive muscle weakness. To minimize the risk of aspiration and to facilitate chewing and swallowing, anticholinesterase inhibitors, such as pyridostigmine (Mestinon), should be taken before meals.

front 497

Parkinson's disease (PD) affects intellectual ability.

T/F

back 497

False

Parkinson's disease does not initially affect intellectual ability; however, some clients with PD may eventually experience changes in memory, thinking or reasoning. Also, many clients may develop depression later in the disease process, which is characterized by withdrawal, sadness, loss of appetite and sleep disturbances.

front 498

One of the initial signs of a stroke is weakness on one side of the body.

T/F

back 498

True

The American Stroke Association lists this as one initial warning sign of a stroke, along with sudden confusion, sudden trouble speaking or understanding, sudden trouble seeing or sudden headache.

front 499

Caused by a bacterial infection, toxins and viruses, this condition can cause inflammation, cirrhosis or cancer of the liver.

back 499

There are several causes of inflammation of the liver, but hepatitis is usually caused by a virus. Hepatitis can heal on its own with no significant consequences or it can progress to scarring of the liver (cirrhosis).

front 500

Clients may develop this condition after some types of surgery and when using certain drugs, especially narcotics.

back 500

Intestinal obstruction is a partial or complete blockage of the bowel. It is usually due to either a mechanical reason or an ileus (a condition where there is no structural problem causing the bowel not to contract correctly - such as following surgery).

front 501

Eating a high-fiber diet can help reduce symptoms of this disease.

back 501

A low-fiber diet is the most common cause of diverticular disease. The disease is made up of two conditions: diverticulosis and diverticulitis.

front 502

A slowly progressing disease in which healthy tissue is replaced with scar tissue, which may result in the need for a transplant.

back 502

Scar tissue from cirrhosis in loss of liver function and can cause: portal hypertension, hepatic encephalopathy, gastrointestinal bleeding, infection, ascites and hepatorenal syndrome.

front 503

Pain localizes to the right upper quadrant, but may radiate to the right shoulder or scapula.

back 503

Cholecystitis is inflammation of the gallbladder caused by an obstruction of the cystic duct (usually by stones). Clients may experience nausea, vomiting and fever. Risk factors include increasing age, obesity or rapid weight loss, medication and pregnancy.

front 504

Chronic inflammation extending deep into the lining of the affected part of the GI tract results in abdominal pain, cramping and diarrhea.

back 504

Crohn's disease is an inflammatory bowel disease. Unlike ulcerative colitis, inflammation affects the entire thickness of the bowel wall and can affect any part of the digestive tract (although it most commonly affects the ilium and beginning of the colon).

front 505

Infection by the bacterium Helicobacter pylori is the most common cause of this condition.

back 505

A peptic ulcer is a sore on the lining of the stomach or duodenum. The bacterium called Helicobacter pylori is a major cause of peptic ulcers; NSAIDs are another common cause of peptic ulcers.

front 506

This condition may be caused by gallstones, chronic alcohol use, infections, medications and trauma.

back 506

Treatment for pancreatitis includes IV fluids, antibiotics and pain relievers; many clients will require an endoscopic retrograde cholangiopancreatography (ERCP) to examine the bile and pancreatic ducts.

front 507

Inflammation in the lining of the colon leads to abdominal discomfort and blood or pus in diarrhea.

back 507

Ulcerative colitis is a disease that causes inflammation and sores (ulcers) in the lining of the rectum and colon (large intestine).

front 508

Barrett's esophagus is a complication of this condition.

back 508

Complications of GERD include bronchospasm, chronic cough or hoarseness, dental problems, esophageal ulcer and Barrett's esophagus (a change in the lining of the esophagus that can increase the risk of cancer).

front 509

Difficulty starting a urine stream; dribbling after urination; urinary retention.

back 509

Benign Prostatic Hypertrophy

An enlarged prostate does not necessarily raise the risk of cancer, but men may develop urinary tract infections, hematuria, bladder stones, and bladder or kidney damage.

front 510

Hematuria; severe pain in low back/flank pain.

back 510

Renal Calculi

Although kidney stones (nephrolithiasis) may be small, passing one can be very painful. Dehydration is a major risk factor for kidney stone formation.

front 511

Herniation of bladder into the vaginal canal.

back 511

Cystocele

This hernia-like disorder occurs when the urinary bladder protrudes through the wall of the vagina. Treatments include estrogen, surgery, or mechanical support by pessary.

front 512

Chancres, flu-like symptoms, hair loss, palmar rash.

back 512

Syphilis

Syphilis is a sexually transmitted disease (STD) with 4 distinct stages. In the primary stage, painless sores appear. Skin rashes and flu-like symptoms occur in the secondary stage. If untreated, syphilis is eventually fatal.

front 513

Ecchymoses, hyperpigmentation, pruritus.

back 513

Chronic Kidney Disease

In addition to pruritus, pigmentary disorders, and ecchymosis, clients with chronic kidney disease may also have xerosis (dry skin), uremic frost, half-and-half nails.

front 514

CD4 count less than 200; Kaposi's sarcoma; pneumocystosis.

back 514

Acquired Immune Deficiency Syndrome (AIDS)

When the CD4 cell (a type of lymphocyte) count falls below 200 cells/microliter, clients are at risk for developing opportunistic infections; antiretroviral treatment should be started or changed.

front 515

Anxiety, exophthalmos, heat intolerance, restlessness, weakness.

back 515

Graves' disease

Graves' disease is an autoimmune disorder that leads to overactivity of the thyroid gland.

front 516

Facial puffiness; macroglossia; ptosis; coarse, sparse hair; confusion; hypothermia; bradycardia.

back 516

Myxedema coma

Myxedema coma/crisis usually affects older women who have long-standing, undiagnosed or undertreated hypothyroidism. The crisis is triggered by a significant stress, such as infection, a systemic disease, certain medications or exposure to a cold environment.

front 517

Dry, scaly skin; muscle cramps; tingling of the lips, fingers and toes.

back 517

Hypoparathyroidism

Hypoparathyroidism is a disorder in which the parathyroid glands do not produce enough parathyroid hormone (PTH). PTH helps control serum levels of calcium, phosphorus, and vitamin D.

front 518

Abdominal pain; amenorrhea; decreased libido; osteoporosis; sensitivity to cold.

back 518

Hypopituitarism

These findings are associated with a deficiency of luteinizing hormone (LH) & follicle stimulating hormone (FSH), which are pituitary hormones. Findings of hypopituitarism are directly related to the missing hormone (thyroid-stimulating hormone (TSH), LH, growth hormone (GH), adrenocorticotropic hormone (ACTH), and/or prolactin).

front 519

Dehydration; fatigue and muscle weakness; hyperpigmentation of the skin; unintentional weight loss.

back 519

Addison's disease

Addison's disease is a disorder that occurs when the adrenal glands do not produce enough hormones (glucocorticoid hormones, mineralcorticoid hormones and sex hormones).

front 520

Acne; buffalo hump; hirsutism; moon-shaped face; upper body obesity, with thin legs and arms.

back 520

Cushing syndrome

Cushing syndrome is caused when the adrenal gland secretes too much cortisol or when someone takes too much corticosteroid medication.

front 521

Acromegaly is the result of excess growth hormone secretion in children.
T/F

back 521

False

In children, too much growth hormone causes gigantism, resulting in an abnormal increase in height and bone growth. Acromegaly occurs in adulthood.

front 522

Central diabetes insipidus may be caused by damage to the pancreas.

T/F

back 522

False

Central diabetes insipidus may be caused by damage to the hypothalamus (or pituitary gland).

front 523

The water deprivation test is used to diagnose diabetes insipidus.

T/F

back 523

True

This test is used to determine the cause of polydipsia and polyuria – central diabetes insipidus (DI), nephrogenic DI or psychogenic polydipsia.

front 524

The client diagnosed with syndrome of inappropriate antidiuretic hormone (SIADH) should be placed on seizure precautions.

T/F

back 524

True

With SIADH, hypersecretion of antidiuretic hormone (ADH) causes hyponatremia. As serum sodium drops, extra water enters cells and causes them to swell. Convulsions, shock, coma and death may occur with cerebral edema and increased brain cell volume.

front 525

Clients diagnosed with hyperosmolar hyperglycemic state (HHS) experience severe ketoacidosis.

T/F

back 525

False

This rare but deadly metabolic state is more common in the elderly with type 2 diabetes mellitus. HHS is characterized by hyperglycemia and severe dehydration without ketoacidosis.

front 526

Management of mild hyperparathyroidism includes increasing oral fluid intake to prevent the development of kidney stones.

T/F

back 526

True

Extra parathyroid hormone (PTH) results in hypercalcemia. There is also increased calcium in the urine, which may cause kidney stones. If the client's serum calcium levels are only slightly elevated, s/he should drink plenty of fluids to minimize the risk of developing kidney stones.

front 527

Type 2 diabetes results when pancreatic beta cells stop producing insulin.

T/F

back 527

False

With type 2 DM, the pancreas produces insulin, but it's not enough and/or the body cannot use it properly (insulin resistance). Type 1 DM is when beta cells stop producing insulin.

front 528

Many clients are able to manage type 2 diabetes through diet and exercise.

T/F

back 528

True

Type 2 diabetes can often be managed with proper diet and exercise. Some clients also require additional treatment with oral hypoglycemic agents, like metformin.

front 529

To treat a conscious adult with a serum glucose below 50 mg/dL, the nurse should prepare to administer 1 mg glucagon.

T/F

back 529

True

If the client is conscious and alert, the nurse can offer 15-20 g of carbohydrates (4 ounces of juice or regular soda, or 1 tablespoon honey) to the client. Glucagon is used if the client is unconscious.

front 530

Clients should take levothyroxine at bedtime.

T/F

back 530

False

Clients should take this medication in the morning with a full glass of water. Levothyroxine should be taken on an empty stomach, at least one hour before any other medications or vitamins.

front 531

Osteoarthritis is an autoimmune disease that causes progressive loss of cartilage in the joints.

T/F

back 531

False

Osteoarthritis is typically the result of normal aging and wear and tear on the joints; it is not an autoimmune disease. With osteoarthritis, there is loss of cartilage in the joints. Eventually, the cartilage wears away and bones rub against each other, causing pain, swelling and stiffness.

front 532

The client with Charcot's joint will benefit from regular aerobic exercise.

T/F

back 532

False

Charcot's joint is a degenerative condition affecting one or more joints and results in joint instability and hypermobility, along with numbness and tingling or loss of sensation in the affected joints (usually in the feet). Treatment includes casting (for up to 12 weeks) and no weight-bearing on the foot followed by wearing a brace.

front 533

A progressive exercise routine is the best therapy for the client with chondromalacia patellae.

T/F

back 533

True

Although this degenerative disorder cannot be cured, it can be traced to a trauma or repeated stress. Selective strengthening of the inner portion of the quadriceps muscle will help normalize the tracking of the patella. Cardiovascular conditioning can be maintained by stationary bicycling, pool running or swimming.

front 534

Obesity is a risk factor for the development of rheumatoid arthritis.

T/F

back 534

False

Obesity, because it stresses joints, is a risk factor in the development of traumatic osteoarthritis. Rheumatoid arthritis, although not fully understood, seems to be an autoimmune disorder.

front 535

A stress fracture is an example of a pathological fracture.

T/F

back 535

False

Pathological means that a bone or joint was weakened by a disease process. Stress fractures are caused by the repetitive application of force (such as overuse) or by a condition that weakens the bone (osteoporosis); stress fractures are most common in the weight-bearing bones of the lower leg and foot.

front 536

Clients diagnosed with systemic lupus erythematosus (SLE) should avoid exposure to sunlight and ultraviolet light.

T/F

back 536

True

Clients with SLE often experience photosensitive rashes. Exposure to sunlight can also cause migraine headaches, nausea and joint pain.

front 537

Rheumatoid nodules are the same thing as Heberden's nodes.

T/F

back 537

False

Firm, non-tender, subcutaneous nodules develop in some chronic active cases of rheumatoid arthritis. They are serious extra-articular manifestations found in the lungs, eyes and blood vessels. Heberden's and Bouchard's nodes are bony enlargements of the joints involving the hand; these nodes are strongly familial (inherited) and are characteristic of osteoarthritis.

front 538

Clients diagnosed with systemic lupus erythematosus (SLE) should avoid exposure to sunlight and ultraviolet light.

T/F

back 538

True

Clients with SLE often experience photosensitive rashes. Exposure to sunlight can also cause migraine headaches, nausea and joint pain.

front 539

Some symptoms of osteomalacia include kyphosis, difficulty walking, deformation of weight-bearing bones and pain in the low back and hips.

T/F

back 539

True

Osteomalacia is softening of bone. It may be caused by poor dietary intake or poor absorption of calcium and other minerals; it is a characteristic feature of vitamin D deficiency in adults. The more obvious effects may appear in major weight-bearing joints such as the back, hips and legs.

front 540

A woman is more likely to develop type 1 osteoporosis if she is postmenopausal, smokes, drinks alcohol and is not taking hormone replacement therapy.

T/F

back 540

True

Type 1 osteoporosis is related to decreased estrogen levels in postmenopausal women. Risk factors include a family history of osteoporosis, low body weight, smoking and drinking a large amount of alcohol.

front 541

Estrogen, calcitonin, bisphosphonates and bone-forming agents can reverse the damage of osteoporosis.

T/F

back 541

False

Nothing can reverse the damage already done by osteoporosis. These medications can sometimes slow or halt the progress of the disease.

front 542

Paget's Disease (neuropathic joint disease) is characterized by overactive osteoclasts.

T/F

back 542

True

Paget's Disease attacks the mechanism that replaces old cells with new ones. The overactive osteoclasts rapidly restore bone cells and, as a result, the bone that is formed is abnormal, i.e., enlarged, not as dense, brittle and prone to fractures.

front 543

An indication for total hip replacement is peripheral vascular disease associated with uncontrolled diabetes.

T/F

back 543

False

Peripheral vascular disease lead to an amputation, often of the foot, but indications for total hip replacement include osteoarthritis, rheumatoid arthritis, trauma (such as fracture of the femoral head), failure of a prosthesis or avascular necrosis of the femur due to steroid use.

front 544

X-rays should be taken both before and after a closed reduction of a fracture.

T/F

back 544

True

X-ray images are necessary to first show where the bone should be moved and afterward to show whether it is positioned for ideal healing.

front 545

An overweight client who has been newly diagnosed with gout should be advised to lose weight as quickly as possible.

T/F

back 545

False

Clients diagnosed with gout and who are overweight should lose weight slowly. Quick weight loss may cause uric acid kidney stones to form.

front 546

Complications of orthopedic surgery include deep vein thrombosis, fat embolism, pulmonary embolism, thrombophlebitis, hemorrhage and wound infection.

T/F

back 546

True

These are all potential complications of orthopedic surgery.

front 547

The nurse should use alcohol or iodine-based products to clean around the pins used in skeletal traction.

T/F

back 547

False

Alcohol and iodine-based products can accelerate corrosion of the metal and can cause skin staining. Skeletal traction pins can be cleaned with normal saline, sterile water or even plain soap and water.

front 548

The nurse should assist a client with an above the knee amputation to lie in the prone position several times a day.

T/F

back 548

True

Lying on the stomach will help stretch the hip flexor muscles. The client should lie in the prone position for about 20 minutes, 3 to 4 times a day.

front 549

When the nurse suspects compartment syndrome, the casted limb should be elevated about the level of the heart.

T/F

back 549

False

When the nurse suspects compartment syndrome, the cast should be split and constrictive bandages released. The limb should not be elevated above the level of the heart because this compromises arterial perfusion, which compounds the ischemic problem.

front 550

Sarcomas are cancers that begin in the cells of the immune system.

T/F

back 550

False

Sarcomas are cancers that begin in connective or supportive tissue, e.g., bone, cartilage, fat or muscle. Lymphomas and myelomas are cancers that begin in the cells of the immune system.

front 551

In the TNM classification (staging) system, the 'M' stands for metastasis.

T/F

back 551

True

This staging system signifies the extent or severity of a client's cancer. The T stands for the extent of the primary tumor and N is for lymph node involvement.

front 552

One monoclonal antibody drug can be used to attack a variety of different types of cancer.

T/F

back 552

False

Each monoclonal antibody recognizes only one particular protein, so different antibodies have to be used to target different types of cancer. For example, trastuzumab (Herceptin®) is used to treat certain breast cancers.

front 553

The most curable form of cancer is Hodgkin disease.

T/F

back 553

True

Hodgkin disease is a malignancy of the of lymph tissue (found in the lymph nodes, spleen, liver and bone cancer).

front 554

The human papillomavirus 9-valent vaccine, recombinant (Gardasil®9) can prevent cervical cancer.

T/F

back 554

True

This vaccine, which is given to adolescent boys and girls, can prevent diseases cause by the human papillomavirus (HPV). This includes several different types of cancer and genital warts.

front 555

The lower legs and upper back are the most common sites for melanoma in fair-skinned women.

T/F

back 555

True

The most common sites for melanoma in fair-skinned women (including fair-skinned Hispanics) are the lower legs and upper back. For fair-skinned men, the most common site for melanoma is the upper back. Melanomas in dark-skinned people often appear in the mouth, palms of the hands, soles of the feet and under the nails.

front 556

Colon cancer may develop from adenomatous polyps.

T/F

back 556

True

Most colon polyps are benign growths. But some growths can turn into colon cancer. Polyps found during a colonoscopy can be removed and examined.

front 557

The prognosis for childhood cancers is generally poor.

T/F

back 557

False

Childhood cancers, if diagnosed and treated early, are highly curable.

front 558

Breast cancer is the most common cause of death in women.

T/F

back 558

False

Lung cancer is the leading cause of cancer deaths in women in the U.S. and Canada.

front 559

External beam radiation is used to damage cancer cell DNA.
T/F

back 559

True

Using high-energy radiation, the DNA of the cancer cells is damaged and the cell will die. X-rays, gamma rays and charged particles are types of radiation used for cancer treatment. Internal radiation therapy (brachytherapy) is another treatment for cancer.

front 560

A priority for septic shock is to treat the cause of infection.
T/F

back 560

True

Along with fluid replacement and medications to increase cardiac output, this type of shock must be treated with the appropriate anti-infective agent(s).

front 561

The sequence of actions in the initial assessment for trauma care is: airway, cervical spine stabilization, breathing and then circulation.
T/F

back 561

True

The cervical spine must be simultaneously stabilized when assessing the airway, and before breathing and circulation are assessed.

front 562

Medical management of hypovolemic shock includes rapid fluid replacement.

T/F

back 562

True

The essential treatment for clients with hypovolemic shock is to restore fluid volume and blood pressure. The client may also need medications to help increase cardiac output and mean arterial pressure, such as dobutamine (Dobutrex) and norepinephrine (Levophed).

front 563

Hypotension is a finding of the initial stage of shock.
T/F

back 563

False

In the initial stage of shock, only subtle changes in clinical signs may be seen. Hypotension does not typically occur until the progressive stage of shock. Pallor, cool and clammy skin, altered level of consciousness and irregular heart rhythms are the other classic findings of the progressive stage.

front 564

Acute myocardial infarction (MI) is the most common cause of cardiogenic shock.
T/F

back 564

True
Cardiogenic shock typically develops following an acute MI, especially a ST-segment elevation MI (STEMI). However, cardiogenic shock can result from any cardiac dysfunction that causes acute myocardial ischemia.

front 565

Cardioversion is used in the emergency treatment of ventricular fibrillation.

T/F

back 565

False

Cardioversion is an elective procedure that is used to treat dysrhythmias, like atrial fibrillation. It involves synchronized shocks specific to the arrhythmia. Defibrillation is used for the immediate treatment of life-threatening arrhythmias, like ventricular fibrillation. It involves non-synchronized shocks during the cardiac cycle.

front 566

Paradoxical chest wall movement is a key assessment finding in the client with a flail chest.

T/F

back 566

True

Flail chest results when two or more rib fractures occur in two or more places, causing the flail segment to separate from the rib cage. It often occurs from blunt trauma associated with accidents. Paradoxical respirations are the inward movement of a part of the thorax during inspiration and the outward movement during expiration. Clients also have severe chest pain, dyspnea and possible tachycardia and hypotension with flail chest.

front 567

Altered level of consciousness (LOC) is often a late sign in a client with increased intracranial pressure (ICP).

T/F

back 567

False

Intracranial pressure is the pressure inside the skull and brain tissue. Altered LOC is often one of the earliest signs that a client has increased ICP. LOC is also the most important component of the neurological assessment in a high acuity and emergent client situation. Increased ICP can be caused by trauma, hemorrhage, tumors, edema or inflammation.

front 568

An infant with spina bifida may have a meningocele and neurological deficits and may experience seizures.

T/F

back 568

False

Spina bifida is the most frequently occurring and permanently disabling birth defect in the U.S. Findings vary depending on the level of the lesion and type of defect, but spina bifida is not associated with seizures.

front 569

A common cause of increased intracranial pressure (ICP) in infants is hydrocephalus.

T/F

back 569

True

Most hydrocephalus occurs in infancy and may be associated with a myelocele or myelomeningocele. Common findings of increased ICP include full or bulging fontanels, macrocephaly, poor feeding, vomiting and irritability.

front 570

Cyanotic heart defects are more dangerous than acyanotic defects.

T/F

back 570

True

In acyanotic (or 'pink') heart defects, blood is shunted from left to right within the heart, so oxygenated blood is recirculated. In contrast, cyanotic (or 'blue') heart defects involve a shunt that recirculates some venous blood, thus starving the body tissues of needed oxygen.

front 571

Respiratory distress syndrome (RDS) in infants is caused by weakness or underdevelopment of chest muscles.
T/F

back 571

False

In RDS (also known as hyaline membrane disease) the lungs lack the surfactant that enables the alveoli to exchange blood gases.

front 572

Treatment for bronchiolitis almost always involves surgery.

T/F

back 572

False

Bronchiolitis is usually caused by the respiratory syncytial virus (RSV). RSV can also cause croup, ear infections and pneumonia in young children. Mild cases usually respond to rest, fluids and humidified air. Hospitalization may be required for severe cases of RSV.

front 573

Ventilator support in infants can lead to bronchopulmonary dysplasia (BPD).

T/F

back 573

True

Ventilators use pressure to blow air into the airways and lungs. Although ventilator support can help premature infants survive, the machine's pressure may irritate the infant's lungs. Other causes of BPD include high levels of oxygen therapy, infections and heredity.

front 574

Apnea is a symptom of any number of different etiologies.

T/F

back 574

True

Some of the more common causes of apnea include apnea of prematurity, obstructive sleep apnea, and apnea secondary to head trauma, infections or toxins. Apnea is an unexplained episode of cessation of breathing for 20 seconds or longer, or a shorter respiratory pause associated with bradycardia, marked hypotonia, and cyanosis and/or pallor.

front 575

Croup syndromes are treated with antibiotics and cool air/mist.

T/F

back 575

False

The most common form of croup is acute laryngotracheobronchitis or viral croup, which is an infection of both the upper and lower respiratory tracts. The classic "barky" harsh cough, stridor and fever are treated with antipyretics and cool air/mist.

front 576

A low protein and low calorie diet is indicated for children with cystic fibrosis (CF).

T/F

back 576

False

Cystic fibrosis is caused by a defective gene. This gene causes the body to produce thick, sticky mucus, which builds up in the lungs and the pancreas. Children with CF need a diet high in protein, fat and calories. Many children with CF also take pancreatic enzymes (to help absorb fats and protein), and supplements for vitamins A, D, E and K.

front 577

Hypothyroidism is a congenital disease that may manifest in children as lethargy, constipation, feeding problems and slow growth.

T/F

back 577

True

An underactive thyroid is a congenital disease in children; symptoms may not appear until the child is 2 or 3 years old. Treatment includes a client taking levothyroxine for the rest of his/her life.

front 578

Neonates with tracheoesophageal fistula (TEF) may develop copious amounts of fine white frothy bubbles of mucus in the mouth and nose.

T/F

back 578

True

Neonates with TEF develop these secretions, which recur despite suctioning. They may also develop rattling respiration and episodes of coughing, choking and cyanosis.

front 579

An abnormal immune reaction to gluten damages the small intestine in people with celiac disease.

T/F

back 579

True

Celiac disease is an inherited autoimmune disease in which the lining of the small intestine is damaged from eating gluten and other proteins found in wheat, barley, rye and possibly oats. Management includes adopting a gluten-free diet.

front 580

A classic finding of Hirschsprung's disease is diarrhea.

T/F

back 580

False

Hirschsprung's disease is a congenital defect with innervation of the rectum and/or colon. Areas without nerves cannot push waste material through the bowel, which causes a blockage. Findings in newborns include failure to take liquids, constipation and bile-stained vomitus.

front 581

Primary enuresis develops several years after a person has learned to control his or her bladder.

T/F

back 581

False

Someone with primary enuresis has never been able to control his or her bladder. Secondary enuresis is a condition that develops at least 6 months after learning to control the bladder. Common underlying problems associated with bedwetting include constipation and cystitis; many times the cause is idiopathic.

front 582

The infant born with bladder exstrophy will most likely experience additional congenital defects.

T/F

back 582

True

Bladder exstrophy is a rare congenital birth defect where the bladder is turned "inside out" and exposed outside of the body. The infant will most likely have many other problems, including clubfoot or major deformity of a lower extremity, hip dislocation, abdominal wall defects (such as inguinal hernias) and epispadias.

front 583

Anemia, thrombocytopenia and acute renal failure are the classic findings of acute hemolytic-uremic syndrome (HUS).

T/F

back 583

True

HUS typically develops after a gastrointestinal infection involving Escherichia coli bacteria (E coli 0157:H7). The bacterium produces toxic substances that destroy red blood cells, resulting in anemia. HUS often begins with vomiting and bloody diarrhea. It is one of the most common causes of acute kidney failure in children.

front 584

Children's bones are more brittle than those of adults, because the bones have not yet fully calcified.

T/F

back 584

False

Children's bones are more flexible and porous than those of adults; in fact, fractures are very rare before age 1.

front 585

Infantile osteochondritis of the hip occurs when the infant's femur is insecurely seated in the acetabulum.

T/F

back 585

False

When the head of the femur is improperly seated in the acetabulum, it is called hip dysplasia. During the physical assessment, the nurse will hear a click or feel a popping sensation (Ortolani's sign) when rotating or abducting the affected hip. This condition is treated using bracing, casting and/or surgery.

front 586

To screen for scoliosis, look at the child's silhouette and note asymmetries in the trunk and legs.

back 586

True

Scoliosis is commonly detected during the preadolescent growth spurt. In a child who has scoliosis, there will be uneven hips or shoulders, an abnormal lateral curvature of the spine, ribs that are higher on one side or a waistline that may be flat on one side.

front 587

Juvenile idiopathic arthritis is best managed by diet, hormones and range-of-motion exercises.

T/F

back 587

False

This autoimmune disorder is managed with exercise, as well as physical and occupational therapies, electrical stimulation, heat and/or whirlpool treatments. NSAIDs can help control symptoms; corticosteroids, disease-modifying antirheumatic drugs, immunosuppressives and cytotoxic agents are also used. Neither diet modification nor hormones are used to treat this disorder.

front 588

The treatment for frostbite includes massaging the affected skin.

T/F

back 588

False

Tissue damage can occur if the skin with frostbite is massaged. The affected site should be rewarmed gently and gradually with warm water or wet heat.

front 589

The first sign of mild hypothermia is shivering.

T/F

back 589

True

Cold-induced shivering is stimulated when body temperatures drop below the set point (which is governed by the hypothalamus). Shivering is activated to raise the body temperature.

front 590

Findings of a partial thickness burn include moist, red skin that's painful to the touch.

T/F

back 590

True

For a superficial partial thickness burn, the skin is red, moist and has blisters; the skin is very painful to the touch. There may be no blisters with a deep partial thickness burn.

front 591

The skin of a client with heat stroke is pale and moist.

T/F

back 591

False

Findings of heat stroke include reddened skin and lack of perspiration. Body temperature may be greater than 106 F (41 C). This is a true medical emergency.

front 592

One way to treat heat exhaustion is to get the client into a cool place.

T/F

back 592

True

Moving the client to a cool place allows for lowering of the client’s body temperature. If possible, also have the client lie down and rest and offer cool water or fruit juice. It is also helpful for the client to loosen or remove any unnecessary clothing.