1. A nurse is reinforcing teaching with a client who has HIV and is being discharged to home. Which of the following instructions should the nurse include in the teaching?

1) Take temperature once a day.

Answer Rationale:

The nurse should reinforce to the client to take his temperature once a daily to identify if a temperature is present due to the client's altered immune system.

INCORRECT

2) Wash the armpits and genitals with a gentle cleanser daily.

Answer Rationale:

The nurse should instruct the client to use an antimicrobial cleanser to wash his armpits and genitals twice daily.

INCORRECT

3) Change the litter boxes while wearing gloves.

Answer Rationale:

The client should avoid changing litter boxes. Litter boxes carry toxoplasmosis which can be life threatening to a client who has HIV.

INCORRECT

4) Wash dishes in warm water.

Answer Rationale:

The nurse should instruct the client to wash dishes in hot soapy water to destroy the bacteria.

2. A nurse is caring for a client who is postoperative following a tracheostomy, and has copious and tenacious secretions. Which of the following is an acceptable method for the nurse to use to thin this client's secretions?

1) Provide humidified oxygen.

Answer Rationale:

Increasing fluid intake as tolerated and providing adequate humidification can help thin secretions safely.

INCORRECT

2) Perform chest physiotherapy prior to suctioning.

Answer Rationale:

Performing chest physiotherapy mobilizes secretions but does not thin them.

INCORRECT

3) Prelubricate the suction catheter tip with sterile saline when suctioning the airway.

Answer Rationale:

Prelubricating the suction catheter tip with sterile saline helps to ease the insertion of the catheter, producing less trauma. However, it has no effect on the tenacity of the client's secretions.

INCORRECT

4) Hyperventilate the client with 100% oxygen before suctioning the airway.

Answer Rationale:
Hyperventilating the client prior to suctioning prevents hypoxia. However, it has no effect on the tenacity of the client's secretions.

3. Following admission, a client with a vascular occlusion of the right lower extremity calls the nurse and reports difficulty sleeping because of cold feet. Which of the following nursing actions should the nurse take to promote the client's comfort?

INCORRECT

1) Rub the client's feet briskly for several minutes.
Answer Rationale:
Massaging the legs or feet could mobilize a clot. Impaired arterial or venous circulation of the lower extremities is a contraindication for leg massage.

2) Obtain a pair of slipper socks for the client.
Answer Rationale:
Slipper socks with nonskid soles will help provide warmth and increase the client's level of comfort.

INCORRECT

3) Increase the client's oral fluid intake.
Answer Rationale:
Increasing the client's fluid intake will not increase circulation to an area an occlusion impairs.

INCORRECT

4) Place a moist heating pad under the client's feet.
Answer Rationale:
Impaired arterial or venous circulation to a lower extremity is a contraindication for applying a heating pad.

4. A nurse is caring for a client is who is 4 hr postoperative following a transurethral resection of the prostate (TURP). Which of the following is the priority finding for the nurse report to the provider?

INCORRECT

1) Emesis of 100 mL
Answer Rationale:
The nurse should recognize postoperative nausea is a complication related to the administration of anesthesia and should treat the nausea with anti-emetics and provide supportive measures; however, it is not the priority finding.

INCORRECT

2) Oral temperature of 37.5° C (99.5° F)
Answer Rationale:
The nurse should monitor a client who develops a fever and encourage deep breathing, coughing, and fluid intake (if permitted); however, it is not the priority finding to report. The increase in temperature is likely due to decreased respiratory effort related to the use of anesthesia and should clear with pulmonary hygiene.

3) Thick, red-colored urine

Answer Rationale:

The nurse should recognize viscous drainage that is red in color may indicate hemorrhage and should be reported to the provider immediately.

INCORRECT

4) Pain level of 4 on a 0 to 10 rating scale

Answer Rationale:

The nurse should assess for and treat postoperative pain which is an expected finding in the postoperative client; however it is not the priority finding to report. Specific pain, such as bladder spasms, may indicate complications however and should be reported to the provider.

5. A nurse is caring for a client who has a temperature of 39.7° C (103.5° F) and has a prescription for a hypothermia blanket. The nurse should monitor the client for which of the following adverse effects of the hypothermia blanket?

1) Shivering

Answer Rationale:

The hypothermia blanket can cause shivering if the client is cooled too quickly. Shivering can cause the client's temperature to increase.

INCORRECT

2) Infection

Answer Rationale:

Infection is not a complication of the hypothermia blanket therapy. A manifestation of infection is hyperthermia.

INCORRECT

3) Burns

Answer Rationale:

Burns are associated with the improper use of heating pads, not hypothermia blankets.

INCORRECT

4) Hypervolemia

Answer Rationale:

Hypervolemia is not a complication of the hypothermia blanket therapy. Dehydration is a risk associated with hyperthermia due to fluid loss.

6. A nurse is reinforcing teaching about exercise with a client who has type 1 diabetes mellitus. Which of the following statements by the client indicates an understanding of the teaching?

INCORRECT

1) "I will carry a complex carbohydrate snack with me when I exercise."

Answer Rationale:

The nurse should reinforce that the client should carry a simple carbohydrate such as hard candy or glucose tablets for use during exercise if the client becomes hypoglycemic.

INCORRECT

2) "I should exercise first thing in the morning before eating breakfast."

Answer Rationale:
The nurse should reinforce that exercise should follow a meal. Exercising first thing in the morning on an empty stomach places the client at risk for hypoglycemia.

INCORRECT

3) "I should avoid injecting insulin into my thigh if I am going to go running."
Answer Rationale:
The nurse should reinforce that the client should avoid injecting insulin into an area that will soon be exercised to avoid increasing the absorption rate of the insulin.

4) "I will not exercise if my urine is positive for ketones."
Answer Rationale:
The nurse should reinforce that exercise should be avoided if ketones are present in the urine as this indicates an elevated blood glucose level or ketoacidosis.

7. A nurse notes a small section of bowel protruding from the abdominal incision of a client who is postoperative. After calling for assistance, which of the following actions should the nurse take first?

1) Cover the client's wound with a moist, sterile dressing.
Answer Rationale:
According to evidence-based practice, the nurse's first action should be to cover the wound with a moist, sterile dressing to prevent entry of bacteria into the wound and to keep the tissue moist.

INCORRECT

2) Have the client lie supine with knees flexed.
Answer Rationale:
The nurse should have the client lie supine with knees flexed to promote adequate circulation to the vital organs. However, evidence-based practice indicates that this is not the first action the nurse should take.

INCORRECT

3) Check the client's vital signs.
Answer Rationale:
The nurse should check the client’s vital signs because the client is at risk for shock following wound evisceration. However, evidence-based practice indicates that this is not the first action the nurse should take.

INCORRECT

4) Inform the client about the need to return to surgery.
Answer Rationale:
The nurse should inform the client about the need to return to emergency surgery to preserve the bowel and prevent complications. However, evidence-based practice indicates that this is not the first action the nurse should take.

8. A nurse is collecting data from a client who has alcohol use disorder and is experiencing metabolic acidosis. Which of the following manifestations should the nurse expect?

INCORRECT

1) Cool, clammy skin

Answer Rationale:

The nurse should expect to find warm, flushed skin in a client who is experiencing metabolic acidosis.

2) Hyperventilation

Answer Rationale:

The nurse should expect to find hyperventilation in a client who is experiencing metabolic acidosis. The system attempts to compensate or return the pH to normal by increasing the rate and depth of respirations.

INCORRECT

3) Increased blood pressure

Answer Rationale:

The nurse should expect to find hypotension in a client who is experiencing metabolic acidosis.

INCORRECT

4) Bradycardia

Answer Rationale:

The nurse should expect to find tachycardia in a client who is experiencing metabolic acidosis.

9. A nurse is reinforcing discharge teaching with a client following a cataract extraction. Which of the following should the nurse include in the teaching?

1) Avoid bending at the waist.

Answer Rationale:

The nurse should reinforce that the client should avoid bending at the waist as this increases intraocular pressure; the client should be instructed to flex the knees and crouch instead.

INCORRECT

2) Remove the eye shield at bedtime.

Answer Rationale:

The client should be instructed to use an eye shield when retiring for the night to protect the eye from accidental injury, such as rubbing that may occur when the client is asleep.

INCORRECT

3) Limit the use of laxatives if constipated.

Answer Rationale:

The client should be encouraged to use laxatives in the event of constipation to avoid straining while attempting to have a bowel movement. Straining increases intraocular pressure and can cause damage to the surgical site.

INCORRECT

4) Seeing flashes of light is an expected finding following extraction.

Answer Rationale:

The nurse should instruct the client that flashes of light indicates a complication of cataract extraction, and should be reported to the provider.

10. A nurse is caring for a client who has heart failure and has been taking digoxin 0.25 mg daily. The client refuses breakfast and reports nausea. Which of the following actions should the nurse take first?

INCORRECT

1) Suggest that the client rests before eating the meal.

Answer Rationale:

The nurse should encourage frequent rest periods for the client who has heart failure, as dyspnea and fluid overload increases the workload to consume adequate nutrition; however, another action is the priority.

INCORRECT

2) Request a dietary consult.

Answer Rationale:

The nurse should consider obtaining a dietary consult for the client who has heart failure to provide nutritional evaluation and counseling; however, another action is the priority.

3) Check the client's vital signs.

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse should place the priority on obtaining vital signs. Nausea is a manifestation of digoxin toxicity, along with other manifestations such as muscle weakness, confusion, abdominal cramping, and changes in vision.

INCORRECT

4) Request an order for an antiemetic.

Answer Rationale:

The nurse should request antiemetics for the client who is experiencing nausea in order to maintain client comfort and nutritional intake; however, another action is the priority.

11. A nurse is caring for a client who is 3 days postoperative following a cholecystectomy. The nurse suspects the client's wound is infected because the drainage from the dressing is yellow and thick. Which of the following findings should the nurse report as the type of drainage found?

INCORRECT

1) Sanguineous

Answer Rationale:

Sanguineous indicates fresh bleeding.

INCORRECT

2) Serous

Answer Rationale:

Serous describes clear, watery plasma.

INCORRECT

3) Serosanguineous

Answer Rationale:

Serosanguineous describes watery drainage that has some blood in it.

4) Purulent

Answer Rationale:

Purulent describes drainage that is thick yellow, green, or brown in color.

12. A nurse is reinforcing discharge teaching to a client following arthroscopic surgery. To prevent postoperative complications which of the following actions should be reinforced during the teaching?

1) Administer an opioid analgesic to the client 30 min prior to initiating CPM exercises.

Answer Rationale:

The nurse should administer analgesics prior to initiating any exercise program for the client who has had joint arthroplasty. It is important that analgesics are administered in time for the medication to work before the start of the exercise program to ensure discomfort is minimized.

INCORRECT

2) Place the client's affected leg into the CPM machine with the machine in the flexed position.

Answer Rationale:

The nurse should place the client's leg in the CPM machine while the machine is in the extended position to allow for proper fit and comfort.

INCORRECT

3) Place the client into a high Fowler's position when initiating the CPM exercises.

Answer Rationale:

The nurse should limit the elevation of the client's head of the bed to no more than 20 degrees while the client is using the CPM machine to avoid extreme flexion of the hip and patient discomfort.

INCORRECT

4) Align the joints of the CPM machine with the knee gatch in the client's bed.

Answer Rationale:

The nurse should align the joints of the CPM machine with the client's knee joint to ensure safe operation of the unit and prevent injury to the client.

13. A nurse is collecting data from a client who has emphysema. Which of the following findings should the nurse expect? (Select all that apply.)

1) Dyspnea

2) Barrel chest

3) Clubbing of the fingers

4) Shallow respirations

INCORRECT

5) Bradycardia

Answer Rationale:

Dyspnea is correct. Dyspnea is experienced by clients who have emphysema due to inadequate oxygen exchange in the lungs.

Barrel chest is correct. The lungs of clients who have emphysema lose their elasticity, and the diaphragm becomes permanently flattened by overdistention of the lungs. The muscles of the rib cage also become rigid, and the ribs flare outward. This produces the barrel chest typical of emphysema clients.

Clubbing of the fingers is correct. Air is trapped in the lungs due to their lack of elasticity, which decreases oxygenation. Clubbing results from these chronic low blood-oxygen levels.

Shallow respirations is correct. Clients who have emphysema lose lung elasticity; consequently, respirations become increasingly shallow and more rapid.

Bradycardia is incorrect. The heart rate will increase as the heart tries to compensate for less oxygen being delivered to the tissues.

14. A nurse is caring for a client who sustained a basal skull fracture. When performing morning hygiene care, the nurse notices a thin stream of clear drainage coming from out of the client's right nostril. Which of the following actions should the nurse take first?

INCORRECT

1) Take the client's temperature.

Answer Rationale:

The nurse should take the client's temperature to ensure the client is afebrile to prevent infection and brain dysfunction; however, another finding is the priority.

INCORRECT

2) Place a dressing under the client's nose.

Answer Rationale:

The nurse should place a dressing under the client's nose to measure and collect the amount of drainage; however, another finding is the priority.

INCORRECT

3) Notify the charge nurse.

Answer Rationale:

The nurse should notify the charge nurse about the client’s condition; however, another finding is the priority.

4) Test the drainage for glucose.

Answer Rationale:

The greatest risk to a client who has a basal skull fracture is injury from cerebral spinal fluid (CSF) leak; therefore, the nurse should first test the drainage for glucose.

15. A nurse is caring for a client who has a spinal cord injury at T-4. The nurse should recognize that the client is at risk for autonomic dysreflexia. Which of the following interventions should the nurse take to prevent autonomic dysreflexia?

INCORRECT

1) Monitor for elevated blood pressure.
Answer Rationale:
Elevated blood pressure is a serious manifestation of autonomic dysreflexia. However, it is not a causative agent.

INCORRECT
2) Provide analgesia for headaches.
Answer Rationale:
A severe headache is one of the manifestations of autonomic dysreflexia. However, it is not a causative agent.

3) Prevent bladder distention.
Answer Rationale:
Autonomic dysreflexia can occur in clients who have a spinal cord injury at or above the T-6 level. Autonomic dysreflexia can occur as a result of an irritation, or stimulus to the nervous system below the level of injury. Triggers of autonomic dysreflexia include bladder distention, insertion of rectal suppository, enemas, or a sudden change in position

INCORRECT
4) Elevate the client's head.
Answer Rationale:
A sudden change in position can trigger autonomic dysreflexia.

16. A nurse is caring for a client who is being evaluated for endometrial cancer. Which of the following findings should the nurse expect the client to report?

INCORRECT

1) Hot flashes
Answer Rationale:
Hot flashes are indicative of hormonal changes such as menopause.

INCORRECT
2) Recurrent urinary tract infections
Answer Rationale:
Urinary tract infections are related to the kidney function and can be related to not drinking enough water.

INCORRECT
3) Blood in the stool
Answer Rationale:
Blood in the stool can be a sign of gastrointestinal disease.

4) Abnormal vaginal bleeding
Answer Rationale:
The nurse should expect the client to experience abnormal vaginal bleeding, including postmenopausal bleeding and bleeding between normal periods. Abnormal vaginal bleeding is the most common finding in endometrial cancer in premenopausal women.

17. A nurse is caring for a client following an open reduction and internal fixation of a fractured femur. Which of the following findings is the nurse's priority?

1) Altered level of consciousness

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse determines that the priority finding is for the nurse to monitor the client's altered level of consciousness. A fracture of one of the long bones of the body places the client is at risk for fat embolism, which causes a decrease in oxygenation and alters the client's level of consciousness.

INCORRECT

2) Oral temperature of 37.7° C (100° C)

Answer Rationale:

The nurse should monitor the client's temperature, as this can be a risk for infection or a fat embolism; however, another action is the priority.

INCORRECT

3) Muscle spasms

Answer Rationale:

The nurse should observe the client for muscle spasms as a manifestation following this type of procedure; however, another action is the priority.

INCORRECT

4) Headache

Answer Rationale:

The nurse should observe the client for a headache to address his pain; however, another action is the priority.

18. A nurse is assisting in the care of a client who is 2 hours postoperative following a wedge resection of the left lung and has a chest tube to suction. Which of the following is the priority finding the nurse should report to the provider?

1) Abdomen is distended

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse should recognize the presence of abdominal distention has the potential to compromise the client’s respiratory status as the distention increases abdominal pressure on the diaphragm and impairs ventilation. This is the priority finding for the nurse to report.

INCORRECT

2) Chest tube drainage of 70 mL in the last hour

Answer Rationale:

The nurse should monitor the drainage from the chest tube system for quantity and characteristics of the drainage, as increases in drainage or the presence of bright red drainage may indicate bleeding. 70 mL of drainage in an hour is within the accepted limits during the first 3 hours postoperatively; therefore, another finding is the priority.

INCORRECT

3) Subcutaneous emphysema is noted to the left chest wall

Answer Rationale:

The nurse should monitor and report subcutaneous emphysema in a client who has a chest tube as this may be an indication of air leaking from the lung into the tissues; however, another finding is the priority.

INCORRECT

4) Pain level of 6 on a 0 to 10 scale

Answer Rationale:
The nurse should assess and manage pain in the postoperative client. Uncontrolled pain results in prolonged healing time, and decreased depth of respirations which might result in pneumonia; however, another finding is the priority.

19. A nurse is reinforcing discharge teaching with a client about how to care for a newly created ileal conduit. Which of the following instructions should the nurse include in the teaching?

INCORRECT

1) Change the ostomy pouch daily.
Answer Rationale:
The ostomy pouch is changed every 3 to 7 days.

2) Empty the ostomy pouch when it is 2/3 full.
Answer Rationale:
The ileal conduit cannot store urine the way the bladder did; urine will flow continuously into a collecting device. Emptying the device when the pouch is 2/3 full will prevent leakage, skin irritation, and infection.

INCORRECT

3) Trim the opening of the ostomy seal to be 1/2 in. wider than the stoma.
Answer Rationale:
The opening of the ostomy seal should be trimmed to be 1/16 to 1/8 in. wider than the stoma. A larger opening allows urine to collect on the skin leading to skin breakdown.

INCORRECT

4) Apply lotion to the peristomal skin when changing the ostomy pouch.
Answer Rationale:
When changing the ostomy pouch, the peristomal skin should be washed and dried completely. Any remaining moisture or lotion on the skin will prevent adherence of the pouch causing leakage of urine.

20. A nurse is assisting in the plan of care for a client who had a removal of the pituitary gland. Which of the following actions should the nurse include in the plan?

INCORRECT

1) Position the client supine while in bed.
Answer Rationale:
The nurse should place the client in a semi-Fowler's position to decrease intracranial pressure, which could lead to a cerebrospinal fluid leak.

2) Change the nasal drip pad as needed.
Answer Rationale:
The nurse should change the nasal drip pad as needed because the client will have nasal packing and bloody nasal drainage until the surgical site is healed.

INCORRECT

3) Encourage frequent brushing of teeth.
Answer Rationale:
The nurse should inform the client not to brush his teeth, because it will interfere with the healing process.

INCORRECT

4) Encourage the client to cough every 2 hr following surgery.

Answer Rationale:

The nurse should instruct the client to not cough, because it may interfere with the healing process and may lead to cerebrospinal fluid leak.

21. A nurse is caring for a client who asks why she is being prescribed aspirin 325 mg daily following a myocardial infarction. The nurse should instruct the client that aspirin is prescribed for clients who have coronary artery disease for which of the following effects?

INCORRECT

1) To provide analgesia

Answer Rationale:

Although aspirin is used to provide analgesia for mild to moderate pain, the nurse should recognize that it is prescribed to this client for a different therapeutic effect.

INCORRECT

2) To reduce inflammation

Answer Rationale:

Although aspirin is used to reduce inflammation for illnesses such as osteoarthritis, the nurse should recognize that it is prescribed to this client for a different therapeutic effect.

3) To prevent blood clotting

Answer Rationale:

Aspirin is used to prevent clot formation by reducing platelet aggregation. Therefore, the nurse should instruct the client the aspirin is prescribed for clients who have coronary artery disease to prevent myocardial infarction caused by clots in the coronary arteries.

INCORRECT

4) To prevent fever

Answer Rationale:

Although aspirin is used as an antipyretic agent for adult clients, the nurse should recognize that it is prescribed to this client for a different therapeutic effect. Aspirin should not be used to treat fever for client suspected to have meningitis.

22. A nurse is collecting data from a client who has open-angle glaucoma. Which of the following findings should the nurse expect?

1) Loss of peripheral vision

Answer Rationale:

The nurse should expect to find the client experiencing a gradual loss of peripheral vision with a narrowing of the visual field with open-angle glaucoma.

INCORRECT

2) Headache

Answer Rationale:

Headache is associated with acute angle-closure glaucoma.

INCORRECT

3) Halos around lights

Answer Rationale:

A halo around lights with blurred vision is associated with acute angle-closure glaucoma.

INCORRECT

4) Discomfort in the eyes

Answer Rationale:

Discomfort in the eyes is associated with acute angle-closure glaucoma.

23. A nurse is collecting data from a client who has acute gastroenteritis. Which of the following data collection findings should the nurse identify as the priority?

INCORRECT

1) Weight loss of 3% of total body weight.

Answer Rationale:

The nurse should monitor a weight loss of 3% of total body weight, which indicates mild fluid volume deficit; however, another finding is the priority.

INCORRECT

2) Blood glucose 150 mg/dL

Answer Rationale:

The nurse should monitor a blood glucose of 150 mg/dL, which indicates mild hyperglycemia; however, another finding is the priority.

3) Potassium 2.5 mEq/L

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse determines that the priority finding is a potassium level of 2.5 mEq/dL. In the presence of fluid volume deficit, potassium depletion can occur. Complications from hypokalemia include cardiac and respiratory manifestations.

INCORRECT

4) Urine specific gravity 1.035

Answer Rationale:

The nurse should monitor a urine specific gravity of 1.035, which indicates concentrated urine; however, another finding is the priority.

24. A nurse is reinforcing discharge teaching with a client who had a total abdominal hysterectomy and a vaginal repair. Which of the following statements by the client indicates a need for further teaching?

INCORRECT

1) "I should increase my intake of protein and vitamin C."

Answer Rationale:

The client should increase her intake of protein and vitamin C to promote wound healing.

INCORRECT

2) "I will no longer have menstrual periods."

Answer Rationale:

Following a total abdominal hysterectomy the client may have vaginal discharge for a short period of time, but the client will no longer have menstrual periods.

INCORRECT

3) "Once I am able to resume sexual activity, I can use a water-based lubricant if I experience discomfort."

Answer Rationale:

The client who has had a vaginal repair may experience discomfort during intercourse. A water-based lubricant may help to reduce the discomfort.

4) "I will take a tub bath instead of a shower."

Answer Rationale:

To reduce the risk of infection, the client should avoid tub baths following a total abdominal hysterectomy.

25. A nurse is assisting with the care of a client who has a femur fracture and is in skeletal traction. Which of the following actions should the nurse take?

INCORRECT

1) Loosen the knots on the ropes if the client is experiencing pain.

Answer Rationale:

The knots should never be loosened on the ropes. Doing this will unsecure the traction and possibly injure the client.

2) Ensure the client's weights are hanging freely from the bed.

Answer Rationale:

The nurse should ensure that the client's weights are hanging freely from the bed to maintain the client in proper body alignment and should never be removed without a provider prescription or the development of a life-threatening situation that requires removal.

INCORRECT

3) Check the client's bony prominences every 12 hr.

Answer Rationale:

The client's bony prominences and skin should be checked every 8 hr for skin breakdown, irritation, and inflammation.

INCORRECT

4) Cleanse the client's pin sites with povidone-iodine.

Answer Rationale:

The nurse should cleanse the client's pin sites with chlorhexidine solution to keep the sites clean and free from bacteria.

26. A nurse in a provider's office is reinforcing teaching with a client who has anemia and has been taking ferrous gluconate for several weeks. Which of the following instructions should the nurse include?

1) Take this medication between meals.

Answer Rationale:

Although taking iron supplements with food can decrease adverse effects, it also drastically reduces the absorption of iron. Therefore, the nurse should instruct the client that taking iron is most effective when supplements are taken in between meals.

INCORRECT

2) Limit intake of Vitamin C while taking this medication.

Answer Rationale:

Taking Vitamin C (ascorbic acid) at the same time as taking iron can enhance the absorption of iron, but it can increase the incidence of adverse effects. However, there is no reason for the client to limit overall intake of ascorbic acid.

INCORRECT

3) Take this medication with milk.

Answer Rationale:

The nurse should instruct the client not to take iron with milk because it decreases the absorption of the iron.

INCORRECT

4) Limit intake of whole grains while taking this medication.

Answer Rationale:

The nurse should instruct the client to increase consumption of high-fiber foods, such as whole grains, while taking iron to prevent constipation.

27. A nurse in a provider's office is reinforcing teaching with a client who has anemia and has been taking ferrous gluconate for several weeks. Which of the following instructions should the nurse include?

1) Take this medication between meals.

Answer Rationale:

Although taking iron supplements with food can decrease adverse effects, it also drastically reduces the absorption of iron. Therefore, the nurse should instruct the client that taking iron is most effective when supplements are taken in between meals.

INCORRECT

2) Limit intake of Vitamin C while taking this medication.

Answer Rationale:

Taking Vitamin C (ascorbic acid) at the same time as taking iron can enhance the absorption of iron, but it can increase the incidence of adverse effects. However, there is no reason for the client to limit overall intake of ascorbic acid.

INCORRECT

3) Take this medication with milk.

Answer Rationale:

The nurse should instruct the client not to take iron with milk because it decreases the absorption of the iron.

INCORRECT

4) Limit intake of whole grains while taking this medication.

Answer Rationale:

The nurse should instruct the client to increase consumption of high-fiber foods, such as whole grains, while taking iron to prevent constipation.

28. A nurse is reviewing the plan of care for a client who has cellulitis of the leg. Which of the following interventions should the nurse recommend?

INCORRECT

1) Apply topical antifungal agents.

Answer Rationale:

Cellulitis is a bacterial infection; therefore, the nurse should not plan to apply an antifungal agent.

INCORRECT

2) Apply fresh ice packs every 4 hr.

Answer Rationale:

The nurse should plan to use warm compresses for a client who has a bacterial infection to reduce edema to the area.

3) Wash daily with an antibacterial soap.

Answer Rationale:

The nurse should plan to have the client wash the area daily with an antibacterial soap to promote tissue health and treat the infection.

INCORRECT

4) Keep draining lesions uncovered to air dry.

Answer Rationale:

The nurse should plan to cover any lesions with exudate using a sterile dressing.

29. A nurse is reinforcing teaching with a client who is postoperative after having an ileostomy established. Which of the following instructions should the nurse include in the teaching?

INCORRECT

1) Empty the pouch immediately after meals.

Answer Rationale:

The client should wait for up to 4 hr after eating to empty the pouch, because the client’s bowel is less active.

INCORRECT

2) Change the entire appliance once a day.

Answer Rationale:

The client should leave the entire appliance in place for 3 days to a week if not leaking.

INCORRECT

3) Limit fluid intake.

Answer Rationale:

The client should drink plenty of water and other liquids to avoid fluid volume deficit, due to the loss of fluid caused by the ileostomy.

4) Avoid medications in capsule or enteric form.

Answer Rationale:

The client should not take medications in capsule or enteric form because the medication may enter the pouch undigested.

30. A nurse is caring for a client with severe burns to both lower extremities. The client is scheduled for an escharotomy and wants to know what the procedure involves. Which of the following statements is appropriate for the nurse to make?

INCORRECT

1) "An escharotomy surgically removes dead tissue."

Answer Rationale:

This statement refers to surgical debridement. Necrotic tissue and exudate are removed to stimulate granulation and revascularization of the burn wound. It can be performed surgically or nonsurgically through mechanical or enzymatic actions.

INCORRECT

2) "A cannula will be inserted into the bone to infuse fluids and antibiotics."

Answer Rationale:

This statement refers to intraosseous infusion therapy. Intraosseous infusion is used in cases of severe trauma, burns, or other life-threatening conditions when intravenous access cannot be obtained.

INCORRECT

3) "A piece of skin will be removed and grafted over the burned area."

Answer Rationale:

This statement refers to a skin graft. A skin graft is a surgical procedure in which a piece of skin from one area of the client's body is transplanted to another area.

4) "Large incisions will be made in the burned tissue to improve circulation."

Answer Rationale:

An escharotomy is a surgical incision made to release pressure and improve circulation in a part of the body that has had a deep burn and is experiencing significant swelling. The swelling that occurs secondary to burn injuries that completely encircle a body part, such as an arm or the chest, can cause tightness and constriction of underlying tissue and can shut off circulation in the affected area. Making surgical incisions into the burned tissue allows the skin to expand and re-establish circulation.

31. A nurse is collecting data from a client who has a possible cataract. Which of the following manifestations should the nurse expect the client to report?

1) Decreased color perception

Answer Rationale:

Visual manifestations associated with cataracts can include decreased color perception and decreased visual acuity, even in daylight.

INCORRECT

2) Loss of peripheral vision

Answer Rationale:

Loss of peripheral vision occurs in clients who have open-angle glaucoma.

INCORRECT

3) Bright flashes of light

Answer Rationale:

Bright flashes of light and floaters are associated with retinal detachment.

INCORRECT

4) Eyestrain

Answer Rationale:

Eyestrain is associated with decreased visual acuity.

32. A nurse is contributing to the plan of care for a client who has an intestinal obstruction and is receiving continuous gastrointestinal decompression using a nasogastric tube. Which of the following interventions should the nurse include in the plan of care?

INCORRECT

1) Measure abdominal girth daily.

Answer Rationale:

An increase in abdominal girth indicates that the client's abdominal distension has increased. The nurse should measure the client's abdominal girth every 4 to 8 hr.

INCORRECT

2) Use sterile water to irrigate the nasogastric tube.

Answer Rationale:

To preserve the client's electrolyte balance, the nurse should use 0.9% sodium chloride to irrigate the nasogastric tube.

3) Maintain the client in Fowler's position.

Answer Rationale:

The nurse should place the client in Fowler's position to reduce pressure on the diaphragm and to promote function of the nasogastric tube.

INCORRECT

4) Moisten the client's lips with lemon-glycerin swabs.

Answer Rationale:

The nurse should avoid using lemon-glycerin swabs because they cause drying of the lips. The nurse should use a water-soluble lip lubricant to moisten the client's lips.

33. A nurse is caring for a client who has Cushing's syndrome. Which of the following clinical manifestations should the nurse expect to observe? (Select all that apply.)

1) Buffalo hump

2) Purple striations

3) Moon face

INCORRECT

4) Tremors

INCORRECT

5) Obese extremities

Answer Rationale:

Buffalo hump is correct. Cushing's syndrome is a disease caused by an increased production of cortisol or by excessive use of corticosteroids. Buffalo hump, a collection of fat between the shoulders, is a common manifestation of Cushing's syndrome.**Purple striations is correct.** Purple striations on the skin of the abdomen, thighs, and breasts are a common manifestation of Cushing's syndrome. This is due to the collection of body fat in these areas.**Moon face is correct.** Moon face is a common manifestation of Cushing's syndrome. Clients who have this manifestation present with a round, red, full face.**Tremors is incorrect.** Tremors are not a common finding of Cushing's syndrome.**Obese extremities is incorrect.** Clients who have Cushing's syndrome have truncal obesity, a protuberant abdomen, with thin extremities, which is due to an alteration in protein metabolism.

34. A nurse is caring for a client who is in the oliguric phase of acute kidney injury. Which of the following actions should the nurse take?

INCORRECT

1) Provide a diet high in protein.

Answer Rationale:

The client with acute kidney injury is limited on their protein intake as this decreases the risk of the client developing chronic renal failure.

INCORRECT

2) Provide ibuprofen for retroperitoneal discomfort.

Answer Rationale:

The nurse should avoid administering medications that are nephrotoxic to a client who has acute kidney injury. The injury to the kidney causes an increase in drug excretion which can lead to toxic levels.

3) Monitor intake and output hourly

Answer Rationale:

The nurse should closely monitor the client for signs of fluid imbalance. This includes hourly monitoring of intake and output, along with daily weights. If there are sudden changes, or the urinary output is less than 30 mL/hr, the provider must be notified immediately.

INCORRECT

4) Encourage the client to consume at least 2 L of fluid daily.

Answer Rationale:

The client who is in the oliguric stage of acute kidney injury is not producing urine and will be placed on fluid restrictions, often less than 1,200 mL daily which includes intravenous fluids. Excessive fluid intake can result in fluid overload.

35. A nurse is reinforcing teaching about an esophagogastroduodenoscopy with a client who has upper gastric pain. Which of the following statements should the nurse include in the teaching?

INCORRECT

1) "A flexible tube is introduced through the nose during the procedure."

Answer Rationale:

The nurse should include in the teaching that a flexible tube is introduced through the client's mouth with the head extended for easier entry and visualization.

INCORRECT

2) "During the procedure you are in a sitting position."

Answer Rationale:

The nurse should include in the teaching that the client will lie down with the head of bed elevated slightly during the procedure. The client's head is extended for easier entry and visualization.

3) "You will remain NPO for 8 hours before the procedure."

Answer Rationale:

The nurse should include in the teaching for the client to remain NPO for 8 hr before the procedure to have the stomach free of food contents, decrease vomiting, and decrease the risk for aspiration.

INCORRECT

4) "You will be awake while the procedure is performed."

Answer Rationale:

The nurse should include in the teaching that the client will receive moderate sedation during the procedure to promote relaxation for easier entry and visualization.

36. A nurse is caring for a client who is difficult to arouse and very sleepy for several hours following a generalized tonic-clonic seizure. Which of the following descriptions should the nurse use when documenting this finding in the medical record?

INCORRECT

1) Aura phase

Answer Rationale:

The nurse should use the term "aura" to describe manifestations the client experienced prior to a seizure.

INCORRECT

2) Presence of automatisms

Answer Rationale:

The nurse should use the term "automatisms" to describe repetitive, non-purposeful actions a client might exhibit as part of a complex, partial seizure.

3) Postictal phase

Answer Rationale:

The postictal phase is the recovery period following a tonic-clonic seizure. The client might be confused or agitated after a seizure and might sleep for several hours.

INCORRECT

4) Presence of absence seizures

Answer Rationale:

The nurse should use the term "absence seizure" to describe a brief loss of consciousness experienced by a client accompanied by staring.

37. A nurse is reinforcing teaching with a client who reports right shoulder pain following a laparoscopic cholecystectomy. Which of the following statements should the nurse make?

INCORRECT

1) "The pain results from lying in one position too long during surgery."

Answer Rationale:

The client who lies in one position during surgery can have stiffness following surgery.

INCORRECT

2) "The pain occurs as a residual pain from cholecystitis."

Answer Rationale:

The client's right shoulder pain is due to the carbon dioxide injected into the abdominal cavity to visualize and access the abdominal structure. The carbon dioxide causes referred pain in the clavicle and shoulder area.

3) "The pain will dissipate if you ambulate frequently."

Answer Rationale:

The client who has right shoulder pain following the procedure should ambulate as soon and as much as possible to dissipate the carbon dioxide gas that was injected into the abdominal cavity to visualize and access the abdominal structure. The carbon dioxide causes referred pain in the clavicle and shoulder area.

INCORRECT

4) "The pain is caused from the nitrous dioxide injected into the abdomen."

Answer Rationale:

The client who had a laparoscopic cholecystectomy will have gas (carbon dioxide) injected into the abdominal cavity to visualize and access the abdominal structures during laparoscopic procedures, which can irritate the diaphragm and cause referred pain in the clavicle and shoulder.

38. A nurse is checking the suction control chamber of a client's chest tube and notes that there is no bubbling in the suction control chamber. Which of the following actions should the nurse take?

INCORRECT

1) Notify the provider.

Answer Rationale:

The nurse should check for kinks and take other measures before notifying the provider.

2) Verify that the suction regulator is on.

Answer Rationale:

The nurse should verify that the suction regulator is turned on because low continual bubbling will occur when the suction is on and there are no kinks in the tubing.

INCORRECT

3) Continue to monitor the client because this is an expected finding.

Answer Rationale:

The nurse should expect the suction control chamber to display gentle bubbling of the water in the suction control chamber; therefore, the nurse should take measures to discover why the suction control chamber is not bubbling.

INCORRECT

4) Milk the chest tube to dislodge any clots in the tubing that may be occluding it.

Answer Rationale:

The nurse should milk the chest tube only when indicated and prescribed by the provider.

39. A nurse is assisting with the care of a client immediately following a lumbar puncture. Which of the following actions should the nurse take? (Select all that apply.)

1) Encourage fluid intake.

2) Monitor the puncture site for hematoma.

INCORRECT

3) Insert a urinary catheter.

INCORRECT

4) Elevate the client’s head of bed.

INCORRECT

5) Apply a cervical collar to the client.

Answer Rationale:

Encourage fluid intake is correct. The nurse should encourage fluids, unless contraindicated, to replace the cerebrospinal fluid that was removed during the procedure and reduce the risk for a headache.

Monitor the puncture site for a hematoma is correct. The nurse should monitor and report a hematoma at the insertion site because this can indicate bleeding.

Insert a urinary catheter is incorrect. There is no indication for a urinary catheter insertion.

Elevate the client’s head of bed is incorrect. The client should remain flat in bed for 1 hr or more to reduce the risk for a headache.

Apply a cervical collar to the client is incorrect. There is no indication for a cervical collar for this client.

40. A nurse is assisting with the care of a client who is postoperative following surgical repair of a fractured mandible. The client’s jaw is wired shut to repair and stabilize the fracture. The nurse should recognize which of the following is the priority action?

INCORRECT

1) Relieve the client's pain.

Answer Rationale:

The nurse should provide pain medications and ice as prescribed to reduce the client’s pain; however, another action is the priority.

INCORRECT

2) Check the client’s pressure points for redness.

Answer Rationale:

The nurse should check the client’s pressure points for redness that could become a pressure ulcer; however, another action is the priority.

INCORRECT

3) Provide oral hygiene.

Answer Rationale:

The nurse should provide oral hygiene for the client to promote comfort; however, another action is the priority.

4) Prevent aspiration.

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse should determine the priority action is to prevent aspiration. Since the client’s jaws are wired together, aspiration is a risk if the client vomits. Therefore, the client should receive medication for nausea, as indicated, and wire cutters and suction are kept at the bedside at all times in case of vomiting or difficulty breathing.

41. A nurse is collecting data from a client who has scleroderma. Which of the following findings should the nurse expect?

INCORRECT

1) A dry raised rash

Answer Rationale:

A dry raised rash, usually located on the client's face, is an expected finding with systemic lupus erythematosus.

INCORRECT

2) Excessive salivation

Answer Rationale:

Excessive salivation is an expected finding with a cholinergic crisis, which can be cause by an overdose of anticholinesterase.

INCORRECT

3) Periorbital edema

Answer Rationale:

Periorbital edema is an expected finding with dermatomyositis or an acute allergic reaction.

4) Hardened skin

Answer Rationale:

Hardened, tight skin is an expected finding with scleroderma. In addition to rigid skin and subcutaneous tissues, the distal extremities stiffen and lose mobility. It can also cause disorders of the heart, lungs and kidneys.

42. A nurse is caring for an older adult client who has dysphagia and left-sided weakness following a stroke. Which of the following actions should the nurse take?

INCORRECT

1) Instruct the client to tilt her head back when she swallows.

Answer Rationale:

The nurse should instruct the client to tilt her head forward when she swallows to facilitate swallowing and prevent aspiration.

INCORRECT

2) Place food on the left side of the client's mouth.

Answer Rationale:

The nurse should place food on the unaffected side of the client's mouth to facilitate swallowing and prevent aspiration.

3) Add thickener to fluids.

Answer Rationale:

The nurse should thicken fluids to make them easier to swallow and prevent aspiration.

INCORRECT

4) Serve food at room temperature.

Answer Rationale:

The nurse should serve food cold or warm to facilitate swallowing and prevent aspiration.

43. A nurse is caring for a client who has partial-thickness and full-thickness burns of his head, neck, and chest. The nurse should recognize which of the following is the priority risk to the client?

1) Airway obstruction

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse determines that the priority risk to this client is airway obstruction. Burns in this area can involve damage to the upper airway, resulting in swelling and respiratory compromise. The nurse should monitor the client for manifestations of respiratory distress.

INCORRECT

2) Infection

Answer Rationale:

The nurse should monitor the client for infection due to compromised skin integrity. However, another risk is the priority.

INCORRECT

3) Fluid imbalance

Answer Rationale:

The nurse should monitor the client for fluid imbalance due to fluid shift and loss of fluids through compromised skin integrity. However, another risk is the priority.

INCORRECT

4) Contractures

Answer Rationale:

The nurse should monitor the client for contractures due to altered tissue elasticity as a result of scarring. However, another risk is the priority.

44. A nurse is reinforcing teaching with a client who is newly diagnosed with myasthenia gravis and is to start taking neostigmine. Which of the following instructions should the nurse include in the teaching?

1) Take the medication 45 minutes before eating.

Answer Rationale:

The nurse should instruct the client to take the medication before eating to allow the medication time to work and limit difficulty chewing and swallowing.

INCORRECT

2) Expect diaphoresis as a side effect of the neostigmine.

Answer Rationale:

The nurse should reinforce that diaphoresis is an indication of cholinergic crisis caused by overmedication with the neostigmine. It is a medical emergency.

INCORRECT

3) If a medication dose is missed, wait until the next scheduled dose to take the medication.

Answer Rationale:

The nurse should reinforce the importance of taking the medication on a strict schedule to minimize the potential for myasthenic crisis. This is manifested as increased muscle weakness, dysphagia, impaired speech, severe respiratory distress and anxiety.

INCORRECT

4) Treat nasal rhinitis with an over-the-counter antihistamine.

Answer Rationale:
The nurse should emphasize that the client should contact her provider before taking any over-the-counter medication. Antihistamines can actually worsen the symptoms of myasthenia gravis and should be avoided.

45. A nurse is caring for a client who is 12 hours postoperative following a transurethral resection of the prostate (TURP) and has a 3-way urinary catheter with continuous irrigation. The nurse notes there has not been any urinary output in the last hour. Which of the following actions should the nurse perform first?

INCORRECT

1) Notify the provider.
Answer Rationale:
The nurse should notify the provider with updates regarding potential complications in the care of the client; however, another action is the priority.

INCORRECT
2) Administer a prescribed analgesic.
Answer Rationale:
The nurse should provide the client who has had a TURP with an analgesic if needed, since bladder spasms are a potential complication of the procedure; however, another action is the priority.

INCORRECT
3) Offer oral fluids.
Answer Rationale:
Increasing oral fluid intake is important for the client who has undergone a TURP in order to ensure adequate renal functioning and urinary output; however another action is the priority.

4) Determine the patency of the tubing.
Answer Rationale:
The first action the nurse should take when using the nursing process is to determine the patency of the tubing by assessing for kinks in the tubing or the presence of clots. A lack of drainage may be the result of kinked drainage tubing, a blood clot, or tissue blocking the drainage tubing.

46. A nurse is caring for a client scheduled for a bone marrow biopsy. The client expresses fear about the procedure and asks the nurse if the biopsy will hurt. Which of the following responses should the nurse make?

INCORRECT

1) "You must be very worried about what the biopsy will show."
Answer Rationale:
This response is nontherapeutic because it is judgmental and does not address the information that the client is seeking.

INCORRECT
2) "You'll be asleep for the whole biopsy procedure and won't be aware of what’s happening."
Answer Rationale:

This response is nontherapeutic because it discourages further communication from the client. The nurse should understand the client will not receive general anesthesia for this procedure.

INCORRECT

3) "Your provider scheduled this, so she will want to know you still have questions about the procedure."

Answer Rationale:

This response is nontherapeutic because it puts the client's concerns on hold and focuses on the provider.

4) "The biopsy can be uncomfortable, but we will try to keep you as comfortable as possible."

Answer Rationale:

This response is therapeutic because it gives the client the information that she needs to cope, and reassures the client of the plan to address her comfort, and allows for further communication of concerns by the client.

47. A nurse is assisting with planning care for a client who is recovering from a left-hemispheric stroke. Which of the following interventions should the nurse include in the plan?

INCORRECT

1) Control impulsive behavior.

Answer Rationale:

A client who has a right-hemisphere lesion is likely to be impulsive. Clients who have a left-hemisphere lesion are typically cautious.

INCORRECT

2) Compensate for left visual field deficits.

Answer Rationale:

A client who has a right-hemisphere lesion is likely to experience visual field deficits of the right side.

3) Re-establish communication.

Answer Rationale:

A stroke is an interruption of the blood supply to a part of the brain, resulting in oxygen-deprived brain tissue. The left hemisphere is usually dominant for language. Because this client had a left-hemispheric stroke, the nurse can anticipate that the client will have some degree of aphasia and will require communication-focused nursing interventions and speech therapy to re-establish communication.

INCORRECT

4) Improve left-side motor function.

Answer Rationale:

A client who has a right-hemisphere lesion can experience hemiplegia on the left side.

48. A nurse is assisting with the care of a client who has diabetes insipidus. The nurse should monitor the client for which of the following manifestations?

1) Hypotension

Answer Rationale:

The client who has diabetes insipidus produces excessive urine resulting in hypovolemia and hypotension. The nurse should monitor the client for hypotension and dehydration.

INCORRECT

2) Polyphagia

Answer Rationale:

Polyphagia, or excessive hunger, is a manifestation of diabetes mellitus.

INCORRECT

3) Hyperglycemia

Answer Rationale:

Hyperglycemia, or elevated blood glucose, is a manifestation of diabetes mellitus.

INCORRECT

4) Bradycardia

Answer Rationale:

Tachycardia is a manifestation of diabetes insipidus.

49. A nurse is reviewing the laboratory results of a client who is postoperative and has a respiratory rate of 7/min. The arterial blood gas (ABG) values include:

    pH 7.22
    $PaCO_2$ 68 mm Hg
    Base excess -2
    PaO_2 78 mm Hg
    Oxygen saturation 80%
    Bicarbonate 28 mEq/L
    Which of the following interpretations of the ABG values should the nurse make?

INCORRECT

1) Metabolic acidosis

Answer Rationale:

The nurse should identify the client who has metabolic acidosis as having an excessive loss of bicarbonate through diarrhea, or an increased retention of hydrogen ions such as that seen in renal failure. A client who has metabolic acidosis would have a pH and a bicarbonate levels that are lower than the normal reference ranges.

2) Respiratory acidosis

Answer Rationale:

The nurse should identify the client who has respiratory problems such as obstruction or depression of the respiratory system as at risk for the development of respiratory acidosis. The expected pH range is 7.35 to 7.45. The pH of 7.22 indicates that this client is acidotic. The pH is decreased while the $PaCO_2$ is elevated. Therefore, the correct interpretation of the results is that the client is in respiratory acidosis.

INCORRECT

3) Metabolic alkalosis

Answer Rationale:

The nurse should identify the client who has metabolic alkalosis as a client who has a loss of hydrochloric acid through vomiting, gastric suction, or excessive use of antacids. The pH of the client would be higher than the normal reference range of 7.35 – 7.45 and the bicarbonate would be higher than the normal reference range of 22 – 26 mEq/L.

INCORRECT

4) Respiratory alkalosis

Answer Rationale:

The nurse should identify the client who is hyperventilating or has an elevated temperature as being at risk for respiratory alkalosis. The pH of the client would be higher than the normal reference range of 7.35 – 7.45 and the $PaCO_2$ would be lower than the normal reference range of 35 – 45 mm Hg.

50. A nurse is reinforcing teaching with a client who has peripheral vascular disease (PVD). The nurse should recognize that which of the following statements by the client indicates a need for further teaching?

INCORRECT

1) "I will avoid crossing my legs at the knees."

Answer Rationale:

The nurse should reinforce with the client to avoid crossing her legs at the knees because this can impair circulation.

INCORRECT

2) "I will use a thermometer to check the temperature of my bath water."

Answer Rationale:

The nurse should reinforce with the client to use a thermometer to check the temperature of bath water to reduce the risk of burns. PVD can impair the client's ability to sense water temperature.

INCORRECT

3) "I will not go barefoot."

Answer Rationale:

The nurse should reinforce with the client to wear shoes at all times to protect her feet from injury.

4) "I will wear stockings with elastic tops."

Answer Rationale:

The nurse should reinforce with the client to avoid constrictive clothing that can impair circulation.

51. A nurse is preparing to provide morning hygiene care for a client who has Alzheimer's disease. The client becomes agitated and combative when the nurse approaches him. Which of the following actions should the nurse plan to take?

INCORRECT

1) Turn the water on and ask the client to test the temperature.

Answer Rationale:

The nurse should recognize that hearing water running could increase the client's agitation, and asking the client to check the water temperature could cause injury to the client.

INCORRECT

2) Obtain assistance to place mitten restraints on the client.

Answer Rationale:

The nurse should not use restraints unless the client is at risk for harm to himself or others, and after attempting all other alternatives to restraints first.

INCORRECT

3) Firmly tell the client that good hygiene is important.

Answer Rationale:

The nurse should avoid using firm speech, which could be interpreted by the client as a threat and could increase his anxiety. The client has impaired cognition and thinking; therefore, reasoning intellectually with the client is not likely to be effective.

4) Calmly ask the client if he would like to listen to some music.

Answer Rationale:

The nurse should remain calm to avoid agitating the client further. By offering to play music, the nurse may be able to distract the client and then reintroduce the idea of morning care.

52. A nurse is collecting data on a client's wound. The nurse observes that the wound surface is covered with soft, red tissue that bleeds easily. The nurse should recognize this is a manifestation of which of the following?

INCORRECT

1) Decreased perfusion

Answer Rationale:

Rationale A. Manifestations of decreased perfusion to wound is tissue is tissue that appears black or necrotic

INCORRECT

2) Infection

Answer Rationale:

Manifestations of a wound infection is tissue that appears erythematous, or red, and can have exudate or pus.

3) Granulation tissue

Answer Rationale:

Granulation tissue forms in healing wounds during the proliferative phase. Granulation tissue is soft, red tissue with a granular appearance that bleeds easily.

INCORRECT

4) An inflammatory response

Answer Rationale:

A manifestation of an inflammatory response is tissue that appears reddened and edematous.

53. A nurse is caring for a client who has multiple myeloma and has a WBC count of 2,200/mm^3. Which of the following food items brought by the family should the nurse prohibit from being given to the client?

INCORRECT

1) Baked chicken

Answer Rationale:

The nurse should encourage the client to consume a diet that is high in proteins, calories, and calcium to enhance nutrition and the client's ability to fight infection. Baked chicken would be an acceptable food to include in the client's diet.

INCORRECT

2) Bagels

Answer Rationale:
The nurse should encourage the client to consume a diet that is high in proteins, calories, and calcium to enhance nutrition and the client's ability to fight infection. A bread product, such as a bagel, is an acceptable food to include in the client's diet.

INCORRECT

3) A factory-sealed box of chocolates
Answer Rationale:
The nurse should recommend the client consume nutrient dense foods that are high in calories and protein; however, a box of chocolates may stimulate the diet and is appropriate as an occasional treat.

4) Fresh fruit basket
Answer Rationale:
The nurse should instruct the client's family that certain food products such as fresh fruit and vegetables should be excluded from the client's diet to reduce the risk of foodborne illness. An alternative to the fresh fruits would be a package of dried fruits.

54. A nurse is contributing to the plan of care for an older adult client who is postoperative following a right hip arthroplasty. Which of the following interventions should the nurse include in the plan?

INCORRECT

1) Perform the client's personal care activities for her.
Answer Rationale:
The client should be encouraged to perform all of the activities of ADLs possible, in order to promote independence. This would include grooming (brushing hair and teeth, washing hands and face) and eating meals.

INCORRECT

2) Limit the client's fluid intake.
Answer Rationale:
The nurse should encourage the client to drink 2.5 to 3 L of fluid daily in order to maintain hydration, bowel and renal function. .

INCORRECT

3) Monitor the Homan's sign.
Answer Rationale:
The nurse should monitor the postoperative client for the development of deep vein thrombosis; however, the presence of a positive Homan's sign is an unreliable indicator of this complication.

4) Maintain abduction of the right hip.
Answer Rationale:
The nurse should use an abductor pillow or other device to maintain abduction of the affected hip to prevent dislocation.

55. A nurse is caring for a client who has heart failure and respiratory arrest. Which of the following actions should the nurse take first?

INCORRECT

1) Establish IV access.
Answer Rationale:

The nurse should establish IV access for the delivery of emergency medications; however, another action is the priority.

2) Feel for a carotid pulse.

Answer Rationale:

The priority action the nurse should take when using the compressions-airway-breathing approach to client care is to feel for a carotid pulse for 5 to 10 seconds to determine the immediate need for chest compressions.

INCORRECT

3) Establish an open airway.

Answer Rationale:

The nurse should establish an open airway to enable ventilation; however, another action is the priority.

INCORRECT

4) Auscultate for breath sounds.

Answer Rationale:

The nurse should auscultate breath sounds to confirm that there is ventilation; however, another action is the priority. The nurse already knows the client has a respiratory arrest. There will be no lung sounds until the nurse establishes ventilation through a patent airway with a bag-valve-mask.

56. A nurse is caring for a client scheduled for coronary artery bypass grafting who reports he is no longer certain he wants to have the procedure. Which of the following responses should the nurse make?

INCORRECT

1) "Why have you changed your mind about the surgery?"

Answer Rationale:

This response is nontherapeutic because it is probing the client for an explanation, which can cause the client to become defensive.

2) "Bypass surgery must be very frightening for you."

Answer Rationale:

This response is therapeutic because it shows empathy and focuses on the client's feelings in a nonthreatening way, and it encourages the client to express his feelings.

INCORRECT

3) "Your provider would not have scheduled the surgery unless you needed it."

Answer Rationale:

This response is nontherapeutic because it minimizes the client's feelings and can appear judgmental or disagreeing.

INCORRECT

4) "I will call your doctor and have him discuss your surgery with you."

Answer Rationale:

This response is nontherapeutic because it does not address the client's feelings by refusal to discuss the issue.

57. A nurse is caring for a client who is postoperative following foot surgery and is not to bear weight on the operative foot. The nurse enters the room to discover

the client hopped on one foot to the bathroom, using an IV pole for support. Which of the following actions should the nurse take?

INCORRECT

1) Walk the client back to bed immediately and get the client a bedpan.

Answer Rationale:

The nurse should not plan to walk the client back to bed because the client can't bear weight on one foot, and this will require the client to have to hop back to bed. This will alter the client's balance and possibly cause injury to the client and nurse.

2) Tell the client to remain in the bathroom after toileting and obtain a wheelchair.

Answer Rationale:

The greatest risk to the client is falling. Since the client is already in the bathroom, the nurse should allow the client to void, and then return the client to bed safely in a wheelchair to prevent a fall.

INCORRECT

3) Warn the client she might have to be restrained if she gets up without assistance.

Answer Rationale:

The nurse should not threaten to restrain the client for nonadherance to the treatment plan because this is a form of assault, and using restraints without just cause is considered false imprisonment.

INCORRECT

4) Keep the bathroom door open to ensure the client is okay.

Answer Rationale:

The nurse should respect the client's privacy and close the client's bathroom door after determining there is no immediate risk for harm.

58. A nurse is assisting with the care of a client who is postoperative and has a closed-wound drainage system in place. Which of the following actions should the nurse take?

1) Fully recollapse the reservoir after emptying it.

Answer Rationale:

To reestablish the vacuum, the reservoir must be compressed fully after it is emptied.

INCORRECT

2) Empty the reservoir once per day.

Answer Rationale:

The reservoir should be emptied before it becomes full or once per shift to maintain suction pressure.

INCORRECT

3) Replace the drainage plug after releasing hand pressure on the device.

Answer Rationale:

The nurse should replace the drainage plug before releasing hand pressure on the device.

INCORRECT

4) Irrigate the tubing with sterile normal saline solution at least once every 8 hr.

Answer Rationale:
The nurse should not irrigate a closed-wound drainage system.

59. A nurse is reinforcing discharge instructions with a client who has hepatitis A. Which of the following statements by the client indicates an understanding of the teaching?

INCORRECT

1) "I will not eat fried foods."
Answer Rationale:
A client who has cholecystitis should avoid fried and fatty foods.

2) "I will abstain from sexual intercourse."
Answer Rationale:
The client who has hepatitis A should abstain from sexual intercourse during the infectious period.

INCORRECT

3) "I will refrain from international travel."
Answer Rationale:
Clients should receive the hepatitis A vaccine before international travel. However, international travel is not prohibited.

INCORRECT

4) "I will not order a salad in a restaurant."
Answer Rationale:
Hepatitis A is transmitted by the fecal-oral route. The client who is infectious should not prepare food during the infectious period.

60. A nurse is reinforcing discharge teaching on actions that improve gas exchange to a client diagnosed with emphysema. Which of the following instructions should be included in the teaching?

INCORRECT

1) Rest in a supine position.
Answer Rationale:
The nurse should reinforce that the client can relieve dyspnea by elevating her head and aligning her head, body, neck, and chest.

INCORRECT

2) Consume a low-protein diet.
Answer Rationale:
The nurse should reinforce that a high protein, high calorie diet is recommended for the client who has COPD, as this helps maintain nutrition and reduces fatigue.

3) Breathe in through her nose and out through pursed lips.
Answer Rationale:
The nurse should reinforce that pursed-lip breathing slows expiration, prevents collapse of alveoli, and helps the client to control the rate and depth of respirations.

INCORRECT

4) Limit fluid intake throughout the day.
Answer Rationale:

The nurse should encourage the client to drink 2.5 to 3L daily in order to thin secretions and make breathing easier.

61. A nurse is caring for a client who is postoperative and has a history Addison's disease. For which of the following manifestations should the nurse monitor?

INCORRECT

1) Hypernatremia

Answer Rationale:

The client who has Addison's disease is at risk for developing Addisonian crisis following a major physiological stressor such as surgery. The nurse should monitor for the development of hyponatremia and dehydration in the client who is at risk for Addisonian crisis.

2) Hypotension

Answer Rationale:

The client who has Addison's disease is at risk for developing Addisonian crisis following a major physiological stressor such as surgery. Manifestations such as hypotension and tachycardia, extreme weakness and a decrease in mental status are noted. Untreated, Addisonian crisis may result in death.

INCORRECT

3) Bradycardia

Answer Rationale:

The client who has Addison's disease is at risk for developing Addisonian crisis following a major physiological stressor such as surgery. Manifestations the nurse should monitor for include tachycardia.

INCORRECT

4) Hypokalemia

Answer Rationale:

The client who has Addison's disease is at risk for developing Addisonian crisis following a major physiological stressor such as surgery. The nurse should monitor for the development of hyperkalemia and dysrhythmias in the client who is at risk for Addisonian crisis.

62. A nurse is reinforcing pre-operative teaching for a client who is scheduled for surgery and is to take hydroxyzine preoperatively. Which of the following effects of the medication should the nurse include in the teaching? (Select all that apply.)

1) Decreasing anxiety

2) Controlling emesis

INCORRECT

3) Relaxing skeletal muscles

INCORRECT

4) Preventing surgical site infections

5) Reducing the amount of narcotics needed for pain relief

Answer Rationale:

Decreasing anxiety is correct. The nurse should include that hydroxyzine is an effective antianxiety agent and is used to decrease anxiety in surgical clients as well as in persons with moderate anxiety.

Controlling emesis is correct. The nurse should include that hydroxyzine is an effective antiemetic and is used to control nausea and vomiting in pre- and postoperative clients.

Relaxing skeletal muscles is incorrect. The nurse should recognize benzodiazepines, such as diazepam (Valium), are used to produce skeletal muscle relaxation.

Preventing surgical site infections is incorrect. The nurse should instruct the client that antibiotics administered prior to surgery are used to diminish the risk of surgical site infections; hydroxyzine, an antiemetic, does not have any effect on bacteria.

Reducing the amount of narcotics needed for pain relief is correct. Hydroxyzine increases the effects of narcotic pain medications. The nurse should instruct the client that when it is used for surgical clients, narcotic requirements may be significantly reduced.

63. A nurse is reinforcing teaching with a client who has a new prescription for epoetin alfa. The nurse should reinforce to the client to take which of the following dietary supplements with this medication?

INCORRECT

1) Vitamin D

Answer Rationale:

There is no need for the client to take a vitamin D supplement because vitamin D is not necessary for red blood cell production.

INCORRECT

2) Vitamin A

Answer Rationale:

There is no need for the client to take a vitamin A supplement because vitamin A is not necessary for red blood cell production.

3) Iron

Answer Rationale:

Epoetin alfa treats anemia by stimulating the production of red blood cells. Supplemental iron is needed for the production of hemoglobin and red blood cells by the bone marrow. The client should take supplemental iron when taking epoetin alfa.

INCORRECT

4) Niacin

Answer Rationale:

There is no need for the client to take a niacin supplement because niacin is not necessary for red blood cell production.

64. A nurse is caring for a client after a radical neck dissection. To which of the following should the nurse give priority in the immediate postoperative period?

INCORRECT

1) Malnourishment related to NPO status and dysphagia

Answer Rationale:

Although ensuring that the client maintains adequate nutrition is an important nursing action, this is not the priority during the immediate postoperative period.

INCORRECT

2) Impaired verbal communication related to the tracheostomy

Answer Rationale:

Although the client's need to communicate is important, this is not the priority during the immediate postoperative period.

INCORRECT

3) High risk for infection related to surgical incisions

Answer Rationale:

Although monitoring the client for infection is an important nursing action, this is not the priority during the immediate postoperative period.

4) Ineffective airway clearance related to thick, copious secretions

Answer Rationale:

According to the airway, breathing, circulation (ABC) priority-setting framework, the priority action is the client's need for adequate oxygenation. A client who has a new tracheostomy requires frequent suctioning in the early postoperative period because of copious secretions and the decreased effectiveness of the cough mechanism.

65. A nurse is contributing to the plan of care for a client who has a spinal cord injury at level C8 who is admitted for comprehensive rehabilitation. Which of the following long-term goals is appropriate with regard to the client's mobility?

INCORRECT

1) Walk with leg braces and crutches.

Answer Rationale:

Crutch walking, even with supportive braces, is an unrealistic goal for this client. A client who has an injury at T1 to T10 may be able to walk with braces.

INCORRECT

2) Drive an electric wheelchair with a hand-control device.

Answer Rationale:

A client who has an injury at C5 would require an electric wheelchair with a hand control device. A client who has a C8 spinal cord injury should have a greater degree of mobility.

INCORRECT

3) Drive an electric wheelchair equipped with a chin-control device.

Answer Rationale:

A client who has an injury at C1 to C3 would require an electric wheelchair with a chin-control device. A client who has a C8 spinal cord injury should have a greater degree of mobility.

4) Propel a wheelchair equipped with knobs on the wheels.

Answer Rationale:

A client who has an injury at C8 has full use of the shoulders and arms but will likely experience hand weakness. The addition of knobs on the wheels will help the client use the wheelchair more effectively.

66. A nurse is reinforcing health teaching about skin cancer with a group of clients. Which of the following risk factors should the nurse identify as the leading cause of non-melanoma skin cancer?

INCORRECT

1) Exposure to environmental pollutants

Answer Rationale:

The nurse should identify exposure to environmental pollutants as a risk factor for cancer due to their potential to change genetic DNA; however, evidence-based practice indicates there is another risk factor that is the leading cause of skin cancer.

2) Sun exposure

Answer Rationale:

According to evidenced-based practice, the nurse should identify exposure to the sun as the leading cause of non-melanoma skin cancer. Ultraviolet light radiation from the sun can cause cancerous changes in the skin. Decreased ozone protection has increased the amount of radiation exposure and increased the risk of cancer for clients regardless of skin color.

INCORRECT

3) History of viral illness

Answer Rationale:

The nurse should identify a history of viral illness as a risk factor for cancer due to the ability of a virus to alter the genetic material of a cell; however, evidence-based practice indicates there is another risk factor that is the leading cause of skin cancer.

INCORRECT

4) Scars from a severe burn

Answer Rationale:

The nurse should identify a burn injury as a risk for skin cancer due to the skin’s greater sensitivity to sunlight; however, evidence-based practice indicates there is another risk factor that is the leading cause of skin cancer.

67. Based on a client's recent history, a nurse suspects that a client is beginning menopause. Which of the following questions should the nurse ask the client to help confirm the client is experiencing manifestations of menopause?

1) "Do you sleep well at night?"

Answer Rationale:

Menopause causes vasomotor instability, which can cause night sweats and sleep disturbances. Therefore, this is an appropriate question for the nurse to ask.

INCORRECT

2) "Have you been experiencing chills?"

Answer Rationale:

The nurse should ask the client about night sweats, which are a common manifestation of menopause.

INCORRECT

3) "Have you experienced increased hair growth?"

Answer Rationale:

The nurse should ask the client about body hair loss, which is a common manifestation of menopause related to declining estrogen levels.

INCORRECT

4) "When did you begin your menses?"

Answer Rationale:

The onset of menopause is unrelated to the age of menarche.

68. A nurse is reinforcing teaching with a client about cancer prevention and plans to address the importance of foods high in antioxidants. Which of the following foods should the nurse include in the teaching?

INCORRECT

1) Cottage cheese

Answer Rationale:

The nurse should identify cottage cheese as a good source of calcium.

2) Fresh berries

Answer Rationale:

The nurse should include fresh berries (blackberries, strawberries, blueberries, and cranberries), coffee, kale, and dark chocolate as food sources high in antioxidants.

INCORRECT

3) Bran cereal

Answer Rationale:

The nurse should identify bran cereal as a good source of fiber.

INCORRECT

4) Skim milk

Answer Rationale:

The nurse should identify skim milk as a good source of calcium.

69. A nurse is assisting with caring for a client who has a new concussion following a motor-vehicle crash. The nurse should monitor the client for which of the following manifestations of increased intracranial pressure?

INCORRECT

1) Polyuria

Answer Rationale:

Polyuria is a manifestation of diabetes insipidus.

INCORRECT

2) Battle's sign

Answer Rationale:

Battle sign, or bruising behind the ear, is a manifestation of a skull fracture.

INCORRECT

3) Nuchal rigidity

Answer Rationale:

Nuchal rigidity, or neck stiffness, is a manifestation of meningitis or bleeding into the subarachnoid space.

4) Lethargy

Answer Rationale:

An early manifestation of increased intracranial pressure is lethargy. The nurse should monitor and report any changes in the client's level of consciousness, such as

restlessness or disorientation, because these are early manifestations of increased intracranial pressure.

70. A nurse is reinforcing teaching about a tonometry examination with a client who has manifestations of glaucoma. Which of the following statements should the nurse include in the teaching?

INCORRECT

1) "Tonometry is performed to evaluate peripheral vision."

Answer Rationale:

The nurse should identify the visual field test as determining the loss of peripheral vision.

INCORRECT

2) "This test will diagnose the type of your glaucoma."

Answer Rationale:

The nurse should identify gonioscopy as the examination used to differentiate between open-and and angle-closure glaucoma. An instrument, the gonioscope, is used to measure the depth of the anterior chamber.

INCORRECT

3) "Tonometry will allow inspection of the optic disc for signs of degeneration."

Answer Rationale:

The nurse should identify fundoscopy as the examination performed to assess the color of the eye’s fundus as well as the optic disc itself.

4) "This test will measure the intraocular pressure of the eye."

Answer Rationale:

A tonometry examination provides a precise and simple way to measure intraocular pressure. This is a component of a comprehensive eye examination and is crucial for clients who have glaucoma or who are at high risk for developing intraocular hypertension.

71. A nurse is reviewing the laboratory results of a client who is taking cyclosporine following a kidney transplant. Which of the following laboratory findings should the nurse identify as the most important to report to the provider?

INCORRECT

1) Increase in serum glucose

Answer Rationale:

The nurse should monitor and report the client's glucose level, as cyclosporine can cause hyperglycemia that can delay healing; however, another finding is the priority.

2) Increase in serum creatinine

Answer Rationale:

The nurse should identify the elevated serum creatinine level as the priority finding to report. Cyclosporine is nephrotoxic, so an increase in the creatinine and BUN levels can indicate the medication dosage is too high and must be decreased to recover renal function.

INCORRECT

3) Decrease in white blood cell count

Answer Rationale:

The nurse should monitor and report a decrease in white blood cell count, as this is an indication that the client will have difficulty fighting infection and is an adverse effect of the medication; however, another finding is the priority.

INCORRECT

4) Decrease in platelets

Answer Rationale:

The nurse should monitor and report a decrease in platelets, as this is an indication of impaired clotting ability and an adverse effect of the medication; however, another finding is the priority.

72. A nurse is checking for paradoxical blood pressure on a client who has constrictive pericarditis. Which of the following findings should the nurse expect?

INCORRECT

1) Apical pulse rate different than the radial pulse rate

Answer Rationale:

An apical pulse rate different than the radial pulse rate is called a pulse deficit and needs further investigation by the nurse.

INCORRECT

2) Increase in heart rate by 20% when standing

Answer Rationale:

The nurse should check the client for orthostatic hypotension when the pulse rate increases by 20% when standing.

INCORRECT

3) Drop in systolic BP by 20 mm Hg when moving from a lying to a sitting position

Answer Rationale:

The nurse should check the client for orthostatic hypotension when the client's systolic BP drops by 20 mm Hg when moving from a lying to a sitting position.

4) Drop in systolic BP more than 10 mm Hg on inspiration

Answer Rationale:

The nurse should expect the client who has constrictive pericarditis to have a decrease in systolic pressure by more than 10 mm Hg during inspiration, which is paradoxical blood pressure. This is also an expected finding for a client who has pulmonary hypertension or pericardial tamponade.

73. A nurse is caring for a client who has Alzheimer's disease. The nurse discovers the client entering the room of another client, who becomes upset and frightened. Which of the following actions should the nurse take?

1) Attempt to determine what the client was looking for.

Answer Rationale:

Clients who have Alzheimer's disease frequently exhibit wandering behavior when they have an unmet need. The nurse should attempt to discover the reason for the client's wandering, which could include a need for toileting, uncontrolled pain, or searching for a familiar object.

INCORRECT

2) Explain the client's Alzheimer's diagnosis to the frightened client.

Answer Rationale:
The nurse should not reveal information about this client's diagnosis because it violates the client's rights to privacy.

INCORRECT

3) Reprimand the client for invading the other client's privacy.
Answer Rationale:
The nurse should recognize the client is confused; therefore, this action is inappropriate.

INCORRECT

4) Ask the client to apologize for his behavior.
Answer Rationale:
The nurse should recognize the client is confused; therefore, this action is inappropriate.

74. A nurse is caring for a client immediately following a cardiac catheterization with a femoral artery approach. Which of the following actions should the nurse take?

1) Check pedal pulses every 15 min.
Answer Rationale:
The observation of a client who has undergone a cardiac catheterization includes monitoring the client's pulses below the puncture site.

INCORRECT

2) Perform passive range-of-motion for the affected extremity.
Answer Rationale:
Moving the affected extremity could dislodge a clot at the femoral access site and cause hemorrhage.

INCORRECT

3) Remind the client not to turn from side to side.
Answer Rationale:
The client can turn from side to side as long as he keeps the affected extremity straight.

INCORRECT

4) Keep the client in high-Fowler's position for 6 hr.
Answer Rationale:
The nurse should keep the head of the client's bed no higher than a 30° elevation after cardiac catheterization with a femoral artery approach.

75. A nurse is assisting with planning an immunization clinic for older adult clients. Which of the following information should the nurse plan to include about influenza?

INCORRECT

1) Individuals at high risk should receive the live influenza vaccine.
Answer Rationale:
The nurse should include that individuals at high risk receive the inactivated influenza vaccine.

INCORRECT

2) Immunization for influenza should be repeated every 10 years.
Answer Rationale:

The nurse should include this recommendation for clients with instructions about the tetanus booster vaccine.

3) The composition of the influenza vaccine changes yearly.

Answer Rationale:

Influenza outbreaks occur annually and the prevalent influenza viruses change yearly. Consequently, the previous year's influenza immunization will not protect a client exposed to the current year's influenza strains.

INCORRECT

4) The influenza vaccine is necessary only for clients who have never had influenza.

Answer Rationale:

The nurse should recommend the influenza vaccine for any client over the age of 6 months. Older adult clients are a high-risk group for contracting influenza. Influenza in older adult clients might result in the development of primary viral influenza pneumonia, which can be life threatening.

76. A nurse is caring for an older adult client who has colon cancer. The client asks the nurse several questions about his treatment plan. Which of the following actions should the nurse take?

INCORRECT

1) Tell the client to have a family member call the provider to ask what options he plans to recommend.

Answer Rationale:

This action implies that the client's concerns can wait and can suggest the client is not competent. This option imposes a communication block by placing the client's concerns on hold.

INCORRECT

2) Assure the client that the provider will tell him what is planned.

Answer Rationale:

This action blocks communication by placing the client's concerns on hold and giving false reassurance.

3) Help the client write down questions to ask his provider.

Answer Rationale:

To empower the client in decision-making, the nurse should help the client write down questions to ask the provider. In doing this, the nurse acts as a client advocate to address the client’s specific questions in a concrete, measurable way.

INCORRECT

4) Provide the client with a pamphlet of information about cancer.

Answer Rationale:

This action does not address the client's concerns about his specific treatment plan.

77. A nurse is caring for a client who has hemiplegia following a stroke. The client's adult son is distressed over his mother's crying and condition. Which of the following responses should the nurse make?

INCORRECT

1) "If you just sit quietly with your mother, I'm sure she will calm down."
Answer Rationale:
This response is non-therapeutic because it ignores the feelings of the son and provides false reassurance.

INCORRECT

2) "I'll talk with your mother and see if I can comfort her."
Answer Rationale:
This response is nontherapeutic because it is closed-ended and ignores the son's feelings of distress.

3) "It must be hard to see your mother so ill and upset."
Answer Rationale:
This response is therapeutic because it demonstrates empathy and acknowledges the son's feelings of helplessness and powerlessness.

INCORRECT

4) "Your mother's crying seems to bother you more than it does her."
Answer Rationale:
This response is nontherapeutic because it belittles or rejects the son's feelings.

78. A nurse is reinforcing teaching with the family of a client who has primary dementia. Which of the following manifestations of dementia should the nurse include in the teaching?

INCORRECT

1) Temporary, reversible loss of brain function
Answer Rationale:
Dementia is a progressive, irreversible, decline that affects thinking and motor skills.

2) Forgetfulness gradually progressing to disorientation
Answer Rationale:
Dementia usually appears first as forgetfulness. Loss of functioning progresses slowly from impaired language skills and difficulty with ordinary, daily activities to severe memory loss and complete disorientation with withdrawal from social interaction.

INCORRECT

3) Sleeping more during the day than nighttime
Answer Rationale:
Clients who have dementia wake frequently during the night. The nurse should expect a client who has acute delirium to exhibit a reversed sleep cycle.

INCORRECT

4) Hyper vigilant behaviors
Answer Rationale:
The nurse should expect a client who has delirium to possibly exhibit hypervigilant behavior.

79. A nurse is contributing to the plan of care for a client who has labyrinthitis. Which of the following interventions should the nurse include in the plan?

INCORRECT

1) Limit fluid intake.

Answer Rationale:

The nurse should encourage fluid intake to minimize the nausea and dizziness experienced by the client.

2) Monitor client's cardinal fields of vision.

Answer Rationale:

The nurse should assess for nystagmus, abnormal jerking movements of the eyes, by evaluating the six cardinal fields of gaze. Nystagmus is a manifestation of labyrinthitis.

INCORRECT

3) Encourage ambulation.

Answer Rationale:

The nurse should encourage bed rest for the client who has labyrinthitis to prevent falls and injury. The client should be instructed to wait for assistance when getting out of bed.

INCORRECT

4) Ensure the room is brightly lit.

Answer Rationale:

The nurse should provide dim lighting for the client to minimize the symptoms of labyrinthitis.

80. A nurse is contributing to the plan of care for a client who is admitted with a deep vein thrombosis (DVT) of the left leg. Which of the following interventions should the nurse include in the plan?

INCORRECT

1) Apply ice to the extremity

Answer Rationale:

The nurse should include the application of warm, moist heat, rather than ice to decrease inflammation and edema, relieve muscle spasms, and promote comfort.

2) Monitor platelet levels

Answer Rationale:

The nurse should monitor platelet levels along with other laboratory results related to blood coagulability and the medication therapy for the treatment of a deep vein thrombosis. Initially, medications such as heparin or enoxaparin are administered; laboratory test would include PTT. Later, warfarin therapy may be initiated for which PT/INR would be monitored. Platelets are monitored because the client is at risk for heparin inducted thrombocytopenia, placing the client at risk for bleeding.

INCORRECT

3) Restrict oral fluids

Answer Rationale:

The nurse should encourage fluids to reduce blood viscosity.

INCORRECT

4) Administer vasodilating medications

Answer Rationale:
The nurse should recognize that anticoagulant medications, such as heparin and warfarin, are used to prevent further clot formation. Administration of vasodilators, which may be used as antihypertensives, have no beneficial effect for thrombophlebitis.

81. A nurse is caring for a client who comes to the clinic to be tested for tuberculosis (TB) after a close family contact tests positive. Which of the following measures should the nurse anticipate preparing for this client?

1) Tuberculin skin test
Answer Rationale:
The nurse should anticipate preparing the client to receive the tuberculin skin test (TST). The TST is an accurate screening tool for the presence of tuberculosis in an individual; however, it does not distinguish between previous exposure and active illness. The TBT requires multiple visits to the clinic, one to receive the injection and another visit, 48-72 hours later, to have the test read by a qualified health professional.

INCORRECT
2) Sputum culture for acid fast bacillus (AFB)
Answer Rationale:
The nurse should recognize that the use of a sputum culture for AFB is used to confirm the diagnosis of active TB after the initial screening.

INCORRECT
3) Bacille Calmette-Guérin (bCG) vaccine
Answer Rationale:
The nurse should recognize that the bCG vaccine is administered in many foreign countries and individuals should be screened to determine if they have received this vaccine in the past. False-positive results are seen with the TST in individuals who have received the bCG vaccine.

INCORRECT
4) Chest x-ray
Answer Rationale:
The nurse should recognize that a chest x-ray is used to confirm the diagnosis after the initial screening and evaluate the presence of calcified tubercular lesions. A chest x-ray is performed on any individual with a history of a positive TST.

82. A nurse is reviewing data for a client who has a head injury. Which of the following findings should indicate to the nurse that the client might have diabetes insipidus?

INCORRECT

1) Serum sodium 145 mEq/L
Answer Rationale:
A client who has diabetes insipidus will have an elevated serum sodium level. This client's serum sodium level is within the expected range.

INCORRECT
2) Urine specific gravity 1.028
Answer Rationale:
With diabetes insipidus, the specific gravity of the client's urine will be below the expected reference range. This client's urine specific gravity is within the expected range.

3) Urine output 650 mL/hr

Answer Rationale:

Diabetes insipidus is an endocrine disorder of the anterior pituitary gland. A decrease in antidiuretic hormone results in an increasingly high output of very dilute urine.

INCORRECT

4) Blood glucose 198 mg/dL

Answer Rationale:

Diabetes mellitus can cause an elevated serum glucose level.

83. A nurse is caring for a client who has recurrent kidney stones and a history of diabetes mellitus. The client is scheduled for an intravenous pyelogram (IVP). The nurse should collect additional data about which of the following statements made by the client?

INCORRECT

1) "I took a laxative yesterday."

Answer Rationale:

The nurse should recognize that laxatives are commonly prescribed for the day before an IVP to remove feces, fluid, and air from the intestines.

2) "I took my metformin before breakfast."

Answer Rationale:

The nurse should identify clients taking metformin are at risk for lactic acidosis when receiving contrast media. Additional data should be collected about this statement.

INCORRECT

3) "I haven't had anything to eat or drink since last night."

Answer Rationale:

It is usually recommended that the client have nothing by mouth after midnight on the night before an IVP.

INCORRECT

4) "The last time I voided it was painful."

Answer Rationale:

The nurse should recognize that pain while voiding is an expected manifestation for clients with kidney stones.

84. A nurse is collecting data from a client who is having an acute asthma exacerbation. When auscultating the client's chest, the nurse should expect to hear which of the following sounds?

1) Expiratory wheeze

Answer Rationale:

Expiratory wheezing is associated with air movement through narrowed airways, as with the bronchospasm associated with asthma.

INCORRECT

2) Pleural friction rub

Answer Rationale:

A pleural friction rub is a sound that originates outside the airways and is associated with inflammatory processes, such as pleurisy.

INCORRECT

3) Fine rales

Answer Rationale:

Fine rales are an intermittent sound heard in clients who have pneumonia.

INCORRECT

4) Rhonchi

Answer Rationale:

Rhonchi are low pitched course sounds heard in clients who have thick secretions.

85. A nurse is planning to change an abdominal dressing for a client who has an incision with a drain. Which of the following actions should the nurse plan to take?

INCORRECT

1) Remove the entire dressing at once.

Answer Rationale:

The nurse should remove the outer layer of the dressing first, then the under layer of dressing. This allows the nurse to monitor the drainage and limits the possibility of disrupting the healing wound and the drain, which can be hidden in the layers of the dressing.

INCORRECT

2) Loosen the dressing by pulling the tape away from the wound.

Answer Rationale:

The nurse should loosen the tape by pulling toward the wound. Pulling the tape away from the wound can be painful and puts tension on the delicate edges of the healing wound.

3) Don clean gloves to remove the dressing.

Answer Rationale:

Standard precautions require the nurse to don clean gloves whenever there is a possibility of coming into contact with secretions. Sterile gloves are not necessary until applying the new sterile dressing.

INCORRECT

4) Open sterile supplies before removing the dressing.

Answer Rationale:

The nurse should prepare the sterile field after removing the dressing to prevent contamination of the sterile field.

86. A nurse is caring for a client who is scheduled to undergo thoracentesis. In which of the following positions should the nurse place the client for the procedure?

INCORRECT

1) Prone with arms raised over the head.

Answer Rationale:

The nurse should place a client who is undergoing postural drainage in a prone position with the arms raised over the head when drainage of the lower posterior lung fields is desired.

2) Sitting, leaning forward over the bedside table.

Answer Rationale:

Thoracentesis is aspiration of fluid or air from the pleural space. The nurse should place the client in a sitting position and leaning over a bedside table to ensure that the diaphragm is dependent. This facilitates the removal of accumulated fluid, which tends to pool in the bases of the pleural space.

INCORRECT

3) High Fowler's position

Answer Rationale:

The nurse should place the client undergoing a paracentesis in a high Fowler's position.

INCORRECT

4) Side-lying with knees drawn up to the chest.

Answer Rationale:

The nurse should place the client undergoing a lumbar puncture in a knee-to-chest, lateral position.

87. A nurse is caring for a client newly diagnosed with ovarian cancer. Which of the following reactions from the client should the nurse initially expect?

1) Denial

Answer Rationale:

According to evidenced-based practice, the nurse should expect the client to first exhibit behaviors of denial following a cancer diagnosis or with other type of loss. This initial stage of grieving is often a self-protective behavior used until the client tis ready to acknowledge and deal with the grief-causing issue.

INCORRECT

2) Bargaining

Answer Rationale:

The nurse should expect the client to exhibit bargaining, where the client acknowledges the disease, but attempts to make a deal or trade in hopes of a cure. However, evidence-based practice indicates that the nurse should expect the client to demonstrate a different grief reaction first.

INCORRECT

3) Acceptance

Answer Rationale:

The nurse should expect the client to exhibit acceptance, at the end of the grieving process, after working through other grief stages and finally resolving that the event is not changing. Therefore, evidence-based practice indicates that the nurse should expect the client to demonstrate a different grief reaction first.

INCORRECT

4) Anger

Answer Rationale:

The nurse should expect the client to exhibit anger, which can be manifested by defensive behaviors towards the situation or others. However, evidence-based practice indicates that the nurse should expect the client to have a different grief reaction first.

88. A nurse is contributing to the plan of care for a client who is postoperative following peritoneal lavage for peritonitis. The client has a nasogastric tube to low-intermittent suction and closed-suction drains in place. Which of the following interventions should the nurse include in the plan?

INCORRECT

1) Irrigate the nasogastric tube with tap water.

Answer Rationale:

The nurse should recognize that the nasogastric tube is primarily used for decompression. Any irrigation of the stomach should be completed with sterile solution to prevent further risk of infection as the peritoneum has already been compromised by bacteria.

INCORRECT

2) Mark abdominal girth once daily.

Answer Rationale:

The nurse should measure abdominal girth every eight hours to monitor for further distention. The same measuring tape should be used and the area being measured should be marked to allow for consistency.

INCORRECT

3) Ambulate the client twice daily.

Answer Rationale:

The nurse should recognize that the client who has peritonitis should be restricted to bed rest in order to minimize the spread of the abdominal infection.

4) Place the client in a high Fowler's position.

Answer Rationale:

The nurse should use measures to facilitate breathing in the client who has peritonitis. Placing the client into a high Fowler's position enhances lung expansion preventing respiratory complications and aids in localizing purulent abdominal materials.

89. A nurse is caring for a client who is receiving hemodialysis. Which of the following client measurements should the nurse compare before and after dialysis treatment to determine fluid losses?

INCORRECT

1) Neck vein distention

Answer Rationale:

The nurse should monitor the presence of neck vein distention as this is an indication of fluid volume excess; however, it should not be present following dialysis and does not measurably reflect fluid losses or gains from dialysis.

INCORRECT

2) Blood pressure

Answer Rationale:

The nurse should monitor the client's blood pressure as this is an indication of fluid volume. The client may develop hypotension as a result of fluid losses; however, blood pressure does not measurably reflect fluid losses or gains from hemodialysis.

3) Body weight

Answer Rationale:

The nurse should weigh the client prior to and following dialysis in order to determine the amount of fluid losses/gains from dialysis. Each kilogram (2.2 lb) of weight gained or lost is equal to 1 L of fluid.

INCORRECT

4) Abdominal girth

Answer Rationale:

The nurse should measure the abdominal girth of clients receiving peritoneal dialysis to determine whether the client is retaining any of the dialysate fluid. It is not measured in the client who is receiving hemodialysis.

90. A nurse is caring for a client who is receiving a unit of packed RBCs. About 15 min following the start of the transfusion, the nurse notes that the client is flushed and febrile, and reports chills. To help confirm that the client is having an acute hemolytic transfusion reaction, the nurse should observe for which of the following manifestations?

INCORRECT

1) Urticaria

Answer Rationale:

Urticaria, wheezing, anxiety, and shock are manifestations of an anaphylactic reaction to a blood transfusion.

INCORRECT

2) Muscle pain

Answer Rationale:

Muscle pain, fever, chills, headache, anxiety, and flushing are manifestations of a febrile, nonhemolytic transfusion reaction.

3) Hypotension

Answer Rationale:

Hypotension, tachycardia, tachypnea, low back pain, flushing, chills, and fever are manifestations of an acute hemolytic reaction to a blood transfusion.

INCORRECT

4) Distended neck veins

Answer Rationale:

Distended neck veins, cough, and dyspnea are manifestations of a transfusion reaction from circulatory overload.

91. A nurse is caring for a client who has a seizure disorder and reports experiencing an aura. The nurse should recognize the client is experiencing which of the following conditions?

INCORRECT

1) A continuous seizure state in which seizures occur in rapid succession

Answer Rationale:

Status epilepticus is a continuous seizure state in which seizures occur in rapid succession.

2) A sensory warning that a seizure is imminent

Answer Rationale:

n aura is a sensory warning that a seizure is imminent. The aura can be similar to a hallucination and may involve any of the senses. The client can report "hearing bells", "seeing lights", or "smelling something".

INCORRECT

3) A period of sleepiness following the seizure during which arousal is difficult

Answer Rationale:

The postictal state is a period of sleepiness or lethargy following a seizure.

INCORRECT

4) A brief loss of consciousness accompanied by staring

Answer Rationale:

An absence, or petit mal, seizure is a brief loss of consciousness accompanied by staring.

92. A nurse is caring for a client who just had cataract surgery. Which of the following comments from the client should the nurse report to the provider?

INCORRECT

1) "The bright light in this room is really bothering me."

Answer Rationale:

Exposure to bright light is uncomfortable after cataract surgery. Wearing sunglasses can prevent most of the client’s discomfort.

INCORRECT

2) "My eye really itches, but I'm trying not to rub it."

Answer Rationale:

Itching is common after cataract surgery. The nurse should remind the client not to rub or place pressure on the eyes.

INCORRECT

3) "It's really hard to see with a patch on one eye."

Answer Rationale:

Clients who wear an eye patch lose their depth perception and part of their peripheral vision, temporarily decreasing visual acuity.

4) "I need something for the horrible pain in my eye."

Answer Rationale:

Following cataract surgery, the client should expect only mild pain, and should immediately report any severe pain in the eye. Severe eye pain after surgery might indicate an increase in intraocular pressure, which can disrupt the surgical site and cause permanent damage to the eye if the client does not receive treatment promptly.

93. A nurse is caring for a client who is scheduled for a colonoscopy. The client asks the nurse if there will be a lot of pain during the procedure. Which of the following responses should the nurse make?

INCORRECT

1) "You shouldn't feel any pain since the local area is anesthetized."

Answer Rationale:

The nurse should recognize the client will receive sedation for the procedure.

INCORRECT

2) "Most clients report more discomfort from the preparation than from the procedure itself."

Answer Rationale:

This response by the nurse is stereotyping, and is therefore not therapeutic communication.

3) "You may feel some cramping during the procedure."

Answer Rationale:

The nurse should reinforce the use of breathing exercises to decrease the effects of cramping during the procedure. This response by the nurse is therapeutic because it appropriately addresses the client's concerns.

INCORRECT

4) "Don't worry; you won't remember anything about the procedure due to the effects of the medication."

Answer Rationale:

While there is a chance the client will experience amnesia following administration of a sedative for the procedure, the client will be aware during the procedure and could remember some events. This response by the nurse dismisses the client's feelings and is therefore not therapeutic communication.

94. A nurse caring for a client at risk for increased intracranial pressure is monitoring the client for manifestations that indicate that the pressure is increasing. To do this, the nurse should check the function of the third cranial nerve by performing which of the following data-collection activities?

INCORRECT

1) Observing for facial asymmetry

Answer Rationale:

Cranial nerve VII, the facial nerve, is a motor nerve that controls facial symmetry.

2) Checking pupillary responses to light

Answer Rationale:

Cranial nerve III, the oculomotor nerve, is responsible for pupillary responses to light. Indications that intracranial pressure is increasing include lethargy, decreasing consciousness, tachypnea, hypertension, bradycardia, bounding pulse, and changes in the pupils, such as a sluggish response to light and dilation of one or both pupils.

INCORRECT

3) Eliciting the gag reflex

Answer Rationale:

Cranial nerves IX and X, the glossopharyngeal and vagus nerves, are nerves that control the gag reflex.

INCORRECT

4) Testing visual acuity

Answer Rationale:

Cranial nerve II, the optic nerve, is responsible for visual acuity.

95. A nurse is caring for a client during the immediate postoperative period following thoracic surgery. When administering an opioid analgesic for pain, the nurse should explain that the medication should have which of the following effects?

1) Reducing anxiety

Answer Rationale:
Besides pain relief, postoperative opioid analgesics can help reduce anxiety and create feelings of well-being.

INCORRECT
2) Increasing blood pressure
Answer Rationale:
A common adverse effect of opioid analgesics is orthostatic hypotension. The nurse should caution the client that he might feel dizzy when the nurse assists him to sit up and then to stand up.

INCORRECT
3) Increasing coughing
Answer Rationale:
A common adverse effect of opioid analgesics is suppressing the client’s cough, which can cause a buildup of secretions in the airway. The nurse should remind the client to cough and breathe deeply.

INCORRECT
4) Increasing the client's respiratory rate
Answer Rationale:
A common adverse effect of opioid analgesics is decreasing the client’s respiratory rate.

96. A nurse is collecting data on a client who has hyperthyroidism. Which of the following manifestations should the nurse expect the client to report?

1) Frequent mood changes
Answer Rationale:
Hyperthyroidism develops when the thyroid gland produces an excess of the thyroid hormones that regulate the metabolic rate. Nervousness and frequent mood changes; hand tremors; a rapid, pounding, irregular heartbeat are common manifestations of hyperthyroidism.

INCORRECT
2) Constipation
Answer Rationale:
Constipation is a manifestation of hypothyroidism.

INCORRECT
3) Sensitivity to cold
Answer Rationale:
Heat intolerance and diaphoresis is a manifestation of hyperthyroidism.

INCORRECT
4) Weight gain
Answer Rationale:
Weight gain is a manifestation of hypothyroidism.

97. A nurse is collecting data from a client who has skeletal traction. Which of the following findings should the nurse identify as an indication of infection at the pin sites?

INCORRECT

1) Serosanguineous drainage

Answer Rationale:

Purulent drainage from the pin sites is an indication of infection.

INCORRECT

2) Mild erythema

Answer Rationale:

Redness is an expected finding after pin insertion. Severe redness at the pin sites is an indication of infection.

INCORRECT

3) Warmth

Answer Rationale:

Warmth is an expected finding after pin insertion. Coolness of the extremity, however, might indicate neurovascular compromise.

4) Fever

Answer Rationale:

Manifestations of inflammation and infection at the pin sites include fever, purulent drainage, odor, loose pins, and tenting of the skin around the pin sites.

98. A nurse is reinforcing teaching with a client who has type 2 diabetes mellitus. The nurse determines that teaching has been effective when the client identifies which of the following manifestations of hypoglycemia? (Select all that apply.)

INCORRECT

1) Polyuria

2) Blurry vision

3) Tachycardia

INCORRECT

4) Polydipsia

5) Sweating

Answer Rationale:

Polyuria is incorrect. Hyperglycemia causes polyuria.

Blurry vision is correct. Manifestations of hypoglycemia include blurry vision, tremors, anxiety, irritability, headache, and hypotension.

Tachycardia is correct. Manifestations of hypoglycemia include tachycardia, tremors, anxiety, irritability, headache, and hypotension.

Polydipsia is incorrect. Hyperglycemia causes polydipsia.

Sweating is correct. Manifestations of hypoglycemia include sweating, tremors, anxiety, irritability, headache, and hypotension.

99. A nurse is collecting data from a client who has an exacerbation of gout. Which of the following findings should the nurse expect? (Select all that apply.)

1) Edema

2) Erythema

3) Tophi

4) Tight skin

INCORRECT

5) Symmetrical joint pain

Answer Rationale:

Edema is correct. Swelling over the affected joints is a classic manifestation of gout.

Erythema is correct. Redness over the affected joints is a classic manifestation of gout.

Tophi is correct. Tophi are a classic manifestation of gout. They are nodules that form in subcutaneous tissue due to the accumulation of urate crystals.

Tight skin is correct. Tight skin over the affected joints is a classic manifestation of gout.

Symmetrical joint pain is incorrect. Symmetrical joint pain is a manifestation of rheumatoid arthritis, not gout.

100. A nurse is caring for a client who has myasthenia gravis (MG). Which of the following is a complication of MG for which the nurse should monitor?

1) Respiratory difficulty

Answer Rationale:

With MG, progressive weakness of the diaphragmatic and intercostal muscles can cause respiratory distress.

INCORRECT

2) Confusion

Answer Rationale:

Myasthenia gravis is a disorder that affects neuromuscular transmission of neurological impulses to the voluntary muscles of the body. It does not affect cognition, level of consciousness, or orientation.

INCORRECT

3) Increased intracranial pressure

Answer Rationale:

MG is a disorder that affects neuromuscular transmission of neurological impulses to the voluntary muscles of the body. It does not affect pressure within the brain.

INCORRECT

4) Joint pain

Answer Rationale:

MG is a disorder that affects neuromuscular transmission of neurological impulses to the voluntary muscles of the body. It does not cause joint pain, but it can cause weakness of the muscles of the extremities.

101.A nurse is caring for a client who is experiencing an acute exacerbation of ulcerative colitis. The nurse should recognize that which of the following actions is the priority?

INCORRECT

1) Review stress factors that can cause disease exacerbation.
Answer Rationale:
The nurse should review stress factors that can cause disease exacerbation for this client to reduce the risk for recurrence; however, there is another action that is the priority.

2) Evaluate fluid and electrolyte levels.
Answer Rationale:
The first action the nurse should take when using the nursing process is to collect data about the fluid and electrolyte levels. The client who has ulcerative colitis loses fluids and electrolytes in diarrhea and can develop hypovolemia. Since problems related to fluid and electrolyte balance can affect all body systems, this is the most important nursing action for this client.

INCORRECT

3) Provide emotional support.
Answer Rationale:
The nurse should provide emotional support for this client to increase coping and improve self-esteem; however, there is another action that is the priority.

INCORRECT

4) Promote physical mobility.
Answer Rationale:
The nurse should provide promote physical motility for this client to prevent complications of immobility; however, there is another action that is the priority.

102. A nurse is reinforcing teaching about rifampin with a female client who has active tuberculosis. Which of the following statements should the nurse include in the teaching?

1) "You should wear glasses instead of contacts while taking this medication."
Answer Rationale:
The nurse should reinforce that rifampin turns body fluids such as tears, sweat, saliva, and urine a reddish-orange color. The nurse should advise the client of possible permanent stains on clothing and soft contact lenses.

INCORRECT

2) "The medication causes amenorrhea if taken along with an oral contraceptive."
Answer Rationale:

The nurse should reinforce that rifampin will decrease the effectiveness of oral contraceptive and may cause break through bleeding to occur. The nurse should encourage the client to use additional forms of birth control while taking rifampin.

INCORRECT

3) "A yellow tint to the skin is an expected reaction to the medication."

Answer Rationale:

The nurse should instruct the client to report any yellowing of the skin or eyes, fever, or flu-like symptoms to her provider, as these may indicate or the development of hepatitis or pancreatitis.

INCORRECT

4) "Lifelong treatment with this medication is necessary."

Answer Rationale:

The nurse should reinforce that treatment for tuberculosis involves taking a combination of medications, including rifampin, which are taken from 6 months to 1 year.

103.A nurse is reinforcing teaching about cyclosporine for a client who is postoperative following a renal transplant. Which of the following statements by the client indicates an understanding of the teaching?

INCORRECT

1) "I will take this medication until my BUN returns to normal."

Answer Rationale:

The nurse should emphasize with the client that the serum blood urea nitrogen (BUN) level is an indication of renal function and is monitored to determine the dosage of the medication.

INCORRECT

2) "This medication will help my new kidney make adequate urine."

Answer Rationale:

The nurse should reinforce with the client that cyclosporine is used to prevent the body from rejecting the transplanted organ.

3) "I will need to take this medication for the rest of my life."

Answer Rationale:

The nurse should reinforce with the client that cyclosporine is an immunosuppressive agent. It is used to reduce natural immunity in clients who receive organ transplants and prevent rejection. They need to take immunosuppressive therapy for the remainder of their lives.

INCORRECT

4) "This medication will boost my immune system."

Answer Rationale:

The nurse should emphasize that cyclosporine decreases the body's ability to fight infection. Client teaching should include monitoring for fever or sore throat, which should be reported to the provider immediately.

104.A nurse is caring for a client who has Parkinson's disease and is taking selegiline 5 mg by mouth twice daily. Which of the following therapeutic outcomes should the nurse monitor for with a client who is taking this medication?

INCORRECT

1) Improved speech patterns

Answer Rationale:

Selegiline preserves dopamine in the brain and is considered a first line medication for the treatment of Parkinson’s disease; however, it will not improve speech patterns.

INCORRECT

2) Increased bladder function

Answer Rationale:

Selegiline slows the progress of Parkinson’s disease; however, it will not increase bladder function.

3) Decreased tremors

Answer Rationale:

Selegiline, an MAO-B inhibitor, improves motor function by decreasing tremors, rigidity and bradykinesia in the client who has Parkinson’s disease.

INCORRECT

4) Diminished drooling

Answer Rationale:

Selegiline delays the progression of Parkinson’s disease by preserving motor function; however, it will not have an effect on drooling.

105.A nurse is assisting in the care of a client who is receiving a transfusion of packed red blood cells. The client develops itching and hives. Which of the following actions should the nurse take first?

INCORRECT

1) Obtain vital signs.

Answer Rationale:

The nurse should obtain vital signs of the client who develops signs of a transfusion reaction such as itching and hives in order to monitor the client's condition; however, another action is the priority.

2) Stop the transfusion.

Answer Rationale:

The client who develops itching and hives during a transfusion is at greatest risk for cardiovascular collapse resulting from the allergic reaction to the blood products; therefore, the priority action the nurse should take is to stop the transfusion.

INCORRECT

3) Notify the registered nurse.

Answer Rationale:

The nurse should notify the registered nurse if the client develops hives and itching so a more in-depth assessment can be made; however, this is not the priority action.

INCORRECT

4) Administer diphenhydramine.

Answer Rationale:

The nurse should administer diphenhydramine as prescribed to minimize the allergic reaction to the blood products; however, another action is the priority.

106.A nurse is reinforcing teaching with a client about how to prevent the onset of manifestations of Raynaud’s phenomenon. Which of the following statements should the nurse identify as an indication that the client needs further teaching?

1) "I will keep my house at a cool temperature."

Answer Rationale:

Raynaud's phenomenon occurs during exposure to extreme temperatures or from stress, resulting in painful vasoconstriction of peripheral blood vessels, typically in the hands and feet. Keeping the house comfortably warm can help prevent the manifestations of Raynaud's phenomenon.

INCORRECT

2) "I will try to anticipate and avoid stressful situations."

Answer Rationale:

Avoiding stressful situations is an action the client should take to manage stress and prevent the onset of the manifestations of Raynaud's phenomenon.

INCORRECT

3) "I will complete the smoking cessation program I started."

Answer Rationale:

Smoking cessation is an action the client should take to prevent the onset of the manifestations of Raynaud's phenomenon. The client should also limit caffeine intake.

INCORRECT

4) "I will wear gloves when removing food from the freezer."

Answer Rationale:

Wearing gloves when removing food from the freezer or reaching inside hot ovens is an action the client should take to prevent the onset of the manifestations of Raynaud's phenomenon.

107.A nurse is reinforcing teaching with a client who has iron deficiency anemia and is to start taking ferrous sulfate twice a day. Which of the following statements by the client indicate an understanding of the teaching?

1) "I will take the medication with orange juice."

Answer Rationale:

The nurse should reinforce with the client that taking iron pills with a citrus fruit juice, such as orange juice, helps to increase the bioavailability of the iron.

INCORRECT

2) "I should expect to have loose stools while taking this medication."

Answer Rationale:

The nurse should reinforce that ferrous sulfate can be constipating. To prevent constipation the nurse should recommend the client increase fluid and fiber intake.

INCORRECT

3) "I will have clay colored stools while taking this medication."

Answer Rationale:

The nurse should reinforce that ferrous sulfate can turn stools dark green or black in color, which is harmless.

INCORRECT

4) "I should take the medication with milk."

Answer Rationale:

The nurse should reinforce that milk will decrease the absorption of the medication and therefore ferrous sulfate should not be taken with milk.

108.A nurse is reinforcing teaching about pernicious anemia with a client following a total gastrectomy. Which of the following dietary supplements should the nurse include in the teaching as the treatment for pernicious anemia?

1) Vitamin B_{12}

Answer Rationale:

The nurse should recommend a lifelong intake of vitamin B_{12} to prevent pernicious anemia. A total gastrectomy brings a complete halt to the production of intrinsic factor, the gastric secretion that is required for the absorption of vitamin B_{12} from the gastrointestinal tract.

INCORRECT

2) Vitamin C

Answer Rationale:

The nurse should recognize that vitamin C aids in wound healing; however, it is not indicated for treatment of pernicious anemia.

INCORRECT

3) Iron

Answer Rationale:

The nurse should recognize that iron is important for the development of red blood cells; however, it is not indicated for the treatment of pernicious anemia.

INCORRECT

4) Folate

Answer Rationale:

The nurse should recognize that folate is important for the formation of hemoglobin and the synthesis of protein; however, it is not indicated for the treatment of pernicious anemia.

109.A nurse is caring for a client who is scheduled for surgical repair of a femur fracture and has a prescription for lorazepam preoperatively. Which of the following statements by the client should indicate to the nurse that the medication has been effective?

INCORRECT

1) "My mouth is very dry."

Answer Rationale:

The nurse should recognize that oral dryness is most likely a result of the client being NPO prior to surgery and not an effect of lorazepam.

2) "I feel very sleepy."

Answer Rationale:

The nurse should recognize that preoperative doses of benzodiazepines such as lorazepam relieve anxiety and promote sedation.

INCORRECT

3) "I am not hungry any longer."

Answer Rationale:

The nurse should recognize anorexia as an adverse, but unintended, effect of lorazepam.

INCORRECT

4) "My leg feels numb."
Answer Rationale:
The nurse should identify that one of the effects of lorazepam is muscle relaxation, which may decrease the pain experienced with a femur fracture; however, numbness of the extremity is not an effect of lorazepam.

110.A nurse is collecting data from a client who has AIDS. When checking the client's mouth, the nurse notes a white, creamy covering on the tongue and buccal membranes. The nurse should recognize this is a manifestation of which of the following conditions?

INCORRECT

1) Xerostomia
Answer Rationale:
Xerostomia, or dry mouth, is caused by Sjögren's syndrome or is an adverse effect of certain medications, such as atropine or sertraline.

INCORRECT
2) Gingivitis
Answer Rationale:
Gingivitis is inflammation of the gums or gingiva typically caused by irritation from dental plaque and poor oral hygiene.

3) Candidiasis
Answer Rationale:
Oral candidiasis is a communicable, opportunistic yeast infection often affecting clients who have AIDS or immunosuppression. It causes creamy white lesions, usually on the client's tongue or inner cheeks (buccal mucosa).

INCORRECT
4) Halitosis
Answer Rationale:
Halitosis, or foul-smelling breath, is the result of poor dental health, poor oral hygiene, or gastrointestinal problems.

111.A nurse is caring for a client who is postoperative open reduction and internal fixation with placement of a wound drain to repair a hip fracture. Which of the following actions should the nurse take?

1) Empty the suction device every 4 hr.
Answer Rationale:
The nurse should empty the client’s wound drain every 4 hr to monitor for bleeding.

INCORRECT
2) Monitor circulation on the affected extremity every 2 hr for the first 12 hr.
Answer Rationale:
The nurse should monitor neurovascular status of the operative leg every hour for the first 12 to 24 hr to monitor for changes that can indicate impaired circulation.

INCORRECT
3) Position the client’s hip so that it is internally rotated.
Answer Rationale:
The nurse should position the client’s hip so that it is abducted to prevent dislocation.

INCORRECT

4) Encourage foot exercises every 4 hr.
Answer Rationale:
The nurse should encourage foot and calf exercises every 2 hr to prevent a deep vein thrombosis.

112.A nurse is assisting with teaching a client who has a history of smoking about recognizing early manifestations of laryngeal cancer. The nurse should instruct the client to monitor and report which of the following manifestations of laryngeal cancer?

INCORRECT

1) Aphagia
Answer Rationale:
Aphagia is a manifestation of a stroke.

2) Hoarseness
Answer Rationale:
Laryngeal cancer is often caused by chronic exposure to tobacco and alcohol. Persistent hoarseness is an early manifestation of cancer of the larynx because the presences of a tumor can impede the action of the vocal cords during speech.

INCORRECT
3) Tinnitus
Answer Rationale:
Tinnitus is a manifestation of an ear canal obstruction.

INCORRECT
4) Epistaxis
Answer Rationale:
Epistaxis is a manifestation of a nasal fracture or a bleeding disorder.

113.A nurse is collecting data from a client who has systemic lupus erythematosus (SLE). Which of the following laboratory values should the nurse review to determine the client's renal function?

INCORRECT

1) Antinuclear antibody
Answer Rationale:
The nurse should identify the antinuclear antibody test is used in the diagnosis of SLE and indicates the presence of an autoimmune disease; however, this test does not reflect renal function.

INCORRECT
2) C-reactive protein
Answer Rationale:
Although this test is elevated during acute exacerbations of SLE, it is reflective of inflammation but does not indicate renal function

INCORRECT

3) Erythrocyte sedimentation rate

Answer Rationale:

Although the client's erythrocyte sedimentation rate might be prolonged during exacerbations (indicating active inflammation), the nurse should recognize that this test does not reflect renal function.

4) Serum creatinine

Answer Rationale:

Many clients with SLE have deposits of protein within the glomeruli of the kidneys and may develop lupus nephritis (persistent inflammation in the kidneys) or chronic renal failure. A disorder of renal function reduces the excretion of creatinine, resulting in increased levels of serum creatinine. The nurse should identify serum creatinine as a sensitive indicator of renal function.

115.A nurse is collecting data from a client who has Cushing's syndrome. Which of the following manifestations should the nurse expect?

1) Bruising

Answer Rationale:

Clients who have Cushing's syndrome can have thin skin that is fragile and easily bruised. These clients can develop ecchymoses, petechiae (small intradermal or submucosal hemorrhages), and striae (purple lines on the skin of the abdomen, thighs, and breasts).

INCORRECT

2) Weight loss

Answer Rationale:

Clients who have Cushing's syndrome will have weight gain due to overproduction of adrenal cortical hormone.

INCORRECT

3) Hyperpigmentation

Answer Rationale:

An insufficient supply of cortisol, as with Addison's disease, results in increased dark pigmentation (bronzing) of the skin.

INCORRECT

4) Double vision

Answer Rationale:

Double or blurred vision is a manifestation of hyperthyroidism.

116.A nurse is caring for a client who is postoperative and requesting something to drink. The nurse reads the client's postoperative prescriptions, which include, "Clear liquids, advance diet as tolerated." Which of the following actions should the nurse take first?

INCORRECT

1) Offer the client apple juice.

Answer Rationale:

The nurse should offer the client clear liquids if the client is displaying readiness to tolerate fluids; however, there is another action the nurse should take first.

INCORRECT

2) Elevate the client’s head of bed.
Answer Rationale:
The nurse should elevate the client’s head to reduce the risk for aspiration before providing oral fluids; however, there is another action the nurse should take first.

3) Auscultate the client’s abdomen.
Answer Rationale:
The first action the nurse should take using the nursing process is to collect data by listening to the client's abdomen to determine the presence of bowel sounds before offering a choice of clear liquids. A common postoperative complication is paralytic ileus or delayed gastric emptying due to decreased peristalsis. Administering liquids to a client who does not have bowel sounds can cause the client to vomit.

INCORRECT
4) Order a lunch tray for the client.
Answer Rationale:
The nurse should order a clear liquid lunch tray for the client if the client is displaying readiness to tolerate fluids; however, there is another action the nurse should take first.

117.A nurse is collecting data on a client who has a surgical wound healing by secondary intention. Which of the following findings should the nurse report to the charge nurse?

INCORRECT

1) The wound is tender to touch.
Answer Rationale:
Tenderness to the touch is an expected finding in a healing wound.

INCORRECT
2) The wound has pink, shiny tissue with a granular appearance.
Answer Rationale:
Pink, shiny tissue with a granular appearance is granulation tissue and indicates the wound is in the proliferative phase of healing.

INCORRECT
3) The wound has serosanguineous drainage.
Answer Rationale:
Serosanguineous drainage, made up of RBCs and plasma, is an expected finding.

4) The wound has a halo of erythema on the surrounding skin.
Answer Rationale:
A ring of redness on the surrounding skin can indicate underlying infection, and the nurse should report any indication of infection such as purulent drainage, swelling, warmth, or strong odor.

118.A nurse is assisting with the care of a client who has multiple injuries following a motor vehicle crash. The nurse should monitor for which of the following manifestations of a pneumothorax?

INCORRECT

1) Inspiratory stridor
Answer Rationale:
Inspiratory stridor indicates a narrowed airway and can be heard in clients who have an upper airway obstruction.

INCORRECT

2) Expiratory wheeze

Answer Rationale:

Wheezes, which can be heard on inspiration or expiration, are often present in clients who have asthma or COPD due to constriction of the bronchus.

3) Absence of breath sounds

Answer Rationale:

A client who has a pneumothorax will have diminished or absent breath sounds on the affected side due to partial or total collapse of the lung.

INCORRECT

4) Coarse crackles

Answer Rationale:

Crackles, which are commonly heard on inspiration, can indicate fluid or mucus in the smaller airways.

119.A nurse is collecting data from a client who has right-sided heart failure. Which of the following findings should the nurse expect?

INCORRECT

1) Frothy sputum

Answer Rationale:

Frothy sputum is a manifestation of left-sided heart failure.

INCORRECT

2) Dyspnea

Answer Rationale:

Dyspnea is a manifestation of left-sided heart failure.

INCORRECT

3) Orthopnea

Answer Rationale:

Orthopnea is a manifestation of left-sided heart failure.

4) Peripheral edema

Answer Rationale:

Peripheral edema is caused by weakness in the right side of the heart, allowing blood to back up into the venous system and leak into interstitial tissues.

120.A nurse is caring for a client who is receiving chemotherapy for treatment of ovarian cancer and experiencing nausea. Which of the following actions should the nurse take?

INCORRECT

1) Advise the client to lie down after meals.

Answer Rationale:

The nurse should advise the client to not lie down for 2 hr after meals to reduce the risk for nausea.

INCORRECT

2) Instruct the client to restrict food intake prior to treatment.

Answer Rationale:

The nurse should instruct the client to eat before treatment to reduce the risk of nausea.

INCORRECT

3) Provide the client with an antiemetic 2 hr prior to the chemotherapy.

Answer Rationale:

The nurse should administer an antiemetic 30 min to 1 hr prior to treatments, to reduce the risk of nausea and vomiting. Preventive treatment should start before the chemotherapy is given and continue for as long as the chemotherapy agent is likely to cause nausea.

4) Encourage the client to drink a carbonated beverage 1 hr before meals.

Answer Rationale:

The nurse should instruct the client to drink a carbonated beverage 1 hr before or after meals to reduce the risk for nausea.

121.A nurse is assisting with the care of a client following a transurethral resection of the prostate (TURP) and has an indwelling urinary catheter. Which of the following actions should the nurse take?

INCORRECT

1) Weigh the client weekly.

Answer Rationale:

The nurse should weigh the client daily to monitor for hypervolemia.

2) Irrigate the catheter as prescribed.

Answer Rationale:

The nurse should irrigate the catheter to remove blood clots and maintain catheter patency.

INCORRECT

3) Instruct the client to report an urge to urinate.

Answer Rationale:

The nurse should instruct the client to expect to feel the urge to urinate.

INCORRECT

4) Instruct the client to bear down as if to have a bowel movement every hour.

Answer Rationale:

The client should not bear down or strain because this action increases the risk for hemorrhage.

122.A nurse is evaluating discharge instructions for a client following a right cataract extraction. Which of the following client statements indicates the teaching is effective?

1) "I will take a stool softener until my eye is healed."

Answer Rationale:
The client should avoid straining during bowel movements to prevent an increase in intraocular pressure.

INCORRECT
2) "I will expect to have moderately severe pain for 1-2 days."
Answer Rationale:
The client should experience only mild pain post operatively. The client should report severe pain to the provider immediately.

INCORRECT
3) "I will refrain from cooking for 1 week."
Answer Rationale:
The client should avoid activities that can increase intraocular pressure, such as vacuuming; however, the client can perform activities, such as cooking, in moderation.

INCORRECT
4) "I will bend at the waist to tie my shoes."
Answer Rationale:
The client should bend at the knees, not the waist, to prevent an increase in intraocular pressure.

123.A nurse is collecting data from a client who is 6 days post craniotomy for removal of an intracerebral aneurysm. The nurse should monitor the client for which of the following manifestations of increased intracranial pressure?

INCORRECT

1) Decreased pedal pulses
Answer Rationale:
Decreased pedal pulses are a manifestation of impaired circulation.

2) Hypertension
Answer Rationale:
Hypertension is an early manifestation of increased intracranial pressure. Other manifestations include restlessness, headache, and change in level of consciousness. The nurse should monitor and report manifestations of increased intracranial pressure.

INCORRECT
3) Peripheral edema
Answer Rationale:
Peripheral edema is a manifestation of fluid overload.

INCORRECT
4) Diarrhea
Answer Rationale:
Diarrhea is an adverse effect of many antibacterial medications, but not a manifestation of increased intracranial pressure.

124.A nurse is caring for a client who has COPD. Which of the following actions should the nurse take?

1) Encourage the client to drink 8 glasses of water a day.
Answer Rationale:
The nurse should instruct the client to drink 6 to 8 glasses of noncaffeinated beverages to thin bronchial secretions.

INCORRECT
2) Instruct the client to cough every 4 hr.
Answer Rationale:
The nurse should instruct the client to cough every 2 hr to clear secretions.

INCORRECT
3) Provide the client with a low protein diet.
Answer Rationale:
The nurse should provide a high protein diet to promote healing and reduce fatigue.

INCORRECT
4) Advise the client to lie down after eating.
Answer Rationale:
The nurse should advise the client to not lie down for 1 hr after eating to increase digestion and prevent reflux.

125.A nurse is caring for a client who was admitted with major burns to the head, neck, and chest. Which of the following complications should the nurse identify as the greatest risk to the client?

INCORRECT

1) Hypothermia
Answer Rationale:
Hypothermia can occur during the emergent phase of burn care, throughout hospitalization, and treatment. However, there is another complication is the greatest risk to the client.

INCORRECT
2) Hyponatremia
Answer Rationale:
Prevention of hyponatremia is an important aspect of burn care throughout the emergent phase of burn treatment. However, there is another complication is the greatest risk to the client.

INCORRECT
3) Fluid imbalance
Answer Rationale:
Although adequate fluid replacement is an important aspect of burn care throughout the emergent phase of burn treatment. However, there is another complication is the greatest risk to the client.

4) Airway obstruction
Answer Rationale:
Burns to the head, neck, and chest may involve damage to the pulmonary tree due to heat as well as smoke and soot inhalation. This kind of damage can result in severe respiratory difficulty. A burn to the chest may limit expansion of the thoracic cage,

resulting in impaired breathing. Therefore, using the airway, breathing, circulation (ABC) priority-setting framework nursing measures to maintain airway patency are the priority nursing actions.

126.A nurse is collecting data from a client who was bitten by a tick one week ago. Which of the following client manifestations should the nurse identify as an indication of the development of Lyme disease?

1) An expanding circular rash

Answer Rationale:

Early Lyme disease is characterized by fever, flu-like manifestations, and erythema migrans, an expanding circular (bull's-eye) rash that often develops at the bite site.

INCORRECT

2) Swollen, painful joints

Answer Rationale:

Lyme arthritis (with stiff, swollen, painful joints) is a manifestation of late or chronic Lyme disease.

INCORRECT

3) Decreased level of consciousness

Answer Rationale:

A decreased level of consciousness is a manifestation of encephalitis caused by West Nile virus.

INCORRECT

4) Necrosis at the site of the bite

Answer Rationale:

An area of necrosis at the site of a bite is a manifestation of a bite from a brown recluse spider.

127.A nurse is contribution to the plan of care for a client who is 12 hr postoperative following a right radical mastectomy with closed suction drains present. The nurse should expect that the client will be unable to perform which of the following activities with her right arm?

1) Combing her hair

Answer Rationale:

The nurse should recognize that combing the hair requires abduction of the arm. This movement is avoided for the client who is in the immediate postoperative period until the drains have been removed. Activities requiring abduction and rotation of the shoulder may resume following healing of the surgical site.

INCORRECT

2) Eating her breakfast

Answer Rationale:

The arm motion necessary for eating mainly involves the hand, wrist, and elbow. The client should be able to position her arm appropriately to perform this activity.

INCORRECT

3) Buttoning her blouse

Answer Rationale:

The arm motion necessary for buttoning mainly involves the hand, wrist, and elbow. The client should be able to position her arm appropriately to perform this activity.

INCORRECT

4) Tying her shoes

Answer Rationale:

The arm motion necessary for tying shoes mainly involves the hand, wrist, and elbow. The client should be able to position her arm appropriately to perform this activity.

128.A nurse in a provider's office is collecting data for a 45-year-old client who is having manifestations associated with perimenopause. Which of the following findings should the nurse expect?

INCORRECT

1) Report of urinary retention

Answer Rationale:

Estrogen plays a key role in maintaining the function of the bladder and urethra. After menopause, these organs may weaken or shrink leading to urinary stress incontinence, not urinary retention.

INCORRECT

2) Elevated blood pressure above 140/90

Answer Rationale:

Blood pressure changes are not related to perimenopause; however, after menopause a woman's risk for heart disease increases.

3) Report of dryness with vaginal intercourse

Answer Rationale:

Perimenopause includes the years surrounding menopause. During this time the ovaries produce less estrogen, and a woman's menstrual periods cease. Because of the changes in the vagina, some women may have dryness, discomfort, or pain during vaginal intercourse.

INCORRECT

4) Elevated body temperature above 37.8° C (100° F)

Answer Rationale:

Hot flashes are a classic sign of menopause, but they are related to hormonal changes, not body temperature elevation.

129.A nurse is reinforcing teaching about breast self-examination (BSE) with a client who has a regular menstrual cycle. The nurse should instruct the client to perform BSE at which of the following times?

INCORRECT

1) On the same day every month

Answer Rationale:

The client should not perform breast self-examination on the same day every month because monthly hormone fluctuations can affect the sensitivity of breast tissue.

INCORRECT

2) Prior to the beginning of menses

Answer Rationale:

The client should avoid performing breast self-examination just prior to menses because the breasts might be too tender to perform an effective examination.

3) Three to seven days after menses stops

Answer Rationale:

The client should plan to perform breast self-examination about 3 to 7 days after menstruation, when the breasts are least tender and not engorged.

INCORRECT

4) On the second day of menstruation

Answer Rationale:

The client should avoid performing breast self-examination during menstruation because the breasts might be too tender to perform an effective examination.

130.A nurse is caring for a client who has second- and third-degree burns and a prescription for a high-calorie, high-protein diet. Which of the following menu choices should the nurse recommend?

INCORRECT

1) ½ cup whole-grain pasta with tomato sauce and pears

Answer Rationale:

While this menu choice contains some calories, it is composed primarily of incomplete proteins; therefore, it does not meet the prescribed dietary regimen.

2) Turkey and cheese sandwich with scalloped potatoes

Answer Rationale:

This menu choice is composed primarily of complete, high-quality proteins and large quantities of carbohydrates. Therefore, the nurse should recommend this selection to meet the prescribed dietary regime.

INCORRECT

3) ½ cup black beans with a brownie

Answer Rationale:

While this menu choice is relatively high in calories, it is composed primarily of incomplete proteins; therefore, it does not meet the prescribed dietary regimen.

INCORRECT

4) Roast beef with romaine lettuce salad

Answer Rationale:

While this menu choice contains some protein, the calorie count is low due to insufficient carbohydrates; therefore, it does not meet the prescribed dietary regimen.

131.A nurse is reinforcing teaching to a client who is scheduled for an intravenous pyelogram. Which of the following should the nurse include in the teaching?

INCORRECT

1) Omit your daily dose of aspirin.

Answer Rationale:

It is not necessary for the client to omit the daily dose of aspirin the day of the procedure. Clients taking medications that are nephrotoxic should be monitored for renal failure.

2) Take a laxative the evening before the procedure.
Answer Rationale:
Stool or gas in the bowel may make it difficult to visualize the renal system during an intravenous pyelogram, so typically the bowel is cleansed the day before.

INCORRECT
3) Expect to be drowsy for 24 hr following the procedure.
Answer Rationale:
Sedatives are not typically given prior to or during the procedure. The client should be able to resume normal activities when the test is completed.

INCORRECT
4) You will feel cold chills after the dye has been injected.
Answer Rationale:
Following intravenous administration of the dye, the client typically feels a warm flush throughout the body.

132.A nurse is collecting data from a client in the health clinic who is reporting epigastric pain. Which of the following statements made by the client should the nurse identify as being consistent with peptic ulcer disease?

INCORRECT

1) "The pain is worse after I eat a meal high in fat."
Answer Rationale:
Clients who have peptic ulcer disease usually experience pain relief after eating. Increased epigastric pain after consumption of a high-fat meal is a common report by clients who have gallbladder disease.

INCORRECT
2) "My pain is relieved by having a bowel movement."
Answer Rationale:
There is no association between stool pattern and peptic ulcer disease.

3) "I feel so much better after eating."
Answer Rationale:
A client who has peptic ulcer disease usually experiences pain when the stomach is empty, 2 to 3 hr after meals or in the middle of the night. It is usually relieved by eating.

INCORRECT
4) "The pain radiates down to my lower back."
Answer Rationale:
Clients who have peptic ulcer disease may complain of chest pain from regurgitation. Pain radiating down to the lower flank area is associated with pancreatitis.

133.A nurse is contributing to the plan of care for a client who has a terminal illness. Which of the following interventions should the nurse identify as the priority?

INCORRECT

1) Promote the client's expression of feelings about loss of self-care ability.
Answer Rationale:

Promoting the client's expression of feelings about loss of self-care ability is important because it meets the client's self-esteem needs; however, there is another intervention that is the priority.

INCORRECT

2) Encourage the client to recall positive life events.

Answer Rationale:

Encouraging the client to recall positive life events is important because it meets the client's self-esteem needs; however, there is another intervention that is the priority.

3) Schedule pain medication on a routine basis.

Answer Rationale:

The priority action the nurse should take when using Maslow's hierarchy of needs is to meet the client's safety and security needs. By scheduling the client's pain medication on a routine basis, the nurse can prevent acute pain exacerbations.

INCORRECT

4) Suggest ways the client can continue interacting with social contacts.

Answer Rationale:

Suggesting ways the client can continue interacting with social contacts is important because it meets the client's love and belonging needs; however, there is another intervention that is the priority.

134.A nurse is reinforcing teaching with a client who has been newly diagnosed with chronic open angle glaucoma. Which of the following statements by the client indicates an understanding of the teaching?

INCORRECT

1) "When my vision improves, I will be able to stop taking the eye drops."

Answer Rationale:

The nurse should reinforce that clients who have open angle glaucoma will need to take eye drops for the remainder of their lives to preserve their vision.

INCORRECT

2) "If I forget to take my eye drops, I should wait until the next time they are due."

Answer Rationale:

The nurse should emphasize that it is important that eye drop instillation not be missed, so a therapeutic level of medication is maintained.

3) "I should call the clinic before taking any over-the-counter medications."

Answer Rationale:

Taking over-the-counter medications that dilate the pupil could cause the client who has chronic open angle glaucoma to experience an increase in intraocular pressure. The nurse should instruct the client to always check with the provider before using over-the-counter medications.

INCORRECT

4) "Every two years I will need to have my vision checked by an eye doctor."

Answer Rationale:

The nurse should reinforce that clients who have open angle glaucoma will need to see their ophthalmologist yearly, if not more frequently, for the remainder of their lives.