SAUNDERS COMPREHENSIVE REVIEW FOR NCLEX FIVE

1) A child with an autism spectrum disorder (ASD) is being admitted to the hospital for diagnostic tests. Which roomassignment is the **most appropriate** for the child?

✓ Private room

2) The labor and delivery room nurse has just received reportson 4 clients. After reviewing the client data, the nurse should assess which client **first?**

✓ A client who has just received an intravenousloading dose of magnesium sulfate to stop preterm labor

3) The nurse has developed a teaching plan for a client withhypertension regarding the administration of prescribed medications. What is the **initial** nursing action?

✓ Assess the client's readiness to learn.

4) A client with cancer is receiving intravenous morphine sulfate for pain. When writing the plan of care for thisclient, the nurse should include which action as the **priority** action?

✓ Monitor respiratory status.

5) The nurse is preparing to suction the airway of a client whohas a tracheostomy tube and gathers the supplies needed for the procedure. In order of **priority**, which actions should the nurse take to perform this procedure? **Arrange the actions in the order that they should be performed. All options must be used.**

✓ 1)Place the client in a semi Fowler'sposition.

✓ 2)Turn on the suction device and set theregulator at 80 mm Hg.

✓ 3)Attach the suction tubing to the suctioncatheter.

✓ 4)Hyperoxygenate the client.

✓ 5)Insert the catheter into the tracheostomyuntil resistance is met, and then pull it back 1cm.

✓ 6) Apply intermittent suction and slowly withdraw the catheter while rotating it back andforth.

6) The nurse notes blanching, coolness, and edema at a client'speripheral intravenous (IV) site. Which nursing action is the **priority?**

✓ Remove the IV catheter.

7) A client has a prescription to begin an infusion of 1000 mL of 5% dextrose in lactated Ringer's solution. The client hasan intravenous (IV) cannula inserted, and the nurse preparesthe solution and IV tubing. **Arrange the actions in the orderthat they should be performed. All options must be used.**

✓ 1)Close the roller clamp on the IV tubing.

✓ 2)Spike the IV bag and half-fill the dripchamber.

✓ 3)Open the roller clamp and fill the tubing.

✓ 4)Uncap the distal end of the tubing.

✓ 5)Attach the distal end of the tubing to theclient.

8) The nurse is caring for 4 pediatric clients. After receivingreports from the night shift, which child should the nurse assess **first?**

✓ A 6-week-old infant admitted to the hospitalfor decreased level of consciousness; shaken babysyndrome is suspected

9) The nurse is assigned to 4 clients on a postoperative surgical unit at a rural hospital. When prioritizing thecare, the nurse recognizes that the **highest priority** is focused on which client?

✓ The client with problems clearing the airwayrelated to abdominal incision pain

10) The emergency department nurse is caring for a childwith suspected epiglottitis and has ensured that the childhas a patent airway. Which action is the **next priority** in the care of this child?

✓ Prepare the child for a chest radiograph.

11) The nursing instructor asks the nursing student to identify the priorities of care for an assigned client. The nursing instructor determines that the nursing student understands the client's needs when which statement is made?

✓ "Actual or life-threatening concerns are thepriority."

12) A hospitalized client with type 1 diabetes mellitus received Humulin N and Humulin R insulin 2 hours ago (at 7:30 a.m.). The client calls the nurse and reports that he is feeling hungry, shaky, and weak. The client ate breakfastat 8 a.m. and is due to eat lunch at noon. Arrange the actions that the nurse will take in the order that they should be performed. All options must be used.

✓ 1)Check the client's blood glucose level.

✓ 2)Give the client ½ cup (118 mL) of fruitjuice to drink.

✓ 3)Take the client's vital signs.

✓ 4)Retest the blood glucose level.

✓ 5)Give the client a small snack ofcarbohydrate and protein.

✓ 6)Document the client's complaints, actionstaken, and outcome.

13) An emergency department nurse is preparing to receive 4clients as a result of a motor vehicle crash. Which victim should the nurse attend to **first?**

✓ A 45-year-old man with chest pain, shortnessof breath, and diaphoresis

14) The nurse is assigned to care for 4 clients. Whichclient should the nurse assess **first?**

✓ A client who has a peripheral (index finger)oxygen saturation percentage of 85%

15) The nurse has received her client assignment for theday. Which client should the nurse care for **first?**

✓ A client with postoperative pain reported at 7 out of 10, with 10 being the worst

16) The nurse has received the client assignment for theday. Which client should the nurse care for **first?**

- ✓ The client admitted with the medical diagnosis of neutropenia who is afebrile and iscomplaining of pain with urination

17) The nurse is the first responder at the scene of a 6- car crash on a highway. Which victim should the nurse attendto **first?**

- ✓ A victim experiencing dyspnea

18) The nurse in charge of a nursing unit is asked to select the hospitalized clients who can be discharged so that hospital beds can be made available for victims of a community disaster. Which clients can be safely discharged?**Select all that apply.**

- ✓ A client with a Holter monitor
- ✓ A client receiving oral antibiotics
- ✓ A client experiencing sinus rhythm

19) The nurse has received her client assignment for theday. Which client should the nurse check **first?**

- ✓ A client who has just returned from surgery

20) The nurse is a responder at the scene of a buildingcollapse. Which victim should the nurse care for **first?**

- ✓ Victim with an apparent chest wall defect andasymmetrical chest wall movement

21) The nurse manager of a medical-surgical unit is askedto select the hospitalized clients who can be discharged sothat hospital beds can be made available for victims of a community disaster. Which clients can be safely discharged?**Select all that apply.**

- ✓ Client postoperative day 1 after inguinalherniorrhaphy, vital signs stable
- ✓ Client 5 days after a myocardial infarction,vital signs stable, absence of dysrhythmias
- ✓ Client 1 day after cardiac catheterization, normal study results, groin site free of hematoma

22) The nurse is the first responder at the scene of an accident in which a tire blowout caused a bus to roll overseveral times. Which victim should the nurse attend to **first?**

✓ The confused 12-year-old with bright red blood pulsing from an open fracture of the femur

23) The nurse in charge of a nursing unit is asked to select those hospitalized clients who can be discharged so that hospital beds can be made available for victims of a community disaster. Which clients can be safely discharged?**Select all that apply.**

✓ The client who 24 hours earlier gave birth toher second child by caesarean delivery

✓ The 48-hour postoperative client who hasundergone an ileostomy because of ulcerative colitis

✓ The 2-day postoperative client who has undergone total knee replacement and is ambulatingwith a walker

✓ The 3-day postoperative client who has undergone coronary artery bypass grafting and isready for rehabilitation

24) The nurse has received her client assignment for theday. Which client should the nurse care for **first?**

✓ The 53-year-old client with heart failure whohas gained 4 pounds (1.8 kg) since yesterday and is short of breath

25) During morning report, the day nurse is given information on the assigned clients. Which client should thenurse assess **first?**

✓ The 60-year-old client with leukemia who isreceiving the first round of chemotherapy, whichwas started at 0630 and is scheduled to end at noon

26) The nurse determines that which client has the **highestpriority** needs?

✓ The client who has an irregular apical pulseof 120 beats per minute

27) When planning care, which client should the nurseassess **first?**

✓ The client with a chest tube for apneumothorax

28) The nurse assigned to 4 clients reviews client data atthe beginning of the shift. To which information should thenurse give **highest priority?**

✓ Pulse oximetry reading 89%

29) A home health care nurse is planning client visits andnursing activities for the day. The nurse begins the visitsat 9 a.m. All clients live within a 5-mile radius. In order of **priority**, how the nurse should plan the assignments for the day? **Arrange the actions in the order that they should be performed. All options must be used.**

✓ 1)A client with diabetes mellitus who needsa fasting blood glucose level drawn

✓ 2)The first dressing change for a clientrequiring twice-daily dressing changes

✓ 3)A client being visited by the home healthaide at 1030

✓ 4)A client requiring supervision of adressing change

✓ 5)A client requiring an admission assessmentto home health care

✓ 6)The second dressing change for a clientrequiring twice-daily dressing changes

30) The nurse is monitoring a client receiving total parenteral nutrition (TPN). The client suddenly develops respiratory distress, dyspnea, and chest pain, and the nurse suspects air embolism. In order of **priority**, how should the nurse plan the actions to take? **Arrange the actions in the order that they should be performed. All options must be used.**

✓ **1**)Clamp the intravenous (IV) catheter.

✓ 2)Position the client in a leftTrendelenburg's position.

✓ 3)Contact the health care provider (HCP).

✓ 4)Administer oxygen.

✓ 5)Take the client's vital signs.

✓ 6)Document the occurrence.

31) A unit of packed red blood cells has been prescribed for a client with low hemoglobin and hematocrit typing and crossmatching. The nurse receives a telephone call from theblood bank and is informed that the unit of blood is ready for administration. In order of **priority**, how should the nurse plan the actions to take? **Arrange the actions in the order that they should be performed. All options must be used.**

✓ 1)Verify the health care provider's (HCP's)prescription for the blood transfusion.

✓ 2)Ensure that an informed consent has beensigned.

✓ 3)Insert an 18- or 19-gauge intravenouscatheter into the client.

✓ 4)Obtain the unit of blood from the bloodbank.

✓ 5) Ask a licensed nurse to assist in confirming vital signs and blood compatibility andverifying client identity.

✓ 6)Hang the bag of blood.

32) The nurse is monitoring a client in labor who is receiving oxytocin and notes that the client is experiencinghypertonic uterine contractions. In order of **priority**, how should the nurse plan the actions to take? **Arrange the actions in the order that they should be performed. All options must be used.**

✓ 1)Stop the oxytocin infusion.

✓ 2)Reposition the client.

✓ 3)Administer oxygen by face mask at 8 to 10L/min.

✓ 4)Perform a vaginal examination.

✓ 5)Check the client's blood pressure.

✓ 6)Administer medication as prescribed toreduce uterine activity.

33) After correctly completing the rights of medication administration, performing hand hygiene, and ensuring the correct position of the client, which steps should the nurse take to administer medication via a volume control container? **Arrange the actions in the order that they shouldbe** performed. All options must be used.

✓ 1) Fill volume control container with desiredamount of IV fluid by opening clamp between volumecontrol container and main IV bag.

✓ 2)Close the clamp and check to be sure thatclamp on air vent volume control container is open.

✓ 3)Clean injection port on top of volumecontrol container with an antiseptic swab.

✓ 4) Remove needle cap and insert needleless syringe tip through the port, and then inject themedication. Label the volume control container with the name of the medication, dosage, total volume including diluents, and time of administration.

✓ 5) Regulate intravenous (IV) infusion rate toallow medication to infuse in the time recommendedby institutional policies.

✓ 6)Dispose of the syringe in puncture-proofand leak-proof container. Discard supplies and perform hand hygiene.

34) The nurse from a medical unit is called to assist withcare for clients coming into the hospital emergency department during an external disaster. Using principles oftriage during a disaster, the nurse should attend to the client with which problem **first?**

✓ Bright red bleeding from a neck wound

35) The nurse is the first responder at the scene of a train accident. Which victim should the nurse attend to**first?**

✓ A victim experiencing airway obstruc

36) The nurse in charge of a nursing unit is asked to select the hospitalized clients who can be discharged so that hospital beds can be made available for victims of a community disaster. Select the clients who can be safely discharged. **Select all that apply.**

✓ A client experiencing sinus rhythm

✓ A client receiving oral anticoagulants

✓ A client with chronic atrial fibrillation

37) The nurse is the first responder at the scene of a train accident. Which victim should the nurse attend to**first?**

✓ A young woman who appears dazed and confusedand is shivering

38) Which client should the emergency department triagenurse classify as emergent?

✓ A client with crushing substernal pain who isshort of breath

39) The nurse has performed a nonstress test on a pregnantclient and is reviewing the fetal monitor strip. How shouldthe nurse document this finding in the client's medical record? **Refer to Figure.** (Figure from McKinney et al. [2013], p. 310.)

View Figure

✓ Normal

40) The nursing instructor asks the nursing student aboutthe physiology related to the cessation of ovulation that occurs during pregnancy. Which response, if made by the student, indicates an understanding of this physiological process? **Select all that apply.**

✓ "Ovulation ceases during pregnancy becausethe circulating levels of estrogen and progesterone are high."

✓ "The release of the follicle-stimulating hormone and luteinizing hormone is inhibited byadaptations related to pregnancy."

41) The nurse encourages a pregnant client who is human immunodeficiency virus (HIV) positive to immediately report any early signs of vaginal discharge or perineal tenderness to the health care provider. The client asks the nurse aboutthe importance of this action, and the nurse responds by making which statement to the client?

✓ "This is necessary to assist in identifying potential infections that may need to be treated."

42) A pregnant client who is anemic tells the nurse thatshe is concerned about her infant's condition after delivery. Which nursing response would **best** support the client?

✓ "The effects of anemia on your baby are difficult to predict, but let's review your planof care to ensure you are providing the best nutrition and growth potential."

43) The client is being seen at 24 weeks' gestation at theprenatal clinic. At her last routine visit, the fundus was located at the umbilicus. Today, the fundus is measured and found to be 23 cm. How should the nurse interpret this finding?

✓ Fundus is at the appropriate level.

44) The nurse is performing a prenatal assessment on a pregnant client. The nurse should plan to implement teachingrelated to risk for abruptio placentae if which information is obtained on assessment?

✓ The client has a history of hypertension.

45) During a prenatal visit, the nurse is explaining dietary management to a client with preexisting diabetesmellitus. The nurse determines that teaching has been **effective** if the client makes which statement?

✓ "Diet and insulin needs change duringpregnancy."

46) The nurse has provided home care instructions to a client with a history of cardiac disease who has just beentold that she is pregnant. Which statement, if made by theclient, indicates a **need for further instruction?**

✓ "During the pregnancy, I need to avoid contact with other individuals as much as possibleto prevent infection."

47) The nurse assists a pregnant client with cardiac disease to identify resources to help her care for her 18- month-old child during the last trimester of pregnancy. The nurse encourages the pregnant client to use these resourcesprimarily for which reason?

✓ Reduce excessive maternal stress and fatigue.

48) The nurse is instructing a pregnant client on measuresto increase iron in the diet. The nurse should tell the client to consume which food that contains the highest source of dietary iron?

✓ Whole-grain cereal

49) The nurse is reviewing a nutritional plan of care witha pregnant client and is identifying the food items highestin folic acid. The nurse determines that the client understands the foods that supply the highest amounts of folic acid if the client states that she will include whichitem in the daily diet?

✓ Leafy green vegetables

50) A pregnant client who is at 30 weeks' gestation comes to the clinic for a routine visit, and the nurse performs anassessment on her. Which observations made by the nurse during the assessment indicates a **need for further teaching?Select all that apply.**

✓ The client is wearing knee-high nylonstockings.

✓ The client is wearing sweatpants with snugelastic ankle bands.

51) A pregnant client tells the nurse that she frequently has a backache, and the nurse provides instructions regarding measures that will assist in relieving the backache. Which statement by the client indicates a **need forfurther instruction?**

✓ "I should do more exercises to strengthen myback muscles."

52) A nonstress test is prescribed for a pregnant client,and she asks the nurse about the procedure. How should thenurse respond?

✓ "A round, hard plastic disk called an ultrasound transducer picks up and marks the fetalheart activity on the recording paper and is secured over the abdomen."

53) The nurse is developing a plan of care for a pregnantclient who is complaining of intermittent episodes of constipation. To help alleviate this problem, the nurse should instruct the client to take which measure?

✓ Drink 8 glasses of water per day.

54) A pregnant client in the prenatal clinic is scheduledfor a biophysical profile (BPP). The client asks the nursewhat this test involves. The nurse should make which appropriate response?

✓ "This test measures amniotic fluid volume andfetal activity."

55) The nurse is taking a nutritional history from a 16-year-old pregnant adolescent. Which statement, if made by the adolescent, should alert the nurse to a potential psychosocial problem?

✓ "I want to gain only 10 pounds because I wantto have a small, petite baby."

56) The nurse is conducting a session about nutrition witha group of adolescents who are pregnant. Which measure is **most appropriate** to teach these adolescents?

✓ Monitor for appropriate weight gain patterns.

57) The nurse is discussing nutrition with a pregnantclient who has lactose intolerance. The nurse should

instruct the client to supplement the dietary source ofcalcium by eating which food?

✓ Dried fruits

58) The nurse has provided instructions to a pregnant client who is preparing to take iron supplements. The nursedetermines that the client understands the instructions if she states that she will take the supplements with which item?

✓ Orange juice

59) A client arrives at the health care clinic and tells the nurse that her last menstrual period was 9 weeks ago. The client tells the nurse that a home pregnancy test was positive but that she began to have mild cramps and is now having moderate vaginal bleeding. On physical examination ofthe client, it is noted that she has a dilated cervix. Whichstatement, if made by the client, indicates that the client is interpreting the situation correctly?

✓ "I will need to prepare myself and my familyfor the loss of this pregnancy."

60) The nurse is reviewing the record of a pregnant clientseen in the health care clinic for the first prenatal visit.Which data, if noted on the client's record, should alert the nurse that the client is at risk for a spontaneous abortion?

✓ History of syphilis

61) The nurse is preparing to care for a client who is being admitted to the hospital with a possible diagnosis of ectopic pregnancy. The nurse develops a plan of care for the client and determines that which nursing action is the **priority?**

✓ Monitoring the apical pulse

62) The nurse reviews the assessment history for a clientwith a suspected ectopic pregnancy. Which assessment findings predispose the client to an ectopic pregnancy? **Select all that apply.**

✓ Use of fertility medications

✓ History of *Chlamydia*

✓ Use of an intrauterine device

✓ History of pelvic inflammatory disease (PID)

63) The nurse is reviewing the record of a pregnant clientseen in the health care clinic for the first prenatal visit.Which data if noted on the client's record would alert the nurse that the client is at risk for developing gestational diabetes during this pregnancy?

✓ The client's last baby weighed 10 pounds atbirth.

64) The nurse is teaching a pregnant client with diabetesabout nutrition and insulin needs during pregnancy. The nurse determines that the client understands dietary and insulin needs if the client states that the second half ofpregnancy may require which treatment?

✓ Increased insulin

65) The nurse is assessing a client with a diagnosis of gestational trophoblastic disease (hydatidiform mole). Thenurse understands that which findings are associated with this condition? **Select all that apply.**

✓ Vaginal bleeding

✓ Excessive nausea and vomiting

✓ Larger-than-normal uterus for gestational age

✓ Elevated levels of human chorionicgonadotropin (hCG)

66) The nurse in the prenatal clinic is providing nutritional counseling to a pregnant client. The nurse instructs the client to increase the intake of folic acidand tells the client that which food item is highest in folic acid?

✓ Dried peas

67) A pregnant client at 16 weeks' gestation reports to thehealth care clinic for a triple screen test. The nurse determines that the client understands the purpose of this test when the client makes which statements? **Select all thatapply.**

✓ "This test can be used as a screening forspina bifida."

✓ "This test is a screening test, and I willneed other testing if I have abnormal results."

✓ "This test can indicate if I may be at anincreased risk for having a child with Down syndrome."

68) A client in the prenatal clinic asks the nurse about the delivery date. The nurse notes that the client's record indicates that the client began her last menses on March 7, 2018, and ended the menses on March 14, 2018. Using Nägele'srule, the nurse should tell the client that the estimated date of delivery is what date? **Fill in the blank. Record your answer using 6 digits (mmddyy).**

✓ Correct Answer: 121418

69) The prenatal clinic nurse asks a nursing student to identify the physiological adaptations of the cardiovascularsystem that occur during pregnancy. The nurse determines that the student understands these physiological changes if the student makes which statement?

✓ "An increase in pulse rate occurs."

70) The prenatal client asks the nurse about substances that can cross the placental barrier and potentially affectthe fetus. The nurse **most appropriately** explains that whichsubstances can cross this barrier? **Select all that apply.**

✓ Viruses

✓ Nutrients

✓ Antibodies

✓ Medications

71) A client who is 8 weeks' pregnant calls the prenatalclinic and tells the nurse that she is experiencing nauseaand vomiting every morning. The nurse should suggest whichmeasure that will **best** promote relief of the signs and symptoms?

✓ Eating dry crackers before arising

72) The home care nurse is visiting a prenatal client whohas a history of heart disease. The nurse provides instructions to the client regarding home care measures to promote a healthy pregnancy and includes which measure in that instruction?

✓ Restrict visitors who may have an activeinfection.

73) A home care nurse is visiting a pregnant client with adiagnosis of mild preeclampsia. What is the **priority** nursingintervention during the home visit?

✓ Monitor for fetal movement.

74) A maternity unit nurse is creating a plan of care for aclient with severe preeclampsia who will be admitted to the nursing unit. The nurse should include which nursing intervention in the plan?

✓ Reduce external stimuli.

75) A client with severe preeclampsia is admitted to thematernity department. Which room assignment is **most appropriate** for this client?

✓ A private room 2 doors away from the nurses'station

76) A couple is seen in the fertility clinic. After severaltests it has been determined that the husband is not sterileand that the wife has nonpatent fallopian tubes. The nurse is preparing the woman and her husband for an in vitro fertilization. Which statement by the woman or her spouse indicates a **need for further information** about the procedure?

✓ "The procedure is performed using artificialinsemination of sperm instilled through the vagina."

77) The nurse in the gynecology clinic is reviewing the record of a pregnant client after the first prenatal visit. The nurse notes that the health care provider has documented that the woman has a platypelloid pelvis. On the basis of this documentation, the nurse anticipates which possible outcomes? **Select all that apply.**

✓ Places the client at risk for dystocia

✓ Has an increased probability of cesareansection

✓ Has a flat shape that may impede fetaldescent

78) The nurse is counseling a pregnant woman diagnosed withgestational diabetes at 29 weeks' gestation. Which information should the nurse discuss with the client? **Selectall that apply.**

✓ Plan for weekly nonstress tests at 32 weeks.

✓ Obtain nutritional counseling with adietitian.

79) The nurse provides dietary instructions to a pregnantwoman regarding food items that contain folic acid. Which food item should the nurse recommend as a good source of folic acid?

✓ Spinach

80) The nurse is caring for a client with preeclampsia who is receiving an intravenous (IV) infusion of magnesium sulfate. When gathering items to be available for the client, which **highest priority** item should the nurse obtain?

✓ Calcium gluconate injection

81) A pregnant client has been diagnosed with a vaginal infection from the organism *Candida albicans*. Which findingshould the nurse expect to note when assessing this client?

✓ Pain, itching, and vaginal discharge

82) The nurse is performing an assessment on a client seenin the health care clinic for a first prenatal visit. The client reports February 9 as the first day of the last menstrual period (LMP). Using Nägele's rule, what date laterthat same year will the nurse relay as the client's due date? **Fill in the blank. Record your answer using 4 digits (mmdd).**

✓ Correct Answer: 1116

83) The nurse is performing a measurement of fundal heightin a client whose pregnancy has reached 36 weeks of gestation. During the measurement the client begins to feel

lightheaded. On the basis of knowledge of the physiologicalchanges of pregnancy, the nurse understands that which is the cause of the lightheadedness?

✓ Compression of the vena cava

84) A pregnant client has been instructed on the preventionof genital tract infections. Which client statement indicates an understanding of these preventive measures?

✓ "I should wear underwear with a cotton panelliner."

85) The nurse is reviewing the results of the rubella screening (titer) with a pregnant client. The test resultsare positive, and the mother asks if it is safe for her toddler to receive the vaccine. What is the nurse's **best** response?

✓ "Your titer supports your immunity to rubella, and it is safe for your toddler toreceive the vaccine at this time."

86) A clinic nurse is explaining to a client the changes inthe integumentary system that occur during pregnancy and should tell the client that which change may persist after she gives birth?

✓ Striae gravidarum

87) A clinic nurse is instructing a pregnant client regarding dietary measures to promote a healthy pregnancy.The nurse tells the client about the importance of an adequate daily fluid intake. Which client statement **best** indicates an understanding of the daily fluid requirement?

✓ "I should drink at least 8 to 10 glasses of fluid each day, of which at least 6 glasses shouldbe water."

88) A prenatal clinic nurse is providing instructions to agroup of pregnant women regarding measures to prevent toxoplasmosis. Which client statement indicates a **need for further instruction?**

✓ "I should drink unpasteurized milk only."

89) A home care nurse is monitoring a 16-year-oldprimigravida who is at 36 weeks' gestation and has

gestational hypertension. Her blood pressure during the past
3 weeks has been averaging 130/90 mm Hg. She has had some swelling in the lower extremities and has had mild proteinuria. Which statement by the woman should alert the nurse to the worsening of gestational hypertension?

✓ "My vision for the past 2 days has beenreally fuzzy."

90) A primigravida is receiving magnesium sulfate for thetreatment of gestational hypertension. The nurse who is caring for the client is performing assessments every 30 minutes. Which finding would be of **most** concern to the nurse?

✓ Respiratory rate of 10 breaths/minute

91) The nurse is reviewing fetal development with a clientwho is at 36 weeks' gestation. Which statements describe thecharacteristics that are present in a fetus at this time? **Select all that apply.**

✓ The fetus is approximately 42 to 48 cm long.

✓ The lecithin-sphingomyelin (L/S) ratio isgreater than 2:1.

92) A client who has just been told that she is pregnant wants to know when the baby's heart will be completely developed and beating. The nurse reads in the client's chartthat the health care provider has determined the client to be at 6 weeks' gestation. What is the nurse's **best** response?

✓ "Your baby's heart right now has double heartchambers and has begun to beat, so we should be able to see it beat using an ultrasound machine."

93) During a woman's 38-week prenatal visit, the nurse assesses the fetal heart rate to be 180 beats/minute. Whatmight the nurse suspect as the **most likely** cause of this tachycardia?

✓ Maternal infection

94) The nurse is reviewing the medical record of a womanscheduled for her weekly prenatal appointment. The nurse notes that the woman has been diagnosed with mild preeclampsia. Which interventions should the nurse include

in planning nursing care for this client? **Select all thatapply.**

- ✓ Assess blood pressure.
- ✓ Check the urine for protein.
- ✓ Assess deep tendon reflexes.
- ✓ Teach the importance of keeping track of adaily weight.

95) During a woman's 20-week prenatal visit, the nurse is measuring fundal height. The nurse locates the fundus at thelevel of the umbilicus. What should be the nurse's **next** intervention?

- ✓ Document findings in the electronic healthrecord.

96) The nurse is teaching a woman in her first trimestermeasures to alleviate nausea and vomiting. Which statementby the woman indicates that **further teaching is required?**

- ✓ "I will eat dry crackers for breakfast afterI get up."

97) The nursing instructor asks a nursing student who is preparing to assist with the assessment of an 18 weeks' gestation gravida 2, para 1 (G2P1) pregnant woman to describe expectations related to the process of quickening.Which statements, if made by the student, indicate an understanding of this process? **Select all that apply.**

- ✓ "It is the fetal movement that is felt by themother."
- ✓ "It is typically experienced by the multigravida client between 16 and 18 weeks'gestation."

98) The nurse is interviewing a 16-year-old client duringher initial prenatal clinic visit. The client is beginning week 18 of her first pregnancy. Which statement, if made bythe client, indicates an **immediate** need for further investigation?

- ✓ "I don't like my face anymore. I always looklike I have been crying."

99) The nurse reviews the plan of care for a woman at 37weeks' gestation who has sickle cell anemia. The nurse determines that which problem listed on the nursing care plan will receive the **highest priority?**

✓ Insufficient fluid volume

100) The nurse provides instructions to a malnourishedclient regarding iron supplementation during pregnancy.Which statement, if made by the client, indicates an understanding of the instructions?

✓ "The iron is best absorbed if taken on anempty stomach."

101) A pregnant woman in her second trimester calls the prenatal clinic nurse to report a recent exposure to a childwith rubella. Which response by the nurse is **most appropriate** and supportive to the woman?

✓ "You were wise to call. I will check your rubella titer screening results, and we can immediately identify whether future interventionsare needed."

102) A pregnant woman has a positive history of genital herpes but has not had lesions during this pregnancy. Whatshould the nurse plan to tell the client?

✓ "You will be evaluated at the time of delivery for genital lesions, and if any are present, a cesarean delivery will be needed."

103) A pregnant primigravida is seen in the health care clinic and asks the nurse what causes the breasts to changein size and appearance during pregnancy. The nurse plans to base the response on which facts? **Select all that apply.**

✓ The breast changes occur because of thesecretion of estrogen and progesterone.

✓ Blood vessels beneath the skin often appear as a blue, intertwining network, especially in aprimigravida.

104) The nurse is conducting a prepared childbirth class andis instructing pregnant women about the method of effleurage. The nurse instructs the women to perform the procedure by doing which action?

✓ Massaging the abdomen during contractions,using both hands in a circular motion

105) During a routine prenatal visit, a client complains ofgums that bleed easily with brushing. The nurse performs an assessment and then teaches the client about proper nutrition to minimize this problem. Which statement, if madeby the client, indicates an understanding of the proper nutritional measures to minimize this problem?

✓ "I will eat fresh fruits and vegetables forsnacks and for dessert each day."

106) A prenatal woman with a history of heart disease has been instructed on care at home. Which statement, if made bythe woman, indicates that she understands her needs?

✓ "I should avoid stressful situations."

107) The nurse is reviewing the record of a pregnant womanand notes that the health care provider has documented thepresence of Chadwick's sign. Which assessment finding supports the presence of Chadwick's sign?

✓ Bluish discoloration of cervix and vagina

108) A contraction stress test is scheduled for a pregnantwoman, and she asks the nurse to describe the test. What should the nurse include in the teaching? **Select all that apply.**

✓ An external monitor is attached in order toview fetal heart rate response to an establishedcontraction pattern.

✓ The uterus is stimulated to contract by the administration of small amounts of oxytocin or bynipple stimulation.

109) A nonstress test is performed on a client who is pregnant, and the results of the test indicate nonreactivefindings. The health care provider (HCP) prescribes a contraction stress test. The test is performed, and the nurse notes that the HCP has documented the results as negative. How should the nurse interpret this finding?

✓ A normal test result

110) A pregnant woman seen in the health care clinic has tested positive for human immunodeficiency virus (HIV). Whatcan the nurse determine based on this information?

✓ HIV antibodies are detected by the enzyme-linked immunosorbent assay (ELISA) test.

111) In the prenatal clinic, the nurse is interviewing a newclient and obtaining health history information. Which action should the nurse plan to elicit the **most** accurate responses to the questions that refer to sexually transmitted infections?

✓ Establish a therapeutic relationship.

112) The clinic nurse is teaching a pregnant woman about thewarning signs in pregnancy. Which, if identified as a warning sign by the woman, should indicate a **need for further education?**

✓ Presence of irregular, painless contractions

113) The nurse is performing a physical assessment on a client during her first prenatal visit to the clinic. The nurse takes the client's temperature and notes that it is 99.2°F. Based on this finding, which nursing action is **mostappropriate?**

✓ Document the temperature.

114) A 39-week-gestation pregnant client calls the maternityunit, stating, "My baby has not moved very much in the past few days. Should I be concerned?" Which is the **best** responsemade by the nurse?

✓ "Fetal movements do not decrease as a woman nears term; therefore, you should be seen by yourhealth care provider for further evaluation."

115) A 25-year-old woman arrives on the maternity unit on February 2. She states that her estimated date of delivery (EDD) is March 22. She is verbalizing complaints of dull lower back pain, pelvic heaviness, and diarrhea for the pastfew days. On admission for observation, the client's blood pressure is 128/80 mm Hg, pulse is 100 beats/minute, respirations are 16 breaths/minute, and temperature is 99°F.The nurse plans care based on which interpretation?

✓ The woman requires further evaluation forpreterm labor.

116) The nurse in an obstetrical clinic is reviewing currentprenatal laboratory results of a pregnant client who is being seen for a routine prenatal visit. The nurse discoversthat the client's 1-hour oral glucose tolerance test (OGTT) result was 163 mg/dL (9.3 mmol/L). Which is the nurse's **best**response to the client?

✓ "The OGTT is a screening tool for gestationaldiabetes, and you will need further testing to confirm a diagnosis owing to your results being elevated."

117) A 35-week-gestation pregnant woman is transferred to the maternity unit from the emergency department, where shewas treated for minor injuries sustained in a motor vehiclecrash. The maternity nurse's **priority** will be to assess forwhich complication?

✓ Abruptio placentae

118) The result of a biophysical profile (BPP) of a 28-year-old client at 36 weeks' gestation after the ultrasound components is 8. Based on this result, the nurse should take which action?

✓ Place the fetal heart monitor on the clientin order to do a nonstress test (NST).

119) A client in week 35 of her pregnancy is placed on thefetal heart monitor for a nonstress test (NST) as a result of her complaints of decreased fetal movement. Twenty minutes after placing the client on the monitor, the nurse sees the following monitor strip and makes which conclusionregarding the NST? **Refer to Figure.** (From McKinney et al. [2013], p. 319.)

View Figure

✓ The FHR is reactive, with a baseline of 130beats/minute, moderate variability, and no decelerations.

120) The charge nurse on a labor and delivery unit has numerous admissions of laboring clients and must transfer 1of the clients to the postpartum/gynecological unit, where

the nurse-to-client ratio will be 1:4. Which antepartumclient is the **most appropriate** one to transfer?

✓ The 26-year-old, gravida I, para 0 client whois at 10 weeks' gestation and is experiencing vaginal bleeding

121) Which medication, if present in the client's history,indicates a **need for teaching** related to the woman's potential risk for carrying a fetus with a congenital cleftlip or cleft palate?

✓ Phenytoin

122) The nurse is caring for a client with a diagnosis of placenta previa. The nurse collects data knowing that whichare characteristic of placenta previa? **Select all that apply.**

✓ Painless, bright red vaginal bleeding

✓ Location in the lower uterine segment

123) A nulliparous woman asks the nurse when she will beginto feel fetal movements. The nurse responds by telling the woman that the first recognition of fetal movement will occur at approximately how many weeks of gestation?

✓ 18 weeks

124) The nurse is assessing a woman in the second trimesterof pregnancy who was admitted to the maternity unit with a suspected diagnosis of abruptio placentae. Which findings should the nurse expect to note if abruptio placentae is present? **Select all that apply.**

✓ Abdominal pain

✓ Firm uterus by palpation

125) A woman in the third trimester of pregnancy with a diagnosis of mild preeclampsia is being monitored at home. The home care nurse teaches the woman about the signs that need to be reported to the health care provider (HCP). The nurse should tell the woman to call the HCP if which occurs?

✓ Weight increases by more than 1 pound in aweek.

126) A woman in the third trimester of pregnancy visits theclinic for a scheduled prenatal appointment. The woman tellsthe nurse that she frequently has leg cramps, primarily whenshe is reclining. Once thrombophlebitis has been ruled out, the nurse should tell the woman to implement which measure to alleviate the leg cramps?

✓ Apply heat to the affected area.

127) The nurse is preparing a pregnant woman for a transvaginal ultrasound examination. The nurse should tellthe woman that which will occur?

✓ She will feel some pressure when the vaginalprobe is moved.

128) The nurse is assisting in conducting a prenatal sessionwith a group of expectant parents. One of the expectant parents asks, "How does the milk get secreted from the breast?" What should be the nurse's response?

✓ "Prolactin stimulates the secretion of milk,which is called lactogenesis."

129) The nurse implements a teaching plan for a pregnant client who is newly diagnosed with gestational diabetes mellitus. Which statement by the client indicates a **need forfurther teaching?**

✓ "I cannot exercise because of the negativeeffects on insulin production."

130) The nurse is caring for a client with a diagnosis ofendometriosis. The client asks the nurse to describe thiscondition. How should the nurse respond? **Select all that apply.**

✓ "It is the presence of tissue outside theuterus that resembles the endometrium."

✓ "Major symptoms of endometriosis are pelvicpain, dysmenorrhea, and dyspareunia."

131) A client calls the health care provider's office to schedule an appointment because she has missed 2 menstrual cycles and has always been very regular. The client receivesan appointment for the next day. The nurse should expect which findings to be present at this prenatal visit if the client is pregnant? **Select all that apply.**

✓ Chadwick's sign

✓ Positive pregnancy test

132) The nurse is teaching a pregnant client about the physiological effects and hormonal changes that occur duringpregnancy. The client asks the nurse about the role of estrogen in pregnancy. Which responses should the nurse givethe client about the role of estrogen? **Select all that apply.**

✓ It increases the blood flow to mucous membranes and causes them to swell and soften.

✓ It stimulates uterine development to providean environment for the fetus and stimulates the breasts to prepare for lactation.

133) The nurse is collecting data from a client during thefirst prenatal visit. The client is anxious to know the sexof the fetus and asks the nurse when she will be able to know. The nurse should respond to the client knowing that the sex of the fetus is determined by which weeks?

✓ 12 to 16

134) The nurse is collecting data from a client seen in thehealth care clinic for a first prenatal visit. The nurse asks the client when the first day of her last menstrual period was and the client reports February 9, 2018. Using Nägele's rule, the nurse determines that what is the estimated date of delivery? **Fill in the blank. Record your answer using 6 digits (mmddyy).**

✓ Correct Answer: 111618

135) A pregnant client is seen in the health care clinic. During the prenatal visit, the client informs the nurse thatshe is experiencing pain in her calf when she walks. Which is the **most appropriate** nursing action?

✓ Assess for signs of venous thrombosis.

136) A client in her second trimester of pregnancy is seenat the health care clinic. The nurse collects data from theclient and notes that the fetal heart rate is 90 beats/minute. Which nursing action is appropriate?

✓ Notify the health care provider (HCP).

137) The nurse is caring for a pregnant woman who has herpesgenitalis. The nurse provides instructions to the woman about treatment modalities that may be necessary for this condition. Which statement made by the woman indicates an understanding of these treatment measures?

✓ "It may be necessary to have a cesareansection for delivery."

138) A pregnant woman tests positive for the hepatitis B virus (HBV). The woman asks the nurse if she will be able tobreast-feed the baby as planned after delivery. Which response by the nurse is **most appropriate?**

✓ "Breast-feeding is allowed after the baby hasbeen vaccinated with immune globulin."

139) The nurse is collecting data from a client who is at 32weeks' gestation. The nurse measures the fundal height in centimeters and expects the findings to be how many centimeters (cm)?

✓ 32 cm

140) A pregnant client is seen in the health care clinic fora regular prenatal visit. The client tells the nurse that she is experiencing irregular contractions. The nurse determines that the client is experiencing Braxton Hicks contractions. Which nursing action should the nurse implement?

✓ Instruct the client that these are common andmay occur throughout the pregnancy.

141) The nurse is reviewing the record of a client who hasjust been told that her pregnancy test is positive. The health care provider has documented the presence of first trimester pregnancy signs. Which signs should the nurse anticipate as being present during this time frame? **Selectall that apply.**

✓ Hegar's sign

✓ Goodell's sign

✓ Chadwick's sign

142) A nursing instructor asks a nursing student to describethe process of quickening. Which statements by the student

indicate an understanding of this term? **Select all thatapply.**

✓ "It is the fetal movement that is felt by themother."

✓ "It is a process that occurs in the pregnantwoman as early as 16 weeks but definitely by week20."

143) A pregnant client asks the nurse in the clinic, "Whenwill I begin to feel fetal movement?" Which response shouldthe nurse make?

✓ Between 16 and 20 weeks

144) A rubella titer is performed on a client who has justbeen told that she is pregnant. The results of the titer indicate that the client is not immune to rubella. Which should the nurse anticipate to be prescribed for this client?

✓ Retesting rubella titer during pregnancy

145) A nursing student is preparing to instruct a pregnant client in performing Kegel exercises. The nursing instructorasks the student the purpose of Kegel exercises. Which response made by the student indicates an understanding of the purpose? **Select all that apply.**

✓ "The exercises will help strengthen thepelvic floor in preparation for delivery."

✓ "The exercises will help strengthen the muscles that support the bladder and urethra."

146) The nurse in a health care clinic is instructing a client on how to perform kick counts. Which statement madeby the client indicates a **need for further teaching?**

✓ "I should lie on my back to perform theprocedure."

147) A pregnant client asks the nurse, "What should I expectduring a nonstress test?" Which information should the nurseprovide to the client?

✓ "An ultrasound transducer that records fetalheart activity is secured over the abdomen where the fetal heart is heard most clearly."

148) The nurse provides teaching on how to relieve discomfort to a client in her second trimester of pregnancy who is having frequent low back pain and ankle edema at the end of the day. Which statement made by the client indicatesan understanding of the teaching?

✓ "When I get home I should lie on the floor, with my legs elevated on a couch, and turn my hipsand knees at right angles."

149) A pregnant client calls the nurse at the health careprovider's office and reports that she has noticed a thin,colorless vaginal drainage. Which information is **most appropriate** for the nurse to provide to the client?

✓ The vaginal discharge may be bothersome butis a normal occurrence.

150) The nurse has assisted in performing a nonstress test on a pregnant client and is reviewing the documentation related to the results of the test. The nurse notes that the health care provider has documented the test results as reactive. How should the nurse interpret this result?

✓ Normal findings

151) A pregnant client calls the clinic and tells the nursethat she is experiencing leg cramps and is awakened by the cramps at night. Which activity should the nurse tell the client to perform when the cramps occur?

✓ Dorsiflex the foot while extending the knee.

152) The nurse is providing instructions about treatment forhemorrhoids to a client in the second trimester of pregnancy. Which statement made by the client indicates a **need for further teaching?**

✓ "I should apply heat packs to the hemorrhoidsto help them shrink."

153) The clinic nurse is discussing nutrition with a pregnant client who has lactose intolerance. Which food should the nurse instruct the client to eat to supplementthe dietary source of calcium?

✓ Broccoli

154) The nurse is providing instructions to a pregnant client visiting the antenatal clinic about foods that are rich in folic acid. Which food should the nurse encourage the client to consume because it is highest in folic acid?

✓ Green leafy vegetables

155) A pregnant client asks the nurse about the types of exercises that are allowed during pregnancy. Which exerciseshould the nurse instruct the client to engage in?

✓ Swimming

156) A pregnant client reports to the health care clinic complaining of loss of appetite, weight loss, and fatigue. Asputum culture is obtained, and *Mycobacterium tuberculosis* is identified in the sputum. Which instruction should the nurse provide to the client regarding therapeutic managementof tuberculosis?

✓ Isoniazid plus rifampin will be required fora total of 9 months.

157) The nurse provides home care instructions to a pregnantclient with a history of cardiac disease. Which statement made by the client indicates a **need for further teaching?**

✓ "During the pregnancy, I need to avoid contact with other individuals as much as possibleto prevent infection."

158) The nurse is collecting data on a pregnant client in the first trimester of pregnancy diagnosed with iron deficiency anemia. The nurse should monitor the client to detect which manifestation indicating that this problem hasnot yet resolved?

✓ Complaints of daily headaches and fatigue

159) The nurse is conducting a routine screening to detect aclient's risk for toxoplasmosis parasite infection during pregnancy. Which factor should the nurse ask the client about to determine this risk?

✓ Presence of cats in the home

160) Which is the **priority** nursing action for the clientwith an ectopic pregnancy?

✓ Monitoring the pulse and blood pressure

161) The nurse is reviewing the record of a pregnant clientseen in the health care clinic for the first prenatal visit.Which data should alert the nurse that the client is at riskfor developing gestational diabetes during this pregnancy? **Select all that apply.**

✓ The client's last baby weighed 10 lb atbirth.

✓ The client has a history of gestationaldiabetes with her previous pregnancy.

162) The nurse is teaching a pregnant client with diabetesabout nutrition and insulin needs during pregnancy. The nurse determines that the client understands dietary and insulin needs if the client states that which may be required during the second half of pregnancy?

✓ Increased insulin

163) The nurse is providing instructions about taking iron supplements to a pregnant client. The nurse determines that the client understands the instructions if the client states that she will take the supplements with which drink?

✓ Orange juice

164) The nurse is assisting the health care provider to perform Leopold's maneuvers on a pregnant client. Whichaction should the nurse perform before the procedure?

✓ Ask the client to urinate.

165) The nurse is collecting data on clients who are in their first trimester of pregnancy. The nurse is concernedwith identifying clients who may be at risk for the development of postpartum complications. Which client is **least likely** to be at risk for the development of thrombophlebitis in the postpartum period?

✓ A 26-year-old client with a family history ofthrombophlebitis

166) The clinic nurse is instructing a pregnant client inher first trimester about nutrition. The nurse should determine that the client **needs further teaching** if the client believes that which is true about nutrition duringpregnancy?

✓ Pregnancy greatly increases the risk ofmalnourishment for the mother.

167) The nurse is providing emergency measures to a client in labor who has been diagnosed with a prolapsed cord. The mother becomes anxious and frightened and says to the nurse,"Why are all of these people in here? Is my baby going to beall right?" Which client problem is **most appropriate** to address at this time?

✓ The client's fear

168) The maternity nurse is caring for a client with abruptio placentae and is monitoring her for disseminated intravascular coagulation (DIC). Which assessment findingsare **most likely** associated with disseminated intravascularcoagulation? **Select all that apply.**

✓ Petechiae

✓ Hematuria

✓ Prolonged clotting times

✓ Oozing from injection sites

169) The nurse in a labor room is assisting with the vaginaldelivery of a newborn infant. The nurse should monitor the client closely for the risk of uterine rupture if which occurred?

✓ Forceps delivery

170) The nurse is caring for a client who is experiencing aprecipitous labor and is waiting for the health care provider to arrive. When the infant's head crowns, what instruction should the nurse give the client?

✓ Breathe rapidly.

171) The nurse explains the purpose of effleurage to aclient in early labor. Which statement should the nurseinclude in the explanation?

✓ "It is light stroking of the abdomen to facilitate relaxation during labor and providetactile stimulation to the fetus."

172) A client in labor is dilated 10 cm. At this point inthe labor process, at least how often should the nurse assess and document the fetal heart rate?

✓ Every 15 minutes

173) The nurse is caring for a client in labor and preparesto auscultate the fetal heart rate (FHR) by using a Dopplerultrasound device. Which action should the nurse take to determine fetal heart sounds accurately?

✓ Palpating the maternal radial pulse whilelistening to the FHR

174) The nurse is caring for a client in labor who is receiving oxytocin by intravenous infusion to stimulateuterine contractions. Which assessment finding should indicate to the nurse that the infusion needs to be discontinued?

✓ A fetal heart rate of 90 beats/minute

175) The nurse is preparing to care for a client in labor.The health care provider has prescribed an intravenous (IV)infusion of oxytocin. The nurse ensures that which intervention is implemented before initiating the infusion?

✓ Continuous electronic fetal monitoring

176) The nurse assists in the vaginal delivery of a newborninfant. After the delivery, the nurse observes the umbilicalcord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of which condition?

✓ Placental separation

177) During the intrapartum period, the nurse is caring fora client with sickle cell disease. The nurse ensures that the client receives adequate intravenous fluid intake and oxygen consumption to achieve which outcome?

✓ Prevent dehydration and hypoxemia.

178) A client with a 38-week twin gestation is admitted to abirthing center in early labor. One of the fetuses is a breech presentation. Which intervention is **least appropriate** in planning the nursing care of this client?

✓ Measure fundal height.

179) The nurse prepares a plan of care for the client withpreeclampsia and documents that if the client progresses from preeclampsia to eclampsia, the nurse should take which **first** action?

✓ Clear and maintain an open airway.

180) A prenatal client with vaginal bleeding is being admitted to the labor unit. The labor room nurse is performing the admission assessment and should suspect a diagnosis of placenta previa if which finding is noted?

✓ Painless vaginal bleeding

181) A prenatal client with severe abdominal pain is admitted to the maternity unit. The nurse is monitoring the client closely because concealed bleeding is suspected. Which assessment findings indicate the presence of concealedbleeding? **Select all that apply.**

✓ Increase in fundal height

✓ Hard, boardlike abdomen

✓ Persistent abdominal pain

182) The nurse is caring for a client during the second stage of labor. On assessment, the nurse notes a slowing of the fetal heart rate and a loss of variability. Which is the **initial** nursing action?

✓ Turn the client onto her side and give oxygenby face mask at 8 to 10 L/min.

183) An amniotomy is performed on a client in labor. On theamniotic fluid examination, the delivery room nurse should identify which findings as normal?

✓ Pale straw in color, with flecks of vernix

184) A labor room nurse is performing an assessment on a client in labor and notes that the fetal heart rate (FHR) is
158 beats/minute and regular. The client's contractions are

every 5 minutes, with a duration of 40 seconds and ofmoderate intensity. On the basis of these assessment findings, what is the appropriate nursing action?

✓ Continue to monitor the client.

185) The nurse is creating a plan of care for a pregnant client with a diagnosis of severe preeclampsia. Which nursing actions should be included in the care plan for thisclient? **Select all that apply.**

✓ Keep the room semi-dark.

✓ Initiate seizure precautions.

✓ Pad the side rails of the bed.

✓ Avoid environmental stimulation.

186) The labor room nurse assists with the administration ofa lumbar epidural block. How should the nurse check for the major side effect associated with this type of regional anesthesia?

✓ Monitoring the mother's blood pressure

187) The nurse assists the health care provider to performan amniotomy on a client in labor. Which is the **priority** nursing action after this procedure?

✓ Assess the fetal heart rate.

188) The goal for a woman with partial premature separationof the placenta is: "The woman will not exhibit signs of fetal distress." Which outcome, documented by the nurse, indicates that this goal has been achieved?

✓ Moderate variability present

189) The nurse is assessing the deep tendon reflexes of a client with severe preeclampsia who is receiving intravenousmagnesium sulfate. The nurse should perform which procedure to assess the brachioradialis reflex? **Click on the image to indicate your answer.**

(From Jarvis [2013], pp. 646–648.)

✓ Correct Answer Indication:

190) The nurse is caring for a client in active labor. Whichnursing intervention would be the **best** method to prevent fetal heart rate (FHR) decelerations?

✓ Encourage an upright or side-lying maternalposition.

191) The nurse is administering magnesium sulfate to a client for preeclampsia at 34 weeks' gestation. What is the**priority** nursing action for this client?

✓ Assess for signs and symptoms of labor.

192) The nurse is preparing to administer an analgesic to aclient in labor. Which analgesic is contraindicated for a client who has a history of opioid dependency?

✓ Butorphanol tartrate

193) The nurse in a delivery room is assessing a client immediately after delivery of the placenta. Which maternalobservation could indicate uterine inversion and require **immediate** intervention?

✓ Complaints of severe abdominal pain

194) The nurse is caring for a client in the transition phase of the first stage of labor. The client is experiencing uterine contractions every 2 minutes and she cries out in pain with each contraction. What is the nurse's**best** interpretation of this client's behavior?

✓ Fear of losing control

195) A pregnant client is admitted in labor. The nursingassessment reveals that the client's hemoglobin and hematocrit levels are low, indicating anemia. What shouldthe nurse observe for following the client's labor?

✓ Postpartum infection

196) Fetal distress is occurring with a woman in labor. Asthe nurse prepares her for a cesarean birth, what other intervention should the nurse implement?

✓ Administer oxygen at 8 to 10 L/min via facemask.

197) A pregnant 39-week-gestation gravida 1, para 0 clientarrives on the labor and delivery unit with signs and

symptoms of active labor. The nurse reviews the client's prenatal record and discovers that she has had a positive group B streptococcus (GBS) laboratory report during her prenatal course. After performing a cervical exam, the nurseconfirms that the cervix is dilated 6 cm and 90% effaced.
Which should be the nurse's **first** action?

✓ Call the health care provider (HCP) to obtaina prescription for intravenous antibiotic prophylaxis (IAP).

198) A pregnant 39-week-gestation client arrives at the labor and delivery unit in active labor. On confirmation oflabor, the client reports a history of herpes simplex virus (HSV) to the nurse, who notes the presence of lesions on inspection of the client's perineum. Which should be the nurse's **initial** action?

✓ Explain to the client why a cesarean deliveryis necessary.

199) The nurse is caring for a client in labor and notes that minimal variability is present on a fetal heart rate (FHR) monitor strip. Which conditions are **most likely** associated with minimal variability? **Select all that apply.**

✓ Tachycardia

✓ Fetal hypoxia

✓ Metabolic academia

✓ Congenital anomalies

200) After the spontaneous rupture of a laboring woman'smembranes, the fetal heart rate drops to 85 beats/minute.Which should be the nurse's **priority** action?

✓ Assess the vagina and cervix with a glovedhand.

201) On assessment of the fetal heart rate (FHR) of a laboring woman, the nurse discovers decelerations that havea gradual onset, last longer than 30 seconds, and return tothe baseline rate with the completion of each contraction. The nurse plans care, knowing that this identifies which category of decelerations?

✓ Periodic, early decelerations that indicatefetal head compression

202) Shortly after receiving epidural anesthesia, a laboring woman's blood pressure drops to 95/43 mm Hg. Which **immediate** actions should the nurse take? **Select all that apply.**

✓ Turn the woman to a lateral position.

✓ Increase the rate of the intravenousinfusion.

✓ Administer oxygen by face mask at 10L/minute.

203) The nurse is administering an intravenous analgesic toa laboring woman. The woman inquires as to why the nurse iswaiting for a contraction to begin before she infuses the medication into the intravenous line. Which is the nurse's **most appropriate** response?

✓ "Because the uterine blood vessels constrictduring a contraction, the fetus will be less affected by the medication."

204) On March 10, the nurse performed an initial assessmenton a client admitted to the labor and delivery unit for "rule out labor." The client has not received prenatal care but is certain that the first day of her last menstrual period (LMP) was July 7 the previous year. The nurse plans care based on which interpretation?

✓ The client is possibly in preterm labor.

205) The nurse is assigned to care for a client with hypotonic uterine dysfunction and signs of a slowing labor.The nurse is reviewing the health care provider's prescriptions and should expect to note which prescribed treatment for this condition?

✓ Oxytocin infusion

206) A woman in active labor has requested a regional anesthetic. She is currently 5 cm dilated. The health care provider has prescribed an epidural block. Which nursing intervention should be implemented after the epidural blockhas been placed?

✓ Palpate the bladder at frequent intervals.

207) The nurse in the labor room is caring for a client whois in the first stage of labor. On assessing the fetal patterns, the nurse notes an early deceleration of the fetalheart rate (FHR) on the monitor strip. Based on this finding, which is the appropriate nursing action?

✓ Document the findings and continue to monitorfetal patterns.

208) The nurse is caring for a client who is receiving oxytocin for induction of labor and notes a nonreassuring fetal heart rate (FHR) pattern on the fetal monitor. On the basis of this finding, the nurse should take which action **first?**

✓ Stop the oxytocin infusion.

209) Which statement, if made by the laboring client, **mostlikely** indicates that the client is in the second stage oflabor?

✓ "I feel like I need to push."

210) The nurse is caring for a client in the active stage oflabor. The nurse notes that the fetal pattern shows a late deceleration on the monitor strip. Based on this finding, the nurse should prepare for which appropriate nursing action?

✓ Administering oxygen via face mask

211) A client in labor is receiving oxytocin by intravenousinfusion to stimulate uterine contractions. Which finding indicates that the rate of infusion needs to be decreased?

✓ A fetal heart rate of 180 beats/min

212) The nurse is monitoring a client in labor whosemembranes ruptured spontaneously. What is the **initial**nursing action?

✓ Determine the fetal heart rate.

213) The nurse assists in the vaginal delivery of a newborn.Following the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse should document these observations as signs of which condition?

✓ Placental separation

214) The nurse is preparing to care for a client in labor. The health care provider (HCP) has prescribed an intravenous (IV) infusion of oxytocin. The nurse should ensure that which is implemented before the beginning of the infusion?

✓ Continuous electronic fetal monitoring

215) The nurse is assisting in the care of a client in laborwho is having an amniotomy performed. The nurse should report which abnormal findings to the health care provider (HCP)? **Select all that apply.**

✓ Clear, dark amber amniotic fluid

✓ Light green amniotic fluid with no odor

✓ Thick white amniotic fluid with no odor

216) The nurse is creating a plan of care for a client experiencing dystocia and includes several nursing interventions in the plan. The nurse prioritizes the planand selects which nursing intervention as the **highest priority?**

✓ Monitoring fetal status

217) The nurse is monitoring a client with dysfunctionallabor for signs of fetal or maternal compromise. Which finding should alert the nurse to a compromise?

✓ The passage of meconium

218) The nurse is preparing to care for a client with hypertonic labor. The nurse is told that the client is experiencing uncoordinated contractions that are erratic intheir frequency, duration, and intensity. Which is the **priority** nursing intervention?

✓ Provide pain relief measures.

219) The nurse performs a vaginal assessment on a pregnant client in labor. On assessment, the nurse notes the presenceof the umbilical cord protruding from the vagina. Which is the **initial** nursing action?

✓ Place the client in Trendelenburg's position.

220) The nurse is caring for a client during the second stage of labor. On assessment, the nurse notes a slowing ofthe fetal heart rate and a loss of variability. What is the**initial** nursing action?

✓ Turn the client on her side and administeroxygen by face mask at 8 to 10 L/min.

221) An ultrasound is performed on a client with suspectedabruptio placentae, and the results indicate that a placental abruption is present. Which intervention should the nurse prepare the client for?

✓ Delivery of the fetus

222) The nurse is monitoring a client who is in the active phase of labor. The client has been experiencing contractions that are short, irregular, and weak. Which typeof labor dystocia should the nurse document that the client is experiencing?

✓ Hypotonic

223) The nurse has collected the following data on a clientin labor. The fetal heart rate (FHR) is 154 beats/min and isregular, and contractions have moderate intensity, occur every 5 minutes, and have a duration of 35 seconds. Using this information, what is the appropriate action for the nurse to take?

✓ Continue to monitor the client.

224) A pregnant client admitted to the labor room arrived with a fetal heart rate (FHR) of 94 beats/minute and the umbilical cord protruding from the vagina. The client tellsthe nurse that her "water broke" before coming to the hospital. What is the appropriate nursing action?

✓ Wrap the cord loosely in a sterile towelsoaked with warm, sterile normal saline.

225) The purpose of a vaginal examination for a client inlabor is to specifically assess the status of which findings? **Select all that apply.**

✓ Station

✓ Dilation

✓ Effacement

226) The nurse is collecting data from a pregnant client inthe second trimester of pregnancy who was admitted to the maternity unit with a suspected diagnosis of abruptio placentae. Which findings are associated with abruptio placentae? **Select all that apply.**

✓ Uterine tenderness

✓ Acute abdominal pain

✓ A hard, "boardlike" abdomen

✓ Increased uterine resting tone on fetalmonitoring

227) The nurse is providing instructions to a new mother regarding cord care for a newborn infant. Which statement,if made by the mother, indicates a **need for further instructions?**

✓ "I need to fold the diaper above the cord toprevent infection."

228) The nursery room nurse is assessing a newborn infant who was born to a mother who abuses alcohol. Which assessment finding should the nurse expect to note? **Selectall that apply.**

✓ Tremors

✓ Irritability

✓ Poor feeding

229) The postpartum nurse teaches a mother how to give a bath to the newborn infant and observes the mother performing the procedure. Which observation indicates a **lackof understanding of the instructions?**

✓ The mother bathes the newborn infant after afeeding.

230) A newborn infant of a mother who has human immunodeficiency virus (HIV) infection is tested for the presence of HIV antibodies. An enzyme-linked immunosorbentassay (ELISA) is performed, and the results are positive. Which is the correct interpretation of these results?

✓ Indicates the presence of maternal infection

231) The nurse employed in a neonatal intensive care nurseryreceives a telephone call from the delivery room and is toldthat a newborn with spina bifida (myelomeningocele type) will be transported to the nursery. The maternity nurse prepares for the arrival of the newborn and places which **priority** item at the newborn's bedside?

✓ A bottle of sterile normal saline

232) The nurse has provided instructions about measures toclean the penis to a mother of a male newborn who is not circumcised. Which statement, if made by the mother, indicates an understanding of how to clean the newborn's penis?

✓ "I need to avoid pulling back the foreskin toclean the penis because this may cause adhesions."

233) The nurse is preparing to instruct a client on how to bathe a newborn. Which statement should the nurse include inthe instruction?

✓ "Begin with the eyes and face."

234) The nurse is preparing to administer an injection ofvitamin K to a newborn and provides the mother with information about the injection. Which information shouldthe nurse provide?

✓ "The injection is extremely important toprevent bleeding in your baby."

235) The nurse is assessing the reflexes of a newborninfant. In eliciting the Moro reflex, the nurse shouldperform which action?

✓ Make a loud, abrupt noise to startle thenewborn.

236) A 4-day-old newborn is receiving phototherapy at homefor a bilirubin level of 14 mg/dL (238 mcmol/L). The nurseshould plan to include which instruction in the teaching plan of care during the home visit to the mother of the newborn?

✓ Assessing skin integrity and fluid status ofthe newborn

237) The nurse is performing Apgar scoring for a newborn immediately after birth. The nurse notes that the heart rateis less than 100 beats per minute, respiratory effort is irregular, and muscle tone shows some extremity flexion. Thenewborn grimaces when suctioned with a bulb syringe, and theskin color indicates some cyanosis of the extremities. What should be the **immediate** nursing intervention for this newborn?

✓ Oxygen supplementation and suctioning

238) The nurse in the newborn nursery is performing admission vital signs on a newborn infant. The nurse notesthat the respiratory rate of the newborn is 50 breaths perminute. Which action should the nurse take?

✓ Document the findings.

239) Methylergonovine has been prescribed for a woman who isat risk for postpartum bleeding in the immediate postpartum period. The nurse preparing to administer the medication ensures that which **priority** item is at the bedside?

✓ Blood pressure cuff

240) Butorphanol tartrate is prescribed for a woman in labor, and the woman asks the nurse about the purpose of themedication. The nurse should make which appropriate response?

✓ "The medication provides pain relief duringlabor."

241) The nurse in the labor room measures the Apgar score ina newborn infant and notes that the score is 4. Which actionby the nurse has **highest priority?**

✓ Administer oxygen via resuscitation bag tothe newborn infant.

242) The nurse in the delivery room is performing an initialassessment on a newborn infant. When examining the umbilicalcord, the nurse observes only 2 vessels. How should the nurse interpret this finding?

✓ Finding 2 vessels may indicate an increasedrisk for other congenital anomalies.

243) The home care nurse is visiting a mother 1 week aftershe gave birth to an infant who is at risk for developing neonatal congenital syphilis. After teaching the mother about the signs and symptoms of this disorder, the nurse instructs the mother to monitor the infant for which findings? **Select all that apply.**

✓ A copper-colored skin rash

✓ Mucopurulent nasal drainage (snuffles)

244) To prevent heat loss by conduction during physicalexamination of a newborn infant, which action should thenurse implement?

✓ Place a warm blanket on the examining tablebefore placing the newborn on the table.

245) The nurse in the delivery room is performing an assessment on a newborn to determine the Apgar score. The nurse notes a heart rate of 92, a weak cry, some flexion ofextremities, grimacing with stimulation, and pink body withblue extremities. On the basis of this score, what should the nurse determine?

✓ The newborn requires some resuscitativeinterventions.

246) The nurse is teaching the mother of a newborn infantmeasures to maintain the infant's health. The nurse identifies which as an example of primary prevention activities for the infant?

✓ Periodic well-baby examinations

247) The nurse is preparing to teach a new mother how to sponge bathe a 1-day-old newborn. Which actions should thenurse take? **Select all that apply.**

✓ Pat the baby dry gently.

✓ Support the newborn's body during the bath.

✓ Make sure that the room temperature is 75°F(23.9°C).

✓ Cleanse one body area at a time keeping otherbody areas covered.

248) On delivery of a newborn, the nurse performs an initialassessment. When should the nurse plan to determine the Apgar score?

✓ At 1 minute after birth and 5 minutes afterbirth

249) The nurse is performing Apgar scoring for a newborninfant immediately after birth. The nurse notes that the heart rate is greater than 100 beats/min, the respiratory effort is good, muscle tone is active, the newborn infantsneezes when suctioned by the bulb syringe, and the skin color is pink. On the basis of these findings, the nurse should document which Apgar score?

✓ 10

250) The nurse in the newborn nursery is determining admission vital signs for a newborn infant. The nurse documents that the vital signs are within normal range if which set of vital signs is noted on assessment?

✓ Heart rate 130 beats/minute, respirations 46breaths/minute

251) The nurse is performing an assessment of a newborn admitted to the nursery after birth. On assessment of the newborn's head, what should the nurse anticipate to be the**most likely** findings related to the fontanels? **Select all that apply.**

✓ A soft and flat anterior fontanel

✓ A triangular-shaped posterior fontanel

252) The nurse is reviewing the record of a newborn infant in the nursery and notes that the health care provider (HCP)has documented the presence of a cephalohematoma. Based on this documentation, what should the nurse expect to note on assessment of the infant?

✓ Edema resulting from bleeding below theperiosteum of the cranium

253) The nurse is admitting a newborn infant to the nursery and notes that the health care provider (HCP) has documentedthat the newborn has an omphalocele and will require a surgical procedure. Preoperative nursing care should includewhich nursing interventions? **Select all that apply.**

✓ Protect defect from trauma.

✓ Maintain a thermoneutral environment.

✓ Assess for associated birth defects such ascleft palate.

254) Which statement, if made by the mother of a 1-day-oldnewborn, indicates the understanding of gastrointestinal system functioning in the infant? **Select all that apply.**

✓ 10 to 20 mL is the stomach capacity of a 1-day-old newborn

✓ 90 to 150 mL is the stomach capacity of a 1-month-old infant

255) A new mother reports that her niece was diagnosed as aninfant with gastroesophageal reflux (GER). The newborn's mother asks the nurse if her newborn also has this diagnosis. Which findings should the nurse identify as potential indicators of GER? **Select all that apply.**

✓ Irritability

✓ Failure to thrive

✓ Choking with feeding

✓ Spitting up and regurgitation

256) The nurse is assessing a newborn infant with a diagnosis of hiatal hernia. Which findings should the nurse**most** specifically expect to note in the infant? **Select all that apply.**

✓ Failure to thrive

✓ Coughing, wheezing, and short periods ofapnea

257) An infant is born to a mother with hepatitis B. Whichprophylactic measure is indicated for the infant?

✓ Hepatitis B immune globulin (HBIG) and hepatitis B vaccine given within 12 hours afterbirth

258) The nurse is caring for a term newborn. Blood samples for serum chemistries are drawn, and the total calcium level

is reported as 8.0 mg/dL (2 mmol/L). Based on this information, which nursing action should be implemented?

✓ Document the finding in the electronic healthrecord.

259) The nurse is caring for a term newborn. Which assessment finding should alert the nurse to suspect thepotential for jaundice in this infant?

✓ Presence of a cephalhematoma

260) The nurse is performing an admission assessment on a newborn infant with the diagnosis of subdural hematoma aftera difficult vaginal delivery. Which assessment technique assists to support the newborn's diagnosis?

✓ Stimulating for reflex responses in theextremities

261) Which medication should the nurse plan to administer toa newborn by the intramuscular (IM) route?

✓ Phytonadione (Vitamin K)

262) The nurse in a newborn nursery is performing an assessment of an infant. What procedure should the nurse useto measure the infant's head circumference?

✓ Place the tape measure under the infant's head, wrap around the occiput, and measure justabove the eyebrows.

263) The mother of a preterm newborn is comparing the appearance of her preterm baby to the nearby full-term babies. She asks why her baby's skin appears so different. What is the **best** response for the nurse to provide?

✓ "A preterm newborn's skin appears moretranslucent due to decreased amounts of subcutaneous fat."

264) The nurse in the labor room is performing an initialassessment on a newborn infant. On assessment of the head,the nurse notes that the ears are low set. Which nursing action would be appropriate?

✓ Notify the health care provider (HCP).

265) The nurse is caring for a post-term, small for gestational age (SGA) newborn infant immediately after admission to the nursery. What should the nurse monitor asthe **priority?**

✓ Blood glucose levels

266) An initial assessment of a large for gestational age(LGA) newborn infant is being done. Which physical assessment technique should the nurse assist in performing to assess for evidence of birth trauma?

✓ Palpate the clavicles for a fracture.

267) The nurse in the newborn nursery is assessing a neonatewho was born of a mother addicted to cocaine. Which assessment findings should the nurse expect to note in the neonate?
Select all that apply.

✓ Tremors

✓ Tachycardia

✓ Exaggerated startle reflex

268) An infant returns to the nursing unit following surgeryfor a diagnosis of esophageal atresia with tracheoesophagealfistula (TEF). The infant is receiving intravenous fluids and a gastrostomy tube is in place. Following assessment, the nurse positions the infant and performs which action?

✓ Elevates the gastrostomy tube

269) Which is considered a normal finding in a newborn lessthan 12 hours old?

✓ Bluish discoloration of the hands and feet

270) The nurse weighing a term newborn during the initial newborn assessment determines the infant's weight to be 4400
g. The nurse determines that this infant may be at risk forwhich complications? **Select all that apply.**

✓ Hypoglycemia

✓ Fractured clavicle

✓ Congenital heart defect

271) A newborn is delivered via spontaneous vaginal delivery. On reception of the crying newborn, the nurse's**highest priority** at this time is to perform which action?

✓ Thoroughly dry the newborn.

272) Which newborn is **most** at risk for a brachial plexusinjury?

✓ A large for gestational age infant with ahistory of shoulder dystocia at delivery

273) The staff nurse in a neonatal intensive care unit is aware that red electrical outlets denote emergency power andwill function in the event of an outage. There are only 2 red outlets in the room of a 4-day-old male newborn being treated for physiological jaundice and to rule out sepsis from group B streptococcal exposure. Which pieces of equipment requiring power would the nurse select to be plugged into the red outlets in case of a power outage? **Select all that apply.**

✓ Phototherapy lights

✓ Intravenous (IV) pump

274) Which is considered a normal finding in a newborn lessthan 12 hours old?

✓ Has not passed meconium yet

275) Which are considered normal findings in a newborn lessthan 12 hours old? **Select all that apply.**

✓ Presence of vernix caseosa

✓ Anterior fontanelle measuring 5.0 cm

✓ Bluish discoloration of hands and feet

276) The nurse is monitoring a newborn infant who has been circumcised. The nurse notes that the infant has a temperature of 100.6°F (38.1°C)and that the dressing at the circumcised area is saturated with a foul-smelling drainage.Which is the **priority** nursing action?

✓ Contact the health care provider (HCP).

277) The nurse is preparing to care for a newborn with respiratory distress syndrome. Which **initial** action should

the nurse plan to **best** facilitate bonding between thenewborn and the parents?

✓ Encourage the parents to touch their newborn.

278) The nurse has a routine prescription to instill erythromycin ointment into the eyes of a newborn. Which statement, if made by the mother, demonstrates understandingof why this medication is used?

✓ "The medication will help protect my baby'seyes from certain infections transmitted during the labor and delivery process."

279) The nurse determines the apical heart rate of a 2-day-old newborn to be 140 beats/minute. Which intervention is **most appropriate** related to this finding?

✓ Document the finding in the electronic healthrecord.

280) The nurse checks the respirations of a newborn who wasjust delivered. The respiratory rate is 40 breaths/minute. Which intervention is **most appropriate** related to this finding?

✓ Document the findings in the electronichealth record.

281) The nurse is performing an assessment on a newborn and is preparing to measure the head circumference of the newborn. Which item is **essential** to perform this assessment?

✓ Tape measure

282) The nurse is checking the reflexes of a newborn. Whichaction should the nurse perform in eliciting the rooting reflex?

✓ Stimulate the perioral cavity with a finger.

283) The nurse is planning to administer an intramuscularinjection of vitamin K to a newborn. To administer the injection, which site should the nurse select?

✓ The lateral aspect of the middle third of thevastus lateralis muscle

284) The nurse is preparing to assist in administeringneonatal resuscitation with a ventilation bag and mask

because the newborn is apneic, gasping, and has a heart ratebelow 100 beats/min. The nurse should perform how many ventilations per minute at which pressure?

✓ 40 to 60 breaths/min, 15 to 20 cm H_2Opressure

285) The nurse is performing an initial assessment on a newborn. On assessment, which finding could be indicative ofa congenital defect?

✓ Low set ears

286) The nurse has provided instructions to a client on howto bathe her newborn. The nurse demonstrates the procedure to the client and on the following day asks the client to perform the procedure. Which observation, if made by the nurse, indicates that the client is performing the procedurecorrectly?

✓ The client begins to wash the newborn bystarting with the eyes and face.

287) The nurse is preparing to provide instructions to a newmother regarding cord care for a newborn infant. Which instructions would the nurse provide? **Select all that apply.**

✓ "The cord needs to be kept clean and dry."

✓ "You need to do cord care until the corddries up and falls off."

288) The nurse is providing instructions to the mother of abreast-fed newborn who has hyperbilirubinemia. Which instruction should the nurse provide to the mother?

✓ Increase the frequency of the breast-feeding.

289) The nurse is providing instructions to the mother of abreast-fed newborn who has hyperbilirubinemia. Which instruction should the nurse provide to the mother?

✓ Irritability

290) The nurse is monitoring a newborn born to a client whoabuses alcohol. Which finding should the nurse expect to note when assessing this newborn?

✓ Tachypnea and retractions

291) The nurse is checking a newborn's 1-minute Apgar scorebased on the following assessment. The heart rate is 160 beats/minute; he has positive respiratory effort with a vigorous cry; his muscle tone is active and well flexed; he has a strong gag reflex and cries with stimulus to the solesof his feet; his body is pink, with his hands and feet cyanotic. Which is the newborn's 1-minute Apgar score?

✓ 9

292) A just delivered newborn is dried immediately by thenurse in the delivery area. The nurse thoroughly dries thenewborn to prevent heat loss by which mechanism?

✓ Evaporation

293) The nurse is assessing a client for signs of postpartumdepression. Which observation, if noted in the new mother, indicates a **need for follow-up** or further assessment relatedto this form of depression?

✓ The mother constantly complains of tirednessand fatigue.

294) A postpartum client is attempting to breast-feed for the first time. The nurse notes that the client has invertednipples. What nursing action should the nurse take to assistthe client in breast-feeding the newborn infant?

✓ Provide breast shells and assist the mother with using a breast pump before each feeding to make the nipples easier for the newborn infant tograsp.

295) A new mother is seen in a health care clinic 2 weeks after giving birth to a healthy newborn infant. The mother is complaining that she feels as though she has the flu andcomplains of fatigue and aching muscles. On further assessment the nurse notes a localized area of redness on the left breast, and the mother is diagnosed with mastitis. The mother asks the nurse about the condition. The nurse should make which response?

✓ "Mastitis can occur at any time duringbreast-feeding."

296) The nurse is developing a plan of care for a client recovering from a cesarean delivery. Which action should the

nurse encourage the client to do to preventthrombophlebitis?

✓ Ambulate frequently.

297) The nurse performs an assessment on a client who is 4hours postpartum. The nurse notes that the client has cool,clammy skin and is restless and excessively thirsty. What **immediate** action should the nurse take?

✓ Assess for hypovolemia and notify the healthcare provider (HCP).

298) The nurse is monitoring a postpartum client in the fourth stage of labor. Which finding, if noted by the nurse,indicates a complication related to a laceration of the birth canal?

✓ The saturation of more than 1 peripad perhour

299) The nurse is providing instructions to a client who hasbeen diagnosed with mastitis. Which statement, if made by the client, indicates a **need for further instruction?**

✓ "I need to stop breast-feeding until thiscondition resolves."

300) A postpartum client with deep vein thrombosis is beingtreated with anticoagulant therapy. The nurse teaches the client that the health care provider (HCP) should be contacted for which noted side and adverse effects? **Select all that apply.**

✓ Epistaxis

✓ Hematuria

✓ Ecchymosis

301) After surgical evacuation and repair of a paravaginalhematoma, a client is discharged 3 days postpartum. The nurse determines that the client **needs further discharge instructions** when the client makes which statement?

✓ "The only medications I will take areprenatal vitamins and stool softeners."

302) The nurse is creating a plan of care for a postpartum client who was diagnosed with superficial venous thrombosis.

The nurse anticipates that which intervention will beprescribed?

✓ Elevation of the affected extremity

303) A new mother received epidural anesthesia during laborand had a forceps delivery after pushing for 2 hours. At 6 hours postpartum her systolic blood pressure has dropped 20 points, her diastolic blood pressure has dropped 10 points, and her pulse is 120 beats/minute. The client is anxious andrestless. On further assessment, a vulvar hematoma is verified. After notifying the health care provider (HCP), what is the nurse's **next** action?

✓ Prepare the client for surgery.

304) The home care nurse visits a client who has delivered ahealthy newborn infant via vaginal delivery. An episiotomy was performed, and the woman has developed a wound infectionat the episiotomy site. The nurse provides instructions to the client regarding care related to the infection. Which statement, if made by the mother, indicates a **need for further instruction?**

✓ "I need to isolate the infant for 48 hoursafter beginning the antibiotics."

305) A client has just had surgery to deliver a nonviable fetus resulting from abruptio placentae. As a result of theabruptio placentae, the client develops disseminated intravascular coagulation (DIC) and is told about the complication. The client begins to cry and screams, "God, just let me die now!" Which client problem should be the **priority** for the client at this time?

✓ Concern about the loss of the baby andpersonal health

306) The rubella vaccine has been prescribed for a new mother. Which statement should the postpartum nurse make when providing information about the vaccine to the client?

✓ "You should not become pregnant for 2 to 3months after administration of the vaccine."

307) The nursing student is assigned to care for a client inthe postpartum unit. The coassigned registered nurse asks the student to identify the **most** objective method to assess

the amount of lochial flow in the client. Which statement, if made by the student, indicates an understanding of thismethod?

✓ "I should weigh the perineal pad before and after use and note the amount of time between eachpad change."

308) The nurse in the postpartum unit is observing the mother-infant bonding process in a client. Which observation, if made by the nurse, indicates the potentialfor a maladaptive interaction?

✓ The mother requests that the nurse feed thenewborn because she is feeling fatigued.

309) The nurse in the postpartum unit is observing the mother-infant bonding process in a client. Which observation, if made by the nurse, indicates the potentialfor a maladaptive interaction?

✓ Retained placental fragments from delivery

310) The nurse is monitoring a postpartum client who is atrisk for developing postpartum endometritis. Which finding,if noted during the first 24 hours after delivery, supportsa diagnosis of postpartum endometritis?

✓ Abdominal tenderness and chills

311) Which nursing intervention is appropriate for apostpartum client with a diagnosis of endometritis tofacilitate participation in newborn care?

✓ Encourage the client to take pain medicationas prescribed.

312) The nurse is caring for a client in the postpartumperiod immediately after delivery. The nurse performs anassessment on the client and prepares to assess uterine involution by taking which action?

✓ Palpating the uterine fundus

313) The nurse is assessing a client in the postpartum period and suspects the presence of uterine atony. Which isthe **initial** nursing action?

✓ Massage the uterus until firm.

314) The postpartum unit nurse is creating a plan of care for a first-time mother and identifies the need for measuresthat will promote parent-infant bonding. Which measure should the nurse include in the plan?

✓ Encourage the mother to hold the infant whenthe infant cries.

315) The postpartum unit nurse has provided discharge instructions to a client planning to breast-feed her normal,healthy infant. Which statement by the client indicates an understanding of the instructions?

✓ "If I notice any pain, redness, or swellingin my breasts, I should contact the health care provider."

316) A client arrives at the postpartum unit after deliveryof her infant. On performing an assessment, the nurse notesthat the client is shaking uncontrollably. Which nursing action is appropriate?

✓ Cover the client with a warm blanket

317) The postpartum unit nurse has provided information onperforming a sitz bath to a new mother after a vaginal delivery. The client demonstrates understanding of the purpose of the sitz bath by stating that it will promote which action?

✓ Assist in healing and provide comfort.

318) The nurse is assessing the fundus in a postpartum womanand notes that the uterus is soft and spongy and not firmly contracted. The nurse should prepare to implement which interventions? **Select all that apply.**

✓ Massaging the uterus

✓ Assisting the woman to urinate

✓ Checking for a distended bladder

319) A woman infected with the human immunodeficiency virus(HIV) has given birth to an infant who appears normal, and the nurse provides instructions about newborn infant care. Which statement by the mother indicates an understanding ofthe instructions? **Select all that apply.**

✓ "I am going to need to bottle-feed my baby."

✓ "I need to wash my hands before and afterbathroom use."

✓ "I can transmit the infection to my baby whenI breast-feed."

✓ "I am going to contact some support groups tohelp me cope and learn ways to deal with things when I get home."

320) The clinic nurse is performing an assessment on a client who is 6 days postpartum. When assessing involution,the nurse expects the uterine fundus to be located at whicharea? **Click on the image to indicate your answer.**

✓ Correct Answer Indication: ✓

321) A client with known cardiac disease has been admitted to the postpartum care unit after an uneventful delivery. The nurse instructs the client to use the call button for assistance whenever she needs to get out of bed or wishes tocare for her infant. Which postpartum complication is the nurse **most** concerned about for this client?

✓ Maternal overexertion

322) A postpartum care unit nurse is reviewing the recordsof 5 new mothers admitted to the unit. The nurse determinesthat which mother is **most likely** at risk for developing a puerperal infection? **Select all that apply.**

✓ A mother who had 10 vaginal exams duringlabor

✓ A mother with a history of previous puerperalinfections

✓ A mother who experienced prolonged rupture ofthe membranes

323) A postpartum unit nurse is caring for a stable client 12 hours after delivering a healthy newborn. At this time inthe postpartum period, what is the recommended frequency forthe nurse to assess the client's vital signs?

✓ Every 4 hours

324) The postpartum unit nurse is performing an assessmenton a client who is at risk for thrombophlebitis. Which nursing action is indicated in assessing for thrombophlebitis?

✓ Ask the client about pain in the calf area.

325) The rubella vaccine is prescribed to be administered toa client 2 days after delivery of her child. The nurse preparing to administer the vaccine develops a list of the potential risks associated with this vaccine. The nurse reviews the list with the client and cautions the client to avoid which situation?

✓ Pregnancy for 2 to 3 months after thevaccination

326) On the second postpartum day, a woman complains of burning on urination, urgency, and frequency of urination. Aurinalysis is done, and the results indicate the presence ofa urinary tract infection. The nurse instructs the new mother on measures to take for treatment of the infection. Which statement, if made by the mother, would indicate a **need for further instruction?**

✓ "Foods and fluids that will increase urinealkalinity should be consumed."

327) A pregnant woman who is infected with the human immunodeficiency virus (HIV) delivers a newborn infant, and the nurse provides instructions to help the mother regardingcare of the infant. Which statements by the client indicate the **need for further instruction? Select all that apply.**

✓ "My baby has no symptoms so it is not likelythat he has gotten the infection from me."

✓ "I need to breast-feed, especially for thefirst 6 weeks postpartum."

328) The home care nurse's assignment is to visit a new mother at home 24 to 48 hours after discharge. What should the nurse expect to note in a healthy mother who is breast-feeding her newborn infant?

✓ The mother is breast-feeding with the infantin a tummy-to-tummy position without signs of

cracked nipples; the baby demonstrates bursts ofsucking, followed by a pause and swallow.

329) The nurse who is employed in a prenatal clinic is performing prenatal assessments on clients who are in their first trimester of pregnancy. The nurse is concerned with identifying clients who may be at risk for the development of postpartum complications. Which clients would be at **most** risk for development of postpartum thromboembolic disorders?**Select all that apply.**

✓ A 39-year-old woman who reports that shesmokes

✓ A 37-year-old woman in her fourth pregnancywho is overweight

✓ A 22-year-old woman in a first pregnancy who states that oral contraceptives taken in the pasthave caused thrombophlebitis

330) The nurse has provided instructions for a postpartum client at risk for thrombosis regarding measures to preventits occurrence. Which statement, if made by the client, indicates a **need for further education?**

✓ "I should apply my antiembolism stockingsafter breakfast."

331) The discharge nurse is discussing mastitis with apostpartum client. Which statement made by the client indicates a **need for further instruction?**

✓ "If I develop a fever, chills, or body aches at any time after discharge, I should stop breast-feeding immediately."

332) On assessment of a client who is 30 minutes into the fourth stage of labor, the nurse finds the client's perinealpad saturated with blood and blood soaked into the bed linenunder the client's buttocks. Which is the nurse's **initial** action?

✓ Gently massage the uterine fundus.

333) After receiving report at the beginning of the 0700 shift, the nurse must decide in what order the clients should be assessed. How should the nurse plan assessments?

Arrange the clients in the order that they should beassessed. All options must be used.

- ✓ 1) A 12-hour post–cesarean section delivery gravida 3, para 3 who reports a return of feeling in her lower extremities as well as a sensation of wetness underneath her
- ✓ 2)A 24-hour post–vaginal delivery gravida 4,para 4 who is complaining of abdominal cramping after nursing her baby and requesting ibuprofen.
- ✓ 3)An 8-hour post–vaginal delivery gravida 2,para 2 client who is scheduled for a bilateral tubal ligation at 1200 today and has a continuous peripheral intravenous (IV) solution of 5% dextrose in lactated Ringer's
- ✓ 4) A 48-hour post–cesarean section delivery gravida 1, para 1 who reports not yet having a bowel movement since delivery and requests a stoolsoftener.

334) A client who is a gravida 3, para 3 had a cesarean section 1 day ago. She is being treated prophylactically forendometritis. She is complaining of abdominal cramping at a 6 on a pain level scale of 1 to 10 (with 10 being the greatest amount of pain) and fears having her first bowel movement. These medications are prescribed and due now. Based on **priority**, in which order should the nurse administer the medications? **Arrange the medications in the order that they should be administered. All options must beused.**

- ✓ 1)Ketorolac 30 mg by intravenous (IV) pushover 3 minutes
- ✓ 2)Ampicillin sodium 1 g IV piggyback over 60minutes
- ✓ 3)Docusate sodium 100 mg orally daily
- ✓ 4)Prenatal vitamin 1 tablet orally daily

335) The nurse is checking lochia discharge in a woman in the immediate postpartum period. The nurse notes that the lochia is bright red and contains some small clots. Based onthese data, the nurse should make which interpretation?

✓ The client is experiencing normal lochiadischarge.

336) A postpartum woman with mastitis in the right breast complains that the breast is too sore for her to breast-feedher infant. The nurse should tell the client to implement which measure?

✓ Breast-feed from the left breast and gentlypump the right breast.

337) The rubella vaccine has been prescribed for a new mother. Which statements should the postpartum nurse make when providing information about the vaccine to the client?**Select all that apply.**

✓ "You need this vaccine because you are notimmune to the rubella virus."

✓ "You should not become pregnant for 1 to 3 months after the administration of the vaccine."

338) The nurse has just received an intershift report. Afterreviewing the client assignment and the appropriate medical records, the nurse determines that which client is **most** at risk for developing postdelivery endometritis?

✓ An adolescent experiencing an emergencycesarean delivery for fetal distress

339) The nurse provides a list of discharge instructions toa client who has delivered a healthy newborn by cesarean delivery. Which statement by the client indicates the **need for further teaching?**

✓ "A fever on and off is expected and isnothing to worry about."

340) The nurse is caring for a client who has just delivereda newborn following a pregnancy with placenta previa. When reviewing the plan of care, the nurse should prepare to monitor the client for which risk that is associated with placenta previa?

✓ Hemorrhage

341) The nurse is preparing to perform a fundal assessment on a postpartum client. The nurse understands that which isthe **initial** nursing action when performing this assessment?

✓ Ask the client to urinate and empty herbladder.

342) The nurse is preparing to care for a client in the immediate postpartum period who has just delivered a healthynewborn. How often should the nurse plan to take the client's vital signs?

✓ 15 minutes during the first hour and thenevery 30 minutes for the next 2 hours

343) The nurse is providing nutritional counseling to a newmother who is breast-feeding her newborn. The nurse should instruct the client that her calorie needs should increase by approximately how many calories a day?

✓ 500

344) Which additional daily dietary intake will **most closely** match the number of additional calories needed by thebreast-feeding mother?

✓ Peanut butter and jelly sandwich and glass of2% milk

345) The postpartum client asks the nurse about the occurrence of afterpains. The nurse informs the client thatafterpains will be especially noticeable during which activity?

✓ Breast-feeding

346) The nursing instructor is reviewing the plan of care for a postpartum client with a student. The instructor asks the nursing student about the taking-in phase according to Rubin's phases of regeneration and the client behaviors thatare **most likely** to occur during this phase. Which responses made by the student indicate an understanding of this phase?**Select all that apply.**

✓ "The client may complain of lack of sleep andfatigue."

✓ "The client is self-focused and talks toothers about labor."

347) The nurse is teaching a new mother how to care for hernewborn. The nurse notes that the client is very fearful andreluctant to handle the newborn and also notes that this is

the client's first child. Which nursing interventions are **most appropriate** in assisting the promotion of mother-infantinteraction and bonding? **Select all that apply.**

✓ Accepting the client's feelings

✓ Acknowledging the client's apprehension

✓ Assisting the client with giving the baths toallow her to become more at ease

348) The nurse is assigned to care for a client who has chosen to formula-feed her infant. The nurse should plan toprovide which instruction to the client?

✓ Wear a supportive brassiere continuously for 72 hours.

349) The nurse is monitoring a new mother in the fourth stage of labor for signs of hemorrhage. Which indicates an**early** sign of excessive blood loss?

✓ An increased pulse rate of 88 to 102beats/min

350) The nurse is providing instructions to a client who hasbeen diagnosed with mastitis. Which statement made by the client indicates a **need for further teaching?**

✓ "I need to stop breast-feeding until thiscondition resolves."

351) The nurse is monitoring the client for signs of postpartum depression. Which behavior indicates the **need forfurther assessment** related to this form of depression?

✓ The client constantly complains of tirednessand fatigue.

352) The nurse caring for a client with a diagnosis of subinvolution should recognize which conditions as causes ofthis diagnosis? **Select all that apply.**

✓ Uterine infection

✓ Retained placental fragments from delivery

353) The nurse has determined that a postpartum client has physical findings consistent with uterine atony. The nurse should take action in which **priority** order? **Arrange the**

action in the priority order that they should be done. Alloptions must be used.

- ✓ **1)Massage the uterus attempting to achievefirmness.**
- ✓ **2)Contact the health care provider.**
- ✓ **3)Monitor vital signs.**
- ✓ **4)Check the amount of drainage on theperipad.**

354) When planning care for a postpartum client who plans to breast-feed her infant, which important piece of information should the nurse include in the teaching plan to prevent thedevelopment of mastitis?

- ✓ Massage distended areas as the infant nurses.

355) Which instructions should the nurse provide to a clientfollowing delivery on care of the episiotomy site to preventinfection? **Select all that apply.**

- ✓ Report a foul-smelling discharge.
- ✓ Take a warm sitz baths 3 times a day.
- ✓ Use warm water to rinse the perineum afterelimination.
- ✓ Wipe the perineum from front to back aftervoiding and defecation.

356) The nurse visits at home a client who delivered a healthy newborn 2 days ago. The client is complaining of breast discomfort. The nurse notes that the client is experiencing breast engorgement. Which instructions shouldthe nurse provide to the client regarding relief of the engorgement? **Select all that apply.**

- ✓ Wear a supportive bra between feedings.
- ✓ Apply moist heat to both breasts for about 20minutes before a feeding.
- ✓ Feed the infant at least every 2 hours for 15to 20 minutes on each side.

✓ Massage the breasts gently during a feeding,from the outer areas to the nipples.

357) A postpartum client is diagnosed with a urinary tractinfection. Which measures should the nurse instruct the client to take regarding treatment and the prevention of a future infection? **Select all that apply.**

✓ Urinate frequently throughout the day.

✓ Increase fluid intake to at least 3000mL/day.

✓ Wipe the perineal area from front to backafter urinating.

✓ Consume foods and fluids that will increaseurine acidity.

358) A woman with preeclampsia is receiving magnesium sulfate. Which indicates to the nurse that the magnesiumsulfate therapy is **effective?**

✓ Seizures do not occur.

359) On assessment, a newborn is exhibiting cyanosis, tachypnea, nasal flaring, and grunting. Respiratory distresssyndrome is diagnosed, and the health care provider (HCP) prescribes surfactant replacement therapy. Through which route should the nurse prepare to administer this medication?

✓ Endotracheally through the endotracheal tube

360) A client with severe preeclampsia is receiving intravenous magnesium sulfate. The nurse is reviewing the laboratory results and determines that which magnesium level is within the therapeutic range?

✓ 5 mEq/L (2.5 mmol/L)

361) A client diagnosed with severe preeclampsia is receiving magnesium sulfate by continuous intravenous infusion. Which assessment finding would indicate that the medication should be discontinued?

✓ Absence of deep tendon reflexes

362) The senior nursing student is assigned to care for aclient with severe preeclampsia who is receiving an

intravenous infusion of magnesium sulfate. The co-assigned registered nurse asks the student to describe the actions and effects of this medication. Which statement, if made bythe student, indicates the **need for further teaching?**

✓ "It increases acetylcholine, blockingneuromuscular transmission."

363) A pregnant client seen in the prenatal clinic tells thenurse that the iron supplement started 1 week ago is causingnausea, constipation, and heartburn and that she would like to stop taking the medication. The nurse responds by making which statement to the client?

✓ "These reactions are most prominent duringinitial therapy and lessen with continued use."

364) A pregnant client is receiving oxytocin for the induction of labor. The nurse should **immediately** discontinuethe oxytocin infusion if which is noted in the client?

✓ Uterine hyperstimulation

365) A pregnant woman of 30 weeks' gestation is admitted tothe maternity unit in preterm labor. The woman asks the nurse about the purpose of betamethasone, which has been prescribed by the health care provider (HCP). The nurse should tell the client that the medication will promote which action?

✓ Enhance fetal lung maturity.

366) The nurse in the postpartum unit notes that a new mother was given methylergonovine intramuscularly followingdelivery. What assessment finding indicates that the medication was **effective?**

✓ Decreased uterine bleeding

367) The nurse performs an assessment of a pregnant womanwho is receiving intravenous magnesium sulfate for management of preeclampsia and notes that the woman's deeptendon reflexes are absent. On the basis of this finding, the nurse should make which interpretation?

✓ The woman is experiencing magnesium excess.

368) Methylergonovine is prescribed for a woman withpostpartum hemorrhage caused by uterine atony. Before

administering the medication, the nurse should check which **most important** client parameter?

✓ Blood pressure

369) Butorphanol tartrate by intravenous push is prescribed for a client in labor. The nurse recognizes which assessmentfindings to be side or adverse effects of this medication? **Select all that apply.**

✓ Tinnitus

✓ Syncope

✓ Palpitations

✓ Nausea and vomiting

370) A client experiencing preterm labor at the 29th week ofgestation has been admitted to the hospital. The client has a prescription to receive betamethasone but delivers too quickly for medication administration. As a result of not receiving this medication, which condition is **most likely** todevelop in the preterm newborn?

✓ Respiratory depression

371) A client with preeclampsia is receiving magnesiumsulfate. The nurse should assess the client closely forwhich sign of magnesium toxicity?

✓ Respiratory rate of 10 breaths/minute

372) The nurse has a routine prescription to administer aninjection of phytonadione (Vitamin K) to the newborn. Whichstatement made by the new mother indicates that teaching onthis medication was **effective?**

✓ "I know that this medication is used to prevent clotting abnormalities in the newborn."

373) A client in preterm labor is being started on intravenous magnesium sulfate to stop the contractions. Several hours later, when the nurse is performing an assessment, the following data are obtained: blood pressure110/66 mmHg, pulse 66 beats per minute, respirations 10 breaths per minute, and deep tendon reflexes absent. What should the nurse do **next?**

✓ Prepare to administer calcium gluconate as anantidote for magnesium toxicity.

374) The nurse gave an intramuscular dose of methylergonovine to a client following delivery of an infant. The nurse determines that this medication had the intended effect if which finding is noted?

✓ Improved uterine tone

375) At 10 days postpartum, a breast-feeding mother developsmastitis in her right breast. The nurse plans to instruct the client on which interventions? **Select all that apply.**

✓ Using ice packs

✓ Using analgesics

✓ Wearing proper breast support

✓ Completing the full course of prescribedantibiotics.

376) The client delivered a newborn baby 3 hours ago. The assigned nurse is reviewing the electronic health record todetermine if the new mother is a candidate for Rh immune globulin administration. Which criteria must be present in order to administer this medication correctly? **Select all that apply.**

✓ The mother must be Rh negative.

✓ The newborn must be Rh positive.

✓ The indirect Coombs' test must be negative.

377) A type 1 diabetic mother delivered a 4400-gram newborn 3 hours ago. She has already initiated breast-feeding. Whatshould the nurse plan to do to maintain euglycemia in this client?

✓ Assess her blood glucose before administeringany glucose-lowering medications.

378) The nurse has developed a plan of care for a client diagnosed with anorexia nervosa. Which client problem wouldthe nurse select as the **priority** in the plan of care?

✓ Nutritional imbalance because of lack ofintake

379) Which statement made by an unlicensed assistive personnel (UAP) indicates to the registered nurse that theUAP understands the concepts related to suicide?

✓ "Discussing suicide with a client is notharmful."

380) Which client is at greatest risk for committingsuicide?

✓ A client with metastatic cancer

381) Which statement by the nurse indicates a **need forfurther teaching** concerning family violence?

✓ "Abusers are more often from low-incomefamilies."

382) Which pre–electroconvulsive therapy intervention willthe nurse implement for a hospitalized client?

✓ Assure that an electrocardiogram is performedwithin 24 hours.

383) A nursing student is assisting with the care of a client with a chronic mental illness. The nurse informs thestudent that a behavior modification approach (operant conditioning) will be used in treatment for the client. Which statement by the student indicates a **need for furtherinformation** about the therapy?

✓ "It uses negative reinforcement."

384) The nurse is performing an admission assessment on aclient at high risk for suicide. Which assessment questionwill **best** elicit data related to this risk?

✓ "Do you have a plan to commit suicide?"

385) The nurse in the mental health unit is performing an assessment in a client who has a history of multiple physical complaints involving several organ systems. Diagnostic studies revealed no organic pathology. The care plan developed for this client will reflect that the clientis experiencing which disorder?

✓ Somatization disorder

386) The mental health nurse is meeting with a client who has a long history of abusing drugs. During the session the

client says to the nurse, "I'm feeling much better now, and I'm ready to go straight." Which response by the nurse wouldbe therapeutic?

✓ "Tell me what makes you feel that you areready."

387) A client diagnosed with depression shares with the outclinic nurse, "I lost my job this week and can't pay myrent. My daughter is my only family, but I don't want to burden her with my problems." Which response by the nurse would **effectively** address the client's concern?

✓ "Wouldn't you want to know if your daughter was having difficulties so you could help if youcould?"

388) During a therapy session a client with a personality disorder says to the nurse, "You look so nice today. I lovehow you do your hair, and I love that perfume you're wearing." Which response by the nurse would **best** address this breech of boundaries?

✓ "The focus of today's session is on yourissues, so let's get started."

389) The nurse assigned to care for a female client diagnosed with acute depression would be appropriate inmaking which statement to the client?

✓ "You're wearing a new blouse."

390) Which activity should the nurse include in the plan of care for a client who is experiencing psychomotor agitation?

✓ Attending a clay-molding class that isscheduled for today

391) The nurse is creating a plan of care for a client diagnosed with depression whose food intake is poor. Thenurse should include which interventions in the plan of care? **Select all that apply.**

✓ Assist the client in selecting foods from thefood menu.

✓ Offer high-calorie fluids throughout the dayand evening.

✓ Offer small high-calorie, high-protein snacksduring the day and evening.

392) The nurse is monitoring a client diagnosed with schizophrenia who demonstrates a dysfunctional affect. Whichsituation is congruent with inappropriate affect?

✓ The client giggled while describing beingphysically abused as a child.

393) The mental health nurse notes that a client diagnosedwith schizophrenia is exhibiting flat affect. Which situation supports this documentation?

✓ During the entire family visit, the clientpresented with an expressionless, blank look.

394) The nurse creating a plan of care for the client demonstrating paranoia should include which interventions inthe plan of care? **Select all that apply.**

✓ Ask permission before touching the client

✓ Eliminate all unnecessary physical contactwith the client.

✓ Defuse any anger or verbal attacks with anondefensive stance.

✓ Use simple and clear language when communicating with the client.

395) The nurse is preparing a client for electroconvulsivetherapy, which is scheduled for the next morning. Which interventions would be included in the preprocedural plan?**Select all that apply.**

✓ Have the client void.

✓ Obtain an informed consent.

✓ Remove dentures and contact lenses.

✓ Withhold food and fluids for 6 hours.

396) A hospitalized client is receiving clozapine for the treatment of a schizophrenic disorder. The nurse determinesthat the client may be having an adverse reaction to the medication if abnormalities are noted on which laboratory study?

✓ White blood cell count

397) Before giving the client the initial dose of disulfiram, what should the psychiatric home health nursedetermine?

✓ When the last alcoholic drink was consumed

398) The nurse determines that a history of which mental health disorder would support the prescription of takingdonepezil hydrochloride?

✓ Dementia

399) The nurse is caring for a client with a diagnosis ofagoraphobia. Which statement made by the client would support this diagnosis?

✓ "I'd be sure to have a panic attack if I leftmy house."

400) A client recently admitted to the hospital in the manicphase of bipolar disorder is unkempt, taking antipsychotic medications, and complaining of abdominal fullness and discomfort. Which intervention addresses the **priority** sign/symptom?

✓ Encourage frequent fluid intake and a high-fiber diet.

401) A homebound client confidentially discusses suicidal plans with the visiting nurse. Based on professional duty toobserve confidentiality, which statement describes the nurse's obligation to the client?

✓ Share that the risk to their safety requiresthat the client's HCP be notified.

402) Which situation will present the **most** prominent problemwhen attempting to manage the outpatient care of a client diagnosed with schizophrenia?

✓ The client's noncompliance with medicationtherapy

403) During a home visit, the nurse suspects that a youngdaughter of the client is bulimic. The nurse bases this suspicion on which **primary** characteristics of bulimia?

✓ Eating a lot of food in a short period oftime and misuse of laxatives

404) What is the appropriate nursing intervention for a client diagnosed with posttraumatic stress disorder and paranoid tendencies who begins to pace and fidget?

✓ Share the observation with the client so the behavior can be recognized.

405) The nurse notes documentation that a newly admitted client experiences flashbacks. What diagnosis would thisnotation support?

✓ Posttraumatic stress disorder

406) During the assessment, what is the nurse's **primary** goalfor a confused and disoriented client diagnosed with posttraumatic stress disorder?

✓ Making the client feel safe

407) What statement should the nurse make to a client diagnosed with posttraumatic stress disorder who appears tobe experiencing anxiety?

✓ "I can see that you are becoming upset."

408) A client diagnosed with depression is scheduled to receive three sessions of electroconvulsive therapy. The nurse should tell the client that he or she will likely start to see improvement in approximately what time frame?

✓ 1 week after the 3rd treatment session

409) A client diagnosed with depression is not eating adequately and at times even refuses to eat at all. What should the nurse plan to do to meet the client's nutritionalneeds?

✓ Provide small, frequent meals that includethe client's food preferences.

410) The client diagnosed with alcoholism has been prescribed medication therapy to assist in the maintenance of sobriety. The nurse will provide the client with education focused on which medication that will **most likely**be prescribed?

✓ Disulfiram

411) The nurse tells the client that a music therapy sessionhas been scheduled as part of the treatment plan. The clienttells the nurse, "I can't sing" and refuses to attend. Which nursing response is **most likely** to meet the client's needs?

✓ "You don't have to sing. Just listen andenjoy the music."

412) When should the nurse determine that it will be safe toremove the restraints from a client who demonstrated violentbehavior?

✓ No aggressive behavior has been observed for 1 hour after the release of two of the extremityrestraints.

413) The nurse notes that a client attending a group therapysession is cooperative, sharing with peers, and making appropriate suggestions during group discussions. How shouldthe nurse interpret this behavior?

✓ Improvement

414) Which information provided by the nurse accurately describes electroconvulsive therapy? **Select all that apply.**

✓ The average series involves 8 to 12treatments.

✓ Some confusion may be noted after theprocedure.

✓ Memory loss will occur but will resolve withtime.

415) The nurse is planning a stress management seminar forclients in an ambulatory care setting. Which concept shouldthe nurse plan to include in the content of the seminar?

✓ Progressive muscle relaxation techniques areuseful for easing tension from many causes.

416) A 15-year-old pregnant, unwed client tells the nurse,"My life was unbearable before I met Bobby. My mother beatsme every day, and my dad has sexually abused me since I was
10 years old!" Which response is appropriate for the nurseto make?

✓ "It seems that you needed Bobby's help toseparate from your family."

417) A 10-year-old referred for evaluation after drawing sexually explicit scenes says to the psychiatric nurse, "Ijust felt like it." Which response by the nurse is focused on assessing for abuse-related symptoms?

✓ "I am concerned about you. Are you now orhave you ever been abused?"

418) During a nursing interview, a client says, "My daughterwas murdered. I can't help wondering if her husband killed her, but he's been eliminated as a suspect." Which statementis a therapeutic nursing response?

✓ "Have you shared your concerns with thepolice?"

419) The nurse is assessing a client who has been admittedto the coronary care unit. The client seems to fluctuate inthe ability to focus during the day. On the basis of this assessment, which client problem should the nurse suspect?

✓ Acute confusion as a result of hospital-induced psychosis

420) A client with diabetes mellitus is told that amputationof the leg is necessary to sustain life. The client is very upset and tells the nurse, "This is all of the health care provider's fault. I have done everything that he has asked me to do!" How should the nurse interpret the client's statement?

✓ An expected coping mechanism

421) The nurse is planning to formulate a psychotherapygroup. Several clients are interested in attending the session. The nurse plans the group, based on which management principle?

✓ The group should be limited to no more than 10 members.

422) A client calls the nurse and reports feeling anxious.What is the appropriate **initial** nursing action?

✓ Sit and talk with the client about thefeelings.

423) Clients with which diagnoses are commonly prescribedinterventions to manage anxiety? **Select all that apply.**

✓ Panic disorder

✓ Posttraumatic stress disorder

✓ Obsessive-compulsive disorder

424) The nurse preparing to admit a client with a diagnosisof obsessive-compulsive disorder to the mental health unit should expect to note which behaviors in the client?

✓ Rigidness in thought and inflexibility

425) The client tells the nurse that she cannot leave homewithout checking numerous times that "everything electricalhas been shut off." The client's statement supports which mental health diagnosis?

✓ Obsessive-compulsive disorder

426) During an admission assessment, the nurse notes that the client's diagnosis is documented as obsessive-compulsivedisorder. The nurse plans care knowing that the client is **most likely** to experience which type of compulsive behavior?

✓ Repetitive actions to manage anxiety

427) The nurse determines that the client understands thebasis of the diagnosis of obsessive-compulsive disorder after making which statement?

✓ "My rituals are ways for me to controlunpleasant thoughts or feelings."

428) The nurse is performing an assessment on a client beingadmitted to the mental health unit. During the interview, the nurse discovers that the client suffered a severe emotional trauma 1 month earlier and is now experiencing paralysis of the right arm. Which is the **initial** nursing action?

✓ Assess the client for organic causes of theparalysis.

429) The nurse is developing a plan of care for a client admitted to the mental health unit with a diagnosis of obsessive-compulsive disorder. What is the nurse's **priority**in the plan of care?

✓ Establish a trusting nurse-clientrelationship.

430) The nurse is preparing to create a care plan for a client admitted to the mental health unit with a diagnosisof obsessive-compulsive disorder. The nurse should plan to include which component as a **priority** in the plan of care?

✓ Individualized goals and objectives

431) A newly admitted client is exhibiting signs and symptoms associated with a loss of physical functioning,although no such loss can be confirmed medically. This situation supports which mental health diagnosis?

✓ Somatization disorder

432) A client who has recently lost her spouse says, "No onecares about me anymore. All the people I loved are dead." Which response demonstrates an understanding of therapeutic communication when dealing with a grieving client?

✓ "You must be feeling all alone at thispoint."

433) A depressed client who appeared sullen, distraught, andhopeless a few days ago now suddenly appears calm, relaxed, and more energetic. Which is the nurse's **best initial** actionwith regard to the client's altered demeanor?

✓ Engage the client in one-to-one supervision,share with the client the observations that have been assessed, and ask whether the client is thinking about suicide.

434) The nurse is performing an assessment on a 16-year-oldfemale client who has been diagnosed with anorexia nervosa.Which statement, made by the client, would the nurse identify as necessitating further assessment on a **priority** basis?

✓ "I exercise 3 to 4 hours every day to keep myslim figure."

435) Which assessment data would indicate that a client is **most** at risk for suicide?

✓ The client has an immediate plan for asuicide attempt.

436) The nurse is planning to instruct a mental health client and the family about the importance of medication compliance. The nurse should plan for which interventionsthat are associated with increased compliance? **Select allthat apply.**

✓ Including the family in the medicationplanning process

✓ Working with the psychiatrist to find theright medication at the right dose

✓ Providing the client with the injectable, long-acting form of the medication if available

✓ Working with the psychiatrist to find the medication that provides the least side effectsfor the client

437) The nurse is planning care for a client who has a history of violent behavior and is at risk for harming others. Which intervention presents a **need for follow-up** because it could potentially present a danger to the client,health care providers, and others on the nursing unit?

✓ Assigning the client to a room at the end ofthe hall

438) The nurse caring for a client diagnosed with severedepression is planning activities for the client. Which activity would be **most appropriate** for this client?

✓ Drawing

439) The nurse is developing a plan of care for a client whois scheduled to have electroconvulsive therapy. Which problem is a **priority** for this client?

✓ Risk for aspiration

440) A client in a manic state presents to the dayroom onlypartially dressed and is making sexual remarks and gesturestoward the staff and other clients. Which is the **initial** nursing action?

✓ Escort the client to his room to getappropriately dressed.

441) The nurse is monitoring a stress management therapygroup that is in the forming stage. Which activity is characteristic of this stage of group development?

✓ Setting the rules of conduct for members ofthe stress management group

442) When planning discharge care for a client diagnosedwith bipolar disorder, the nurse determines the **need forfurther teaching** when the client makes which statement?

✓ "I will take the medicine until I am sure Ican handle my own problems."

443) Which statement by the client **best** reflects the development of an effective coping response style and effective processing of information for a hospitalizedclient participating in Alcoholic Anonymous (AA)?

✓ "I'm looking forward to leaving here. I willmiss all of you. So, I'm happy and I'm sad, I'm excited, and I'm scared. I know that I have to work hard to be strong and that not everyone willbe as helpful as you people."

444) In formulating a discharge teaching plan, the nurseshould include which precaution for a client who is prescribed lithium carbonate therapy?

✓ Check with the psychiatrist before using anyover-the-counter medications.

445) The home health nurse visits an agoraphobic client whoexperiences panic attacks. Which statement by the client would indicate a therapeutic response to behavioral and pharmacological treatment?

✓ "I went to the movies with my family and stayed through the whole film by sitting in a seatalong the aisle."

446) The psychiatric home care nurse visits a client diagnosed with a phobia that triggers panic attacks. Whenteaching the client to use paradoxical intention, which intervention will the nurse demonstrate?

✓ Instructing the client to do what the clientfears and, if possible, to exaggerate the outcomeof this exposure to the point of humor

447) A client diagnosed with a borderline personality disorder says to the nurse, "Sometimes I do things to get myparents mad, and sometimes I do them because I'm bored. That's what happened the night I crashed the family car. I wasn't drunk or suicidal or anything like the police thought. It was just for kicks!" Which is the appropriate nursing response?

✓ "It is scary when you feel out of control with such feelings of emptiness and anger that youcan't stop."

448) The nurse is reviewing the medical record of a hospitalized client who received electroconvulsive therapy (ECT) 3 years ago. Which assessment data would support that the therapy resulted in retrograde amnesia in the client?

✓ During the admission interview, the clientcan't remember why the ECT treatment was originally prescribed.

449) The mother of a teenage client states that her daughter, diagnosed with an anxiety disorder, "eats nothingbut junk food, has never liked going to school, and hangs out with the wrong crowd." What discharge instruction will be **most effective** in helping the mother to manage her daughter's condition?

✓ Restrict the amount of chocolate and caffeineproducts in the home.

450) The nurse is reviewing the record of a client scheduledfor electroconvulsive therapy (ECT). Which medical diagnosis, if noted on the client's record, would indicate a need to contact the health care provider scheduled to perform the ECT?

✓ Recent myocardial infarction

451) During a group therapy session a client begins yelling,"I can't listen to this. You people are no different from the ones I have to deal with at home." What is the nurse's **immediate** action?

✓ Firmly reinforce limits on behavior, statingthat aggressive yelling will not be tolerated.

452) The nurse is discussing discharge and outpatientfollow-up plans with a client hospitalized for acute depression. Which statement demonstrates the client's use ofa defense mechanism and would indicate the **need for follow- up** treatment?

✓ "I was really depressed about not getting thepromotion I was promised. Looking back on it, the pay raise wouldn't have been worth the huge increase in responsibility. It's just as well; it all worked out in the end."

453) During a support group session, a client says, "My husband hit me a lot, but when he threatened to start hitting our kids, I stabbed him. No jury will believe me because my husband can lie to anyone and be believed." If noone in the group responds, which statement is the therapeutic response by the nurse?

✓ "Abuse is a horribly difficult thing to experience. Can anyone in the group relate to whatshe's feeling?"

454) The nurse is caring for a client diagnosed with Alzheimer's disease who is demonstrating characteristics of agnosia. Which client behavior supports the presence of thiscognitive deficiency?

✓ When asked to pick up the cup, the clientconsistently fails to identify the cup.

455) A client diagnosed with schizophrenia says to the nurse, "Will you protect me from the Grand Duchess?" and points to an older client who is sitting reading a book. Which statement is the therapeutic response by the nurse?

✓ "You will be safe here. Your thinking will beclearer after your medication starts to work."

456) A client admitted to the mental health unit after attacking his father for disturbing him at his computer, interrupts the nurse during morning rounds and says, "I needto get out of here so I can work on my computer project to save the world!" Which nursing response will have the greatest therapeutic impact?

✓ "I will be back to talk with you in 15minutes after I complete nursing rounds."

457) During a mental status examination, the client states,"Glass breaks if you throw stones or shoot at it with a gun.My cousin shoots guns at the police all the time at target practice. People who live in glass houses shouldn't throw stones." How will the nurse appropriately document the client's speech?

✓ Speech is illogical and loosely associated.

458) The nurse is caring for a client diagnosed with schizophrenia who states, "I decided not to take my medication because I realize that it really can't help me.Only I can help me." Which question asked by the nurse hasthe **best** therapeutic value?

✓ "Do you recall what it was like before youstarted your medication?"

459) Which client's death was achieved by what is considereda soft suicide method?

✓ Sat in a running car parked in her locked garage to die of the carbon monoxide inhalation

460) The nurse determines that which client is at highestrisk for suicide?

✓ An 18-year-old who abuses both alcohol and drugs and who will not meet the requirements forgraduation

461) The spouse of an alcoholic client is attending a support group and says to the group members, "It's all verywell for everyone to label me an enabler, but if I didn't call him in sick at work, he'd lose his job. Where would webe then?" Which statement by the nurse co-leader would be therapeutic?

✓ "It is a difficult situation, but do youagree that enabling creates codependency?"

462) A heroin-addicted client who is taking methadone hydrochloride discontinues the methadone without consultingthe health care provider. The client says to the nurse, "I thought I didn't need the methadone after 1 year. I had a job and was even saving money. I can't believe I ruined everything." Which statement by the nurse is therapeutic?

✓ "We need to prepare you to recognize thosethings that trigger you to relapse."

463) An alcohol-troubled client says, "The 12 Steps of Alcoholics Anonymous (AA) meeting really upset me. I had togo for a drink after 1 hour with those people; they're fanatics!" Which statement by the nurse would be therapeutic?

✓ "Not any one strategy for remaining sober isbest for everyone."

464) A client who is recovering from benzodiazepine dependence says, "I've lost so many people. First, my brother dies of cancer; then my husband leaves me for a 20-year-old. I wish I had one of those pills right now." Whichstatement by the nurse would be therapeutic?

✓ "Can you tell me what you think the pills cando for you?"

465) The husband of an alcohol-dependent wife says, "Ifanyone had said I'd be henpecked, I'd have called them aliar, but now I realize that I'm codependent." Which statement by the nurse would be therapeutic?

✓ "Can you tell me more about that? You seeyourself as being codependent with your wife?"

466) A client's alcohol consumption suggests the developmentof a tolerance for alcohol. Which statement supports the existence of an alcohol tolerance problem?

✓ "I have a cocktail after work, wine withdinner, and no more than 2 drinks to sleep."

467) A battered wife says, "My husband is a bully and a womanizer and certainly doesn't provide for his family, buthe's never beat me up, so I don't think I can say he's abusive." Which response by the nurse is therapeutic?

✓ "Do you believe that there are other forms ofabuse besides the physical kind?"

468) An older resident in a long-term care facility preparesto walk out into a rainstorm after saying, "My father is waiting to take me for a ride." Which is the appropriate response by the nurse?

✓ "Let's have a cup of coffee, and you can tellme about your father."

469) A client who is exhibiting psychotic behaviors is admitted to the psychiatric unit. In developing a plan of care, the nurse should identify which as the **priority** client problem?

✓ Disturbed thought processes

470) The nurse is developing a daily care program for a depressed client who was just admitted to the mental healthunit. Which is the **best** approach when planning activities for this client?

✓ Provide a structured daily program ofactivities, and encourage the client to participate.

471) A client with a history of panic disorder comes to theemergency department and states to the nurse, "Please help me. I think I'm having a heart attack." What is the **priority**nursing action?

✓ Assess the client's vital signs.

472) The nurse reviews the assessment data of a client admitted to the hospital with a diagnosis of anxiety. Thenurse should assign **priority** to which assessment finding?

✓ Fist clenched, pounding table, fearful

473) A home care nurse suspects that a client's spouse isexperiencing caregiver strain. Which nursing action will assist in supporting the nurse's suspicion?

✓ Gathering subjective and objective assessmentfrom the caregiver and the client

474) A client who has a history of being sexually assaultedis found sucking her thumb while rocking in her bed and doesnot respond to verbal communication. The nurse should recognize that this behavior demonstrates which coping mechanism?

✓ Regression

475) Which is a **primary** behavior of a client diagnosed withantisocial personality disorder?

✓ Will take personal items from other clients'rooms

476) The client with a diagnosis of dependent personality disorder is **most likely** to have problems coping with whichsituation?

✓ Making decisions about living arrangementsafter discharge

477) Which piece of subjective data obtained during assessment of a severely anxious client would indicate thepossibility of posttraumatic stress disorder?

✓ "I keep reliving the abuse."

478) The nurse is performing an assessment on a client beingadmitted with a diagnosis of alcohol dependence who reports it's been 6 hours since the last drink. The information supports which assumption about the appearance of withdrawalsymptoms?

✓ Signs may appear at any time.

479) Thiamine supplementation and other nutritional vitaminsupport measures are prescribed for clients who have been using alcohol to prevent or decrease the risk of which complication?

✓ Wernicke-Korsakoff syndrome

480) Which intervention demonstrates responsibility for themilieu in an inpatient psychiatric setting?

✓ The nurse managing an aggressive client

481) A client asks the nurse about the meaning of behavioraltherapy. Which description describes the purpose of behavioral therapy?

✓ Fosters positive behavioral change

482) The client experiencing a great deal of stress and anxiety is being taught to use self-control therapy. Whichstatement by the client indicates a **need for further teaching** about the therapy?

✓ "It provides a negative reinforcement whenthe stimulus is produced."

483) Laboratory work is prescribed for a client who has beenexperiencing delusions. When the nurse approaches the clientto obtain a specimen of blood, the client begins to shout, "You're all vampires. Let me out of here!" Which nursing response addresses the client's anxiety?

✓ "It must be frightening to think that otherswant to hurt you."

484) A supervisor reprimands the charge nurse for not adhering to the unit budget. What behavior by the chargenurse is an example of displacement?

✓ The charge nurse blames staff for wastingsupplies.

485) What is the appropriate nursing intervention in dealingwith a suicidal client?

✓ Provide authority, action, and participation.

486) Immediately after an assault, the client is extremelyagitated, trembling, and hyperventilating. What is the appropriate **initial** nursing action?

✓ Remain with the client until the anxietydecreases.

487) Soon after an assault, a client is assessed in the emergency department with behavior that is associated with severe anxiety. Which client behaviors support this level ofanxiety?

✓ Is pacing while describing the situationusing a rapid speech pattern

488) The nurse is creating a plan of care for the client whois upset following the loss of a job and is verbalizing concerns regarding the ability to meet financial obligations. Which problem is the basis of the client's concerns?

✓ Inability to meet role expectations

489) A client arrives in the emergency department in a crisis state demonstrating signs of profound anxiety. Whatshould the **initial** nursing assessment focus on?

✓ The client's physical condition

490) A clinic nurse is monitoring a client with anorexia nervosa. Which client statement should indicate to the nursethat treatment has been **effective?**

✓ "My friends and I went out to lunch today."

491) A client with a history of anxiety appears to be in thesecond phase of crisis response. The nurse prepares for which client behavior?

✓ The client will employ new coping methodsthat will resolve the problem.

492) Which is the **primary** goal of crisis interventiontherapy?

✓ Assist the client in returning to the levelof precrisis functioning.

493) Which statement, made by a client who has recently experienced an emotional crisis, is **most likely** to assurethe nurse that the client has returned to her precrisis level of functioning?

✓ "My boss tells me that I'm being consideredfor a promotion and a raise."

494) A homeless shelter has sustained severe damage as a result of a fire, and most of the structure and people's belongings were destroyed. Ten of the individuals who are being displaced have a history of chronic mental illness. The mental health team coordinating support **initially** shouldfocus their efforts on which action?

✓ Providing the clients with shelter, clothing,and food

495) Community mental health teams recognize that in the immediate postdisaster period, the **most effective** means ofidentifying individuals experiencing difficulty coping psychologically with the disaster is to take which action?

✓ Station mental health professionals atestablished assistance centers.

496) Which client behavior is indicative of negative symptoms associated with schizophrenia? **Select all thatapply.**

✓ Verbal communication is almost nonexistent.

✓ The client needs frequent redirection becauseof short attention span.

497) The nurse caring for a client diagnosed with schizophrenia should include which interventions in the planof care to assist in managing the client's concrete thinking?

✓ Present verbal instructions regardingexpectations in single, simple commands.

498) Which behavior in a client with schizophreniademonstrates the client's cognitive inability to appropriately process data from external stimuli?

✓ The client is convinced that the curtains areactually ghosts.

499) During the admission assessment process, the nurse observes that a client diagnosed with paranoid schizophreniahas multiple dental caries and mouth ulcers. The client denies oral pain or difficulty eating and does not present any concern over the nurse's finding. The nurse recognizes the client's response as **most likely** the result of which client factor?

✓ Impaired pain perception

500) A client who is watching television in the dayroom shares with the nurse that he has begun seeing his motherbeing assaulted on the television screen. Which is the nurse's **initial** intervention?

✓ Turn off the television.

501) The nurse is planning relapse prevention informationfor a client diagnosed with schizophrenia. The nurse understands that it is important to ensure which **primary** intervention?

✓ Including the client's support system in theteaching

502) A client with depression verbalizes feelings of low self-esteem and self-worth typified by statements such as,"I'm such a failure. I can't do anything right." Which is the **best** nursing response?

✓ Identify recent behaviors or accomplishmentsthat demonstrate the client's skills.

503) The history assessment of a client diagnosed with schizophrenia confirms a routine that includes smoking two packs of cigarettes and drinking 10 cups of coffee daily. Considering the assessment data, the nurse recognizes whichas placing the client at **most** risk for injury?

✓ Diminishing the effectiveness of psychotropicmedication

504) Which goal addresses the therapeutic management needsof a client experiencing hallucinations?

✓ Facilitate the client's awareness that thehallucination is not the reality of the world.

505) The nurse recognizes which assessment and diagnosticdata as being associated with a newly diagnosed schizophrenic client? **Select all that apply.**

✓ A birthday of March 30

✓ A loss of interest in hobbies

✓ A suicide attempt 6 months ago

✓ Magnetic resonance imaging shows temporallobe atrophy

506) The nurse reviewing a client's diagnostic results recognizes that which is a possible positive indication fora diagnosis of schizophrenia?

✓ Atrophy of the lateral and/or thirdventricles of the brain

507) What information regarding possible prognosis will thenurse provide to the parents of a 15-year-old newly diagnosed with schizophrenia?

✓ Their child will be treated for an imbalanceof the chemical dopamine.

508) The nurse should include which information in themedication teaching plan for a client diagnosed with schizophrenia?

✓ Coffee, tea, and soda consumption should belimited.

509) Which statement made by a severely depressed clientrequires the nurse's **immediate** attention?

✓ "Feeling better really isn't important to meanymore."

510) The nurse is creating a discharge plan for the family of a client diagnosed with a mood disorder. The nurse shouldplan to provide which **priority** information to the family?

✓ Signs that indicate the client may beconsidering suicide

511) Which characteristics would the nurse expect to notefor a client with seasonal affective disorder? **Select allthat apply.**

✓ Is related to abnormal melatonin metabolism

✓ Improves during the spring and summer months

✓ Is a result of alterations in the availableamounts of sunlight

✓ A craving for carbohydrates lessens duringsunnier and spring months

512) When assessing a client for a possible physical dependency on alcohol, the nurse should ask which **priority**question?

✓ "How do you feel when you haven't had a drinkall day?"

513) Which are the **most likely** characteristics of a clientwho abuses alcohol? **Select all that apply.**

✓ Male gender

✓ Abuses drugs as well as alcohol

✓ History of at least one suicide attempt

514) The nurse is providing a health promotion session to agroup of teenagers and is discussing the abuse of barbiturates. The nurse should provide which information tothe teenagers?

✓ Barbiturate abuse is the cause of many drugoverdose deaths.

515) The nurse explains to a group of clients that methamphetamine abuse results in which vascular systemdysfunction?

✓ Impaired wound healing

516) An adolescent has been prescribed an amphetamine to help manage a diagnosis of attention deficient hyperactivitydisorder. To **best** minimize the risk of abuse and/or overdose, the nurse expects that the medication will be administered via which method?

✓ Transdermal patch

517) A client with a history of opiate abuse asks the nurse,"Why do I crave this stuff so much?" The nurse responds, knowing that the client's craving is a result of which factor?

✓ Lack of naturally occurring endorphins

518) The nurse should be prepared to manage which occurrenceunique to the abuse of hallucinogenic drugs?

✓ Flashbacks

519) When discussing an individual's tendency to substanceabuse, the nurse should identify which assessment data as a**primary** biological factor?

✓ The client has two family members who haveabused.

520) During the termination phase of the nurse-client relationship, the clinic nurse observes that the client has made several sarcastic remarks and has an angry affect. Which is the **most appropriate** interpretation of the client'sbehavior?

✓ The client is displaying typical behaviors.

521) The spouse of a client prescribed an antidepressant tells the home health nurse, "Now that the antidepressant isworking, the suicidal risk is over and you can stop making these home visits." How does the nurse appropriately respond?

✓ "I need to continue visiting since the clientmay now have the energy to act on suicidal intentions."

522) A client comes into the emergency department in a severe state of anxiety after a car crash. Which is the **best**nursing intervention at this time?

✓ Remain with the client.

523) Which assessment finding would be a manifestationassociated with dementia?

✓ Confabulation

524) Which is the appropriate nursing intervention to address the poor nutritional intake demonstrated by a clientdiagnosed with depression?

✓ Arrange for the client to receive several small meals daily, and plan to be present whilethe meals are being served.

525) To create a safe environment for the client diagnosedwith major depression with psychotic features, the nurse **most importantly** devises a plan of care that deals specifically with which problem?

✓ Disturbed thinking

526) The nurse monitors a client diagnosed with anorexianervosa understanding that the client manages anxiety bywhich action?

✓ Observing rigid rules and regulations

527) Which short-term initial goals would be realistic for aclient who was recently sexually abused? **Select all that apply.**

✓ The client will keep scheduled appointments.

✓ The client's physical wounds will begin toheal properly.

✓ The client will verbalize feelings about theabusive event.

✓ The client will participate in the variousaspects of the treatment plan.

528) Which is the **best** therapeutic approach for the nurse touse in crisis counseling?

✓ Active, with focus on the current situation

529) A client comes to the clinic after losing all of his personal belongings in a hurricane. The nurse notes that theclient is coping ineffectively with the situation. Which arethe **most** realistic goals for this client? **Select all that apply.**

✓ The client will develop adaptive copingpatterns.

✓ The client will identify a realisticperception of stressors.

✓ The client will express and share feelingsregarding the present crisis.

✓ The client will identify effective copingpatterns that have worked in the past.

530) The nursing care plan indicates a problem of self- directed violence and the risk for suicide, related to suicidal ideations with a specific plan. The nurse developsa plan of care for the client and identifies which expectedclient outcome?

✓ Denies presence of suicidal ideations

531) What is an appropriate short-term outcome for a clientgrieving the recent loss of a spouse?

✓ The client verbalizes stages of grief andplans to attend a community grief group.

532) A client who has been hospitalized with a paranoid disorder refuses to turn off the lights in the room at nightand states, "My roommate will steal me blind." Which is the appropriate response by the nurse?

✓ "I hear what you are saying, but I have noreason to believe your roommate steals."

533) A client who has just received a diagnosis of asthmasays to the nurse, "This condition is just another nail inmy coffin." Which response by the nurse is therapeutic?

✓ "You seem very distressed over learning youhave asthma."

534) A client whose spouse of 42 years recently died shares with the nurse, "My sister came over yesterday and started talking about how I need to move on with my life. I feel badly, but I got mad and told her to mind her own business."Which response by the nurse would be therapeutic?

✓ "You need to grieve, and expressing anger canbe part of grieving."

535) A client whose wife recently died of cancer says to thehome care nurse, "I can't believe that my wife died yesterday. I keep expecting to see her everywhere I go in this house." What is the therapeutic nursing response?

✓ "It must be hard to accept that she haspassed away."

536) A hospitalized client experiencing delusions reports tothe nurse, "I know that the doctor is talking to the top manin the mob to get rid of me." Which response should the nurse make to the client?

✓ "Do you feel afraid that people are trying tohurt you?"

537) Which behavior would the nurse anticipate a clientdiagnosed with nyctophobia to demonstrate?

✓ Always turns on the overhead light beforeentering a darkened room

538) Which behavior demonstrated by a client diagnosed withdepression indicates a need for suicide precautions?

✓ Asks about how to get a will notarized

539) A client is diagnosed with rape trauma syndrome. Thenurse plans care based on which syndrome-associated fact?

✓ The client regularly re-experiences theevents associated with the assault.

540) When planning activities for a child diagnosed withautism, the nurse should give **priority** to which consideration?

✓ Assessing all activities for safety risks

541) The nurse is assigned to care for a chemically dependent client who has the potential for violent episodes.In planning care for the client, which action by the nurse should receive **priority?**

✓ Projects an attitude of calmness

542) The client says to the nurse, "I wish you would just bemy friend." Which is the appropriate response by the nurse?

✓ "Our relationship is a therapeutic andhelping one."

543) The client asks the nurse, "Could you ask the health care provider (HCP) to let me have a pass for the weekend?"Which response is appropriate that assists the client in achieving the goal of optimal personal functioning?

✓ "When the HCP arrives on the unit, I will letthem know that you have a question."

544) Which subject should the nurse address in preparing forthe orientation phase of the therapeutic relationship?

✓ Establishing the parameters of therelationship

545) The nurse who is reviewing the record of a client admitted to the mental health unit notes that the client wasadmitted by voluntary status. Based on this fact, what assumption can the nurse make about the client?

✓ The client has the right to demand and obtainrelease from the hospital.

546) The client diagnosed with mild depression says to thenurse, "I haven't had an appetite at all for the last few weeks." Which response by the nurse **best** assesses the client's nutritional issue?

✓ "You haven't had an appetite at all?"

547) Which client behavior demonstrates denial of a sexualabuse event?

✓ Sitting quietly and calmly reading a magazine

548) Several nurses are engaged in an assignment report whena client with a history of aggressive behavior approaches the nurses' station. The client becomes very loud and

offensive, and demands to be seen by the health care provider (HCP) immediately. Which intervention will addressthe needs of both the client and the milieu?

✓ Offer to assist the client to an examinationroom until the HCP is notified.

549) The nurse is developing a plan of care for a client whobelieves the unit's food is being poisoned. Which strategy should the nurse plan to implement that will encourage the client to discuss feelings?

✓ Use open-ended questions and silence.

550) When a client is consistently 15 to 20 minutes late forweekly therapy sessions, the nurse attempts to **best** manage this behavior by implementing which intervention?

✓ Asking the client if she or he is dealingwith some new stressor

551) When a client is consistently 15 to 20 minutes late forweekly therapy sessions, the nurse attempts to **best** manage this behavior by implementing which intervention?

✓ A normal behavior that can occur during thetermination period

552) The nurse orienting a new client to a residential treatment center prepares to explain to the client that the emphasis of the center involves milieu therapy. Which is the focus of this type of therapy?

✓ Involves group and social interaction with rules and expectations mediated by peer pressure

553) A client's phobia is being treated with systematicdesensitization. Which modality is the focus of this therapy?

✓ Short exposure to the phobic object

554) A client who has shared with the group at a previoussession now suddenly gets up and announces, "I'm leaving."How can the nurse **initially** meet the needs of both the client and the group?

✓ Ask the client to stay and share what he isfeeling.

555) During a group session, a client threatens to "punch every one of you." Which is the appropriate **initial** nursingaction?

✓ Remind the client that talking about personalanger is appropriate, but acting on it is not.

556) The nurse is creating a plan of care for a client withan autistic disorder. A behavior modification approach (operant conditioning) is being used to improve communication. Which should the nurse include in the plan ofcare?

✓ Reward the client when a desired behavior isperformed.

557) Which statement indicates an understanding of the focusof milieu therapy?

✓ "A living, learning, or working environmentis the focus of milieu therapy."

558) A client states that she was raped a few weeks ago butstill feels "as if it just happened to me." Which response should the nurse make to the client?

✓ "Tell me more about what happened and what causes you to feel like the rape just occurred."

559) The nurse is creating a plan of care for a newly admitted client at high risk for suicide. With the focus ofthe plan being to promote a safe and therapeutic environment, which intervention should the nurse include?

✓ Establish a therapeutic relationship.

560) A client states to the nurse, "My life has been such afailure. Nothing I do turns out right." Which response by the nurse will **best** address the client's low sense of self-esteem?

✓ "You seem very discouraged. Let's identifysomething that you are proud of doing."

561) A client is admitted to the psychiatric unit with a diagnosis of bipolar affective disorder and mania. The nurseshould prioritize which assessment finding as requiring **immediate** intervention?

✓ Constant physical activity and poor oralintake

562) The nurse is working with a client who is demonstratingdelusional thinking. The client says to the nurse, "The leaders of a religious cult are being sent to assassinate me." Which is the **best** response by the nurse?

✓ "I don't know about a religious cult. Are youafraid that people are trying to hurt you?"

563) A woman is seen in the emergency department in a severestate of anxiety following assault and battery. Which nursing action should the nurse place **highest priority** on atthis time?

✓ Remaining with the client

564) An older client diagnosed with delirium becomes agitated and confused at night. Which action should be thenurse's **most important** strategy to minimize the client's risk for injury?

✓ Turn off the television and radio, and use anight-light.

565) The nurse caring for a client with a diagnosis of acuteschizophrenia should use which approach when planning care?

✓ Provide assistance with grooming and nutrition until the client's thinking has cleared.

566) The client who is actively hallucinating is fearfulthat the voices will direct him to kill himself. Which therapeutic statement should the nurse make at this time?

✓ "I don't hear them, but it must be frightening to hear voices that others can't hear"

567) An understanding of borderline personality disordershould help the nurse determine that which problem is the**priority** for the client?

✓ Risk for self-harm

568) A client admitted to the inpatient unit is being considered for electroconvulsive therapy (ECT). While the client is calm, the daughter anxiously tells the nurse, "My mother's brain will be shocked with electricity. How can the

doctor even think about doing this to her?" Which responseby the nurse will **best** address the daughter's concerns?

✓ "It sounds as though you are very concerned.Let's discuss the procedure."

569) The nurse is assigned to a client who is pacing, agitated, and using aggressive gestures and rapid speech. The nurse should determine that which action is the **priority**of care at this time?

✓ Providing a safe place for the client to pacethat is away from the other clients

570) A client is withdrawn, immobile and mute. Whichappropriate action should the nurse should take?

✓ Sit beside the client and occasionallyintroduce open-ended questions.

571) Which client behavior indicates to the nurse that thestatus of a client diagnosed with intensive care unit psychosis is improving?

✓ Increased number of hours slept at one timeand is increasingly alert

572) The nurse finds a client recently admitted with adiagnosis of anorexia nervosa engaged in a strenuous exercise routine. Which action should be the **priority?**

✓ Interrupt the client, and offer to take herfor a walk.

573) A postsurgical client with a history of heavy alcoholintake has returned to the nursing unit. Which signs/symptoms of delirium tremens should the nurse plan to continuously assess for?

✓ Fever, hypertension, changes in level ofconsciousness, and hallucinations

574) The nurse working in a detoxification unit is admitting a client for alcohol withdrawal. The client's spouse states, "I don't know why I don't get out of this rotten situation."Which response by the nurse addresses the spouse's concerns?

✓ "What aspects of this situation are the mostdifficult for you?"

575) The nurse should monitor a client with a history ofopioid abuse for which signs and symptoms associated withopioid withdrawal?

✓ Increased pulse and blood pressure, low-gradefever, yawning, restlessness, anxiety, diarrhea, and mydriasis

576) The nurse is working with a client who shows signs of benzodiazepine withdrawal. The nurse should suspect that theclient has suddenly discontinued taking which prescribed medication?

✓ Diazepam

577) Which roommate choice is least appropriate for a clientdiagnosed with anorexia nervosa who is in a state of starvation?

✓ A client with pneumonia

578) A hospitalized client with a history of alcohol abuse tells the nurse, "I am leaving now. I don't want help. I have other things to attend to that are more important." Thenurse attempts to discuss the client's concerns, but the client dresses and begins to walk out of the hospital room. Which action should the nurse take at this time?

✓ Call the nursing supervisor.

579) The nurse should monitor the client with a history ofheroin addiction for which signs/symptoms of heroin withdrawal?

✓ Nausea, vomiting, diarrhea, muscle aches, anddiaphoresis

580) The nurse is interviewing a client in crisis to assess the risk for self-harm. The nurse interprets that the clientis **most** at risk for suicide when which factor is identified?

✓ Client has an immediate plan for a suicideattempt.

581) A client with a potential for violence is exhibitingaggressive gestures, making belligerent comments to the other clients, and is continuously pacing in the hallway. Which comment by the nurse would be therapeutic at this time?

✓ "What is causing you to behave so agitated?"

582) A client diagnosed with acute depression says to thenurse, "Things would be so much better for everyone if I just weren't around." Which response should the nurse makeat this time to assess the client's state of mind?

✓ "You sound very unhappy. Are you thinking ofharming yourself?"

583) The nurse should interpret which comment by a clientdiagnosed with battered wife syndrome as being consistentwith the presence of low self-esteem?

✓ "Things would be fine at home if I just coulddo better. He has a lot of pressures on him at work."

584) The nurse is caring for an older client whose husband died approximately 6 weeks ago. The client says, "There's noone left to care about me. Everyone that I have loved is nowgone." Which nursing response allows for continued communication about the client's state of mind?

✓ "It sounds as though you are feeling allalone right now."

585) When planning care for a client with a history of violent behavior toward others, the nurse should includewhich interventions? **Select all that apply.**

✓ Admitting the client to a room near thenurses' station

✓ Arranging for a security officer to be nearbyand available but out of the client's sight

586) What is the **priority** nursing action when admitting a client who has just attempted suicide?

✓ Ensure constant observation of the client atall times.

587) A client admitted 72 hours ago with a diagnosis of major depression presents for breakfast today appropriatelydressed and well groomed, and appears to be calm and relaxed, yet more energetic than before. Which **initial** action should the nurse take after noting this client's behavior?

✓ Ask the client directly about the presence ofany suicide-related thoughts.

588) The nurse suspects that the client hospitalized with adiagnosis of acute depression could benefit from further development of coping strategies. Which client statement supports this suspicion?

✓ I know that I won't become depressed again aslong as I reduce my stressors

589) Which interventions should the nurse include in the plan of care for an acutely depressed client involved in cognitive-behavioral therapy? **Select all that apply.**

✓ Assisting the client to identify and testnegative cognition

✓ Assisting the client to participate in thetreatment process

✓ Assisting the client to develop alternativethinking patterns

✓ Assisting the client to rehearse newcognitive and behavioral responses

590) Which assessments should the nurse closely monitor whencaring for a hospitalized client diagnosed with bulimia nervosa? **Select all that apply.**

✓ Electrolyte levels

✓ Intake and output

✓ Elimination patterns

591) The health care provider is planning to prescribe amedication for a client with major depression. Which medication should the nurse expect to be prescribed?

✓ Paroxetine hydrochloride

592) The nurse should provide instructions concerning whichside effect to a client prescribed chlorpromazine?

✓ Dry mouth

593) A monoamine oxidase inhibitor is prescribed for a client. Which sign or symptom is indicative of toxicity?

✓ Restlessness

594) To determine whether the client is experiencing akathisia as an adverse effect of the medication haloperidol, what should the nurse observe the client for?

✓ Restlessness or constant generalized movement

595) A client is prescribed imipramine once daily. The nursedetermines that **additional teaching is needed** on the basis of which statement by the client?

✓ "I'll take the medication in the morningbefore breakfast."

596) A client has a lithium level of 2.4 mEq/L. The nurseshould **immediately** assess the client for which sign or symptom?

✓ Blurred vision

597) A client diagnosed with anxiety is starting therapy with lorazepam. Which factor in the client's history shouldprompt the nurse to consult with the health care provider before administering the medication?

✓ Narrow-angle glaucoma

598) The mother of a child diagnosed with attention deficithyperactivity disorder has been given instructions about howto administer methylphenidate. Which response by the mother shows she understands the information about the **best** way to administer the medication?

✓ After breakfast

599) The nurse taking a medication history for a client whohas been admitted to the nursing unit notes that the clientis receiving olanzapine. The nurse interprets that this client **most likely** has a history of which disorder?

✓ Schizophrenia

600) A client diagnosed with schizophrenia has a new prescription for risperidone. Which baseline laboratoryresult should the nurse review before administering thefirst dose of this medication?

✓ Liver function studies

601) A client diagnosed with depression has a prescription for sertraline. The nurse should withhold the medication andquestion the prescription if the client has a history of which disorder?

✓ Phenelzine sulfate use

602) The nurse has given instructions to a client prescribedlithium carbonate. What statement by the client indicates that the client **needs further information?**

✓ "I will decrease fluid intake while takingthe lithium."

603) The nurse should assess for which toxic effect whenmanaging the care of a client prescribed haloperidol?

✓ Excessive salivation

604) Buspirone hydrochloride is prescribed for a client withan anxiety disorder. The nurse plans to include which teaching point when reviewing this medication with the client?

✓ Dizziness and nervousness may occur

605) A client diagnosed with bipolar mood disorder has beengiven a prescription for carbamazepine. The nurse teaching the client about medication side and adverse effects instructs the client to notify the health care provider if which symptom develops?

✓ Sore throat

606) When a client develops neuroleptic malignant syndrome,the nurse ensures that which medication is available on theunit to address this complication?

✓ Bromocriptine

607) When should the nurse advise a client being prescribedfluoxetine hydrochloride to take the medication?

✓ In the morning on first arising

608) A client diagnosed with schizophrenia is taking haloperidol. The nurse understands that this medication willexert its therapeutic effect through which mechanism?

✓ Blocking dopamine from binding topostsynaptic receptors in the brain

609) The nurse assesses for a therapeutic effect ofziprasidone by asking the client which question?

✓ Have you experienced an increase inconcentration during daily activities?"

610) A client diagnosed with bipolar disorder is prescribedlithium carbonate. The nurse who administers the medicationknows that lithium is used **primarily** to treat which condition?

✓ The manic phase of bipolar disease

611) A client prescribed thioridazine hydrochloride reportsfeeling faint when trying to get out of bed in the morning.The nurse recognizes this complaint as a symptom of which disorder?

✓ Postural hypotension

612) A client diagnosed with depression and prescribed tranylcypromine sulfate has been instructed on the appropriate diet. The nurse determines that the client understands the diet if which foods are selected from thedietary menu?

✓ Fried haddock, baked potato, and a cola drink613) A client diagnosed with depression is prescribed amitriptyline hydrochloride. During the initial phases oftreatment, the client's care plan should include which nursing intervention?

✓ Obtain postural blood pressure prior to eachmedication administration.

614) Over the course of a few hours, a client receiving lithium carbonate reports being nauseous, then drowsy and "achy." What action should the nurse take when consideringthe client's next scheduled dose of lithium?

✓ Withhold the next scheduled dose and notify the health care provider of the client's complaints.

615) Which assessment findings suggest to the nurse that theclient is experiencing tardive dyskinesia?

✓ Movements of the mouth, tongue, and face thatare both abnormal and involuntary

616) The nurse is providing dietary instructions to a clientwho is prescribed tranylcypromine sulfate. The nurse emphasizes that it is important to avoid eating which food?

✓ Salami

617) The nurse is caring for a client who has been prescribed disulfiram. Which statement by the client indicates to the nurse the **need for further teaching** aboutthis medication?

✓ "As long as I don't drink alcohol, I'll befine."

618) A client is prescribed a monoamine oxidase inhibitor.What is the **primary** reason the nurse needs to assess this client closely?

✓ Headache, hypertension, and nausea andvomiting may indicate toxicity.

619) The nurse is caring for a client who is taking a maintenance dosage of lithium carbonate. What nursing actionshould be included in the client's plan of care?

✓ Monitoring intake and output

620) Which assessment finding would the nurse anticipatewhen monitoring a client who is at risk for developing neuroleptic malignant syndrome?

✓ Hyperpyrexia

621) The nurse developing a teaching plan for a client beingprescribed phenelzine sulfate should instruct the client to avoid which item?

✓ Aged cheeses

622) A client diagnosed with an anxiety disorder is prescribed buspirone orally. The client tells the nurse thatit is difficult to swallow the tablets. Which is the **best** instruction to provide the client?

✓ Crush the tablets before taking them.

623) A client is prescribed fluphenazine daily. The nurseteaches the client to take which measure to minimize a common side/adverse effect of this medication?

✓ Use hard sour candy or sugarless gum.

624) A client prescribed chlorpromazine hydrochloride callsthe mental health clinic to report urine that is much darkerthan usual. The client currently has no other urinary symptoms. What instructions should the nurse provide the client based on this information?

✓ That this is an expected side effect of themedication

625) A client who is receiving lithium carbonate has a serumlevel of 1.8 mEq/L. Which intervention will the nurse implement in response to this diagnostic result?

✓ Monitor the client for behaviors thatsuggests ataxia.

626) A client begins to experience extrapyramidal side effects from an antipsychotic medication. The nurse anticipates that the health care provider will prescribewhich medication to treat this condition?

✓ Benztropine

627) A client is prescribed tranylcypromine. The nurse educating a client about tranylcypromine should instruct theclient to avoid which activity?

✓ Drinking any amount of wine

628) At what time of day does the nurse recommend that a child prescribed methylphenidate be given the last dose ofthe day of the medication?

✓ Just before the noontime meal

629) What is the **most** serious risk associated with the useof benzodiazepine?

✓ Dependence

630) A client receiving long-term therapy with lithiumcarbonate has a serum lithium level of 1.0 mEq/L. Whichnursing intervention should the nurse be prepared to implement based on this result?

✓ Provide positive support for the client'scompliance with the therapy.

631) The nurse should monitor the client prescribed thioridazine hydrochloride carefully for which adverseeffect?

✓ Cardiac dysrhythmias

632) The nurse instructs the client to be sure to take which action while taking newly prescribed lithium carbonate?

✓ Maintain a fluid intake of 2 to 3 L/day. 633) The nurse is discussing the past week's activities with a client receiving amitriptyline hydrochloride. The nurse determines that the medication is **most effective** for thisclient if the client reports which information?

✓ Ability to get to work on time each day 634) The nurse gathers data from the client who was prescribed buspirone hydrochloride 1 month ago. The nurse interprets that the medication is **effective** when the clientreports an absence of which event?

✓ Severe anxiety

635) The nurse suspects that a client prescribed clomipramine hydrochloride has been noncompliant with takingthe medication as prescribed. Which client behavior would support the nurse's suspicion?

✓ Frequently checking for the car key 636) When providing client education on the medication alprazolam, why is it **essential** to include the importance ofavoiding abrupt discontinuation of the medication?

✓ Rebound central nervous system excitationcould cause seizure activity.

637) A client has been prescribed clozapine. The nurse reviews the result of which laboratory study to detect aserious adverse effect associated with this medication?

✓ White blood cell count

638) A client diagnosed with schizophrenia has been prescribed clozapine. The nurse should monitor the client

for which side/adverse effects of this medication? **Selectall that apply.**

✓ Sedation

✓ Dry mouth

✓ Orthostatic hypotension

✓ Presence of a fixed stare

639) A client has begun taking phenelzine. At the initiationof therapy, the client is taught which foods are acceptable to consume? **Select all that apply.**

✓ Carrots or radishes

✓ Sweet potatoes and squash

640) A client is brought to the emergency department complaining of substernal chest pain. To distinguish betweenangina and myocardial infarction, the nurse assesses for which characteristics of angina? **Select all that apply**

✓ Chest pain that resolves with rest

✓ Chest pain that is relieved by nitroglycerin

✓ Chest pain that is usually precipitated byexertion

641) A pregnant client tells the nurse that she has beencraving "unusual foods." The nurse gathers additional assessment data and discovers that the client has been ingesting daily amounts of white clay dirt from her backyard. Laboratory studies are performed and the nursedetermines that which finding indicates a physiological consequence of the client's practice?

✓ Hemoglobin 9 g/dL (90 mmol/L)

642) A pregnant client asks the nurse about the types ofexercises that are allowed during pregnancy. The nurse should tell that client that which exercise is safest?

✓ Swimming

643) A health care provider has prescribed transvaginalultrasonography for a client in the first trimester of

pregnancy, and the client asks the nurse about the procedure. How should the nurse respond to the client?

✓ "The probe that will be inserted into the vagina will be covered with a disposable cover andcoated with a gel."

644) The nurse has instructed a pregnant client in measuresto prevent varicose veins during pregnancy. Which statement by the client indicates a **need for further instruction?**

✓ "I should wear knee-high hose, but I shouldnot leave them on longer than 8 hours."

645) A pregnant client calls a clinic and tells the nursethat she is experiencing leg cramps that awaken her at night. What should the nurse tell the client to provide relief from the leg cramps?

✓ "Bend your foot toward your body whileextending the knee when the cramps occur."

646) The nurse is providing instructions regarding the treatment of hemorrhoids to a client who is in the secondtrimester of pregnancy. Which statement by the client indicates a **need for further instruction?**

✓ "I should apply heat packs to the hemorrhoidsto help the hemorrhoids shrink."

647) The nurse is providing instructions to a client in thefirst trimester of pregnancy regarding measures to assist inreducing breast tenderness. Which instruction should the nurse provide?

✓ Wash the breasts with warm water and keepthem dry.

648) The nurse is describing cardiovascular system changes that occur during pregnancy to a client. Which findings are normal for a client in the second trimester? **Select all thatapply.**

✓ Increase in pulse rate

✓ Increase in red blood cell production649) The clinic nurse is providing instructions to a pregnant client regarding measures that assist in

alleviating heartburn. Which statement by the clientindicates an understanding of the instructions?

✓ "I should avoid eating foods that produce gasand fatty foods."

650) The nurse is providing instructions to a pregnant client with genital herpes about the measures that are needed to protect the fetus. Which instruction should the nurse provide to the client?

✓ A cesarean section will be necessary if vaginal lesions are present at the time of labor.

651) The nurse is reviewing the record of a client who has just been told that a pregnancy test is positive. Based on her last normal menstrual period, she is 8 weeks' gestation.Appropriate physical assessments are completed. Which findings are anticipated to be present at this time? **Select all that apply.**

✓ A softening of the cervix

✓ Bluish discoloration of the vaginal tissue

✓ The presence of human chorionic gonadotropinin the urine

652) The health care provider (HCP) is assessing the clientfor the presence of ballottement. To make this determination, the HCP should take which action?

✓ Initiate a gentle upward tap on the cervix.653) A primigravida asks the nurse in the clinic when she
will be able to begin to feel the fetus move. The nurse responds by telling the mother that fetal movements will benoted between which weeks of gestation?

✓ 18 and 20

654) The nurse is performing an assessment of a primigravidawho is being evaluated in a clinic during her second trimester of pregnancy. Which findings concern the nurse and indicate the **need for follow-up? Select all that apply.**

✓ Fetal heart rate of 180 beats/minute

✓ Elevated level of maternal serum alpha-fetoprotein (MSAFP)

655) The home health nurse visits a child with infectiousmononucleosis and provides home care instructions to the parents. Which instruction should the nurse give to the parents?

✓ Notify the HCP if the child developsabdominal pain or left shoulder pain.

656) A child is scheduled to receive inactivated poliovirusvaccine (IPV), and the nurse who is preparing to administerthe vaccine reviews the child's record. The nurse questions the administration of IPV if which is documented in the child's record?

✓ A history of anaphylactic reaction toneomycin

657) The clinic nurse prepares to administer a measles, mumps, and rubella (MMR) vaccine to a 5-year-old child. Thenurse should administer this vaccine by which method?

✓ Subcutaneously in the outer aspect of theupper arm

658) A child with rubeola (measles) is being admitted to thehospital. In preparing for the admission of the child, the nurse should plan to place the child on which precautions?

✓ Airborne

659) The nurse is interviewing a client with type 2 diabetesmellitus who is taking a sulfonylurea. Which statement by the client indicates an understanding of this treatment for this disorder?

✓ "The medications I'm taking help release theinsulin I already make."

660) The nurse is caring for a client who is 2 days postoperative from abdominal hysterectomy. The client has a history of diabetes mellitus and has been receiving regular insulin based on capillary blood glucose testing 4 times a day. A carbohydrate-controlled diet has been prescribed, butthe client has not been eating. On entering the client's room, the nurse finds the client to be pale and diaphoretic.Which action is appropriate at this time?

✓ Obtain a capillary blood glucose level andquickly perform a focused assessment.

661) The nurse is caring for a client with pheochromocytomawho is scheduled for adrenalectomy. In the preoperative period, what should the nurse monitor as the **priority?**

✓ Vital signs

662) The nurse discovers that an infusion of total parenteral nutrition (TPN) through a central line is empty,and a replacement bag is not yet ready. What should the nurse do **next** while waiting for the replacement bag?

✓ Hang an intravenous infusion of 10% dextrosein water.

663) The nurse is caring for a client diagnosed with cirrhosis of the liver with portal hypertension. The clientvomited 500 mL bright red emesis and states that he is feeling lightheaded. In which **priority** order should the nurse perform these interventions? **Arrange the actions in the order they should be performed. All options must be used.**

✓ **1**)Apply oxygen.

✓ 2)Ensure that 2 large-bore intravenous linesare present with an isotonic solution infusing.

✓ 3)Check the client's blood pressure.

✓ 4) Ask the client if he is taking anynonsteroidal antiinflammatory medications.

664) The nurse is providing discharge instructions for a client following a Roux-en-Y gastric bypass surgery 3 days ago. What will the nurse include in the instructions? **Select all that apply.**

✓ Do not drink fluids with meals.

✓ Avoid foods high in carbohydrates.

✓ Eat 6 small meals a day that are high inprotein.

665) The nurse cares for a client following a Roux-en-Ygastric bypass surgery. Which nursing intervention is appropriate?

✓ Encourage the client to ambulate.

666) A client with a history of gastroesophageal reflux disease (GERD) is diagnosed with peptic ulcer disease (PUD).The health care provider prescribes sucralfate in addition to the client's other medications. What teaching should the nurse include in this client's instructions?

✓ Take the sucralfate before meals and atbedtime on an empty stomach.

667) A client diagnosed with peptic ulcer disease is prescribed an over-the counter antacid suspension containingaluminum hydroxide, magnesium hydroxide, and simethicone.
What should the nurse include in the client instructions fortime of administration of this medication?

✓ 1 and 3 hours after meals

668) The nurse is providing instructions to a client diagnosed with irritable bowel syndrome (IBS) who is experiencing abdominal distention, flatulence, and diarrhea.What interventions should the nurse include in the instructions? **Select all that apply.**

✓ Eat yogurt.

✓ Take loperamide to treat diarrhea.

✓ Use stress management techniques.

✓ Avoid foods such as cabbage and broccoli. 669) The nurse is caring for a client with a Penrose drain from an abdominal incision. Which is an appropriate nursingintervention for this client?

✓ Ensure that a sterile safety pin is throughthe drain.

670) The nurse cares for a client who is at risk for wounddehiscence after abdominal surgery. Which action is the **priority** to minimize this risk?

✓ Place a pillow over the incision site duringdeep breathing and coughing.

671) The nurse is caring for a client experiencing an exacerbation of Crohn's disease. Which intervention shouldthe nurse anticipate the health care provider prescribing?

✓ Oral corticosteroids

672) The nurse caring for a client diagnosed with inflammatory bowel disease (IBD) recognizes that which classifications of medications may be prescribed to treat the disease and induce remission? **Select all that apply.**

✓ Antimicrobial

✓ Corticosteroid

✓ Aminosalicylate

✓ Biological therapy

✓ Immunosuppressant

673) A client with type 2 diabetes mellitus presents to thehealth care provider's office with a glycosylated hemoglobin($HgbA_{1C}$) level of 10.5%. Which statement by the client indicates an understanding of this test and its results?

✓ "Well, I have 3 months to really work on watching my diet and lowering my blood sugar. My next glycosylated hemoglobin test should be betterthen."

674) The nurse is caring for a client with a history of heart failure just diagnosed with type 2 diabetes mellitus. The health care provider prescribes an oral hypoglycemic forthe client. Which oral hypoglycemic medication prescribed for this client should the nurse question?

✓ Pioglitazone

675) Glyburide is prescribed for a client with type 2 diabetes mellitus. What is the **most important** instructionthe nurse should provide to the client?

✓ Assess for signs of hypoglycemia.

676) Acarbose is prescribed for a client diagnosed with type 2 diabetes mellitus. What should the nurse include in theclient's instructions?

✓ Take the medication with the first bite ofeach meal.

677) The nurse is caring for a client diagnosed with type 1diabetes mellitus experiencing the Somogyi effect. Which blood glucose results and treatment would the nurse expect?

✓ 0300 blood glucose 68 mg/dL (3.8 mmol/L) and0700 blood glucose 200 mg/dL (11.1 mmol/L). Instruct to decrease amount of evening insulin.

678) The nurse teaches a class on foot care for clients diagnosed with diabetes mellitus. Which instructions shouldthe nurse include in the class? **Select all that apply.**

✓ Wear closed-toe shoes

✓ Cut toenails straight across and file theedges.

✓ Pat feet dry gently, especially between thetoes.

679) The nurse is providing discharge instructions to a client who has Cushing's syndrome. Which client statementindicates that instructions related to dietary managementare understood?

✓ "I should eat foods that have a lot ofpotassium in them."

680) A client is admitted with suspected diabetic ketoacidosis (DKA). Which clinical manifestations **best**support a diagnosis of DKA?

✓ Blood glucose 350 mg/dL (19.4 mmol/L); arterial blood gases: pH 7.28, $PaCo_2$ 30, HCO_3^- 14.

681) The nurse is monitoring a diabetic client with a bloodglucose level of 400 mg/dL (22.2 mmol/L). Which clinical manifestation would indicate diabetic ketoacidosis (DKA)?

✓ Rapid, deep respirations

682) A client with type 1 diabetes mellitus in the emergencydepartment is diagnosed with diabetic ketoacidosis (DKA).
Which interventions should the nurse anticipate beingprescribed **initially? Select all that apply.**

✓ Monitoring urine for ketones

✓ Intravenous potassium replacement

✓ Administration of intravenous insulin

✓ Administration of a liter of 0.9% NaClintravenously.

683) The nurse is caring for a client recovering from asubtotal thyroidectomy. Which supplies should be readilyaccessible for the care of this client? **Select all that apply.**

✓ Suction supplies

✓ Calcium gluconate

✓ Tracheostomy tube insertion set

684) The nurse is caring for a client the day after a lefttotal knee arthroplasty surgery. In reviewing the client's past medical history, the nurse notes that the client has ahistory of urinary incontinence and heart failure, which ismanaged with a potassium-retaining diuretic and a beta- adrenergic blocker. Which prescription, if not already prescribed, should the nurse contact the health care provider to obtain?

✓ Resume the client's dose of metoprolol 685) The nurse cares for a client prior to surgery. The client asks the nurse, "What is the advantage of spinal anesthesia over general anesthesia for controlling my pain?"Which is the **best** response by the nurse?

✓ "Your pain can be managed without making youas sleepy."

686) The nurse is teaching a graduate nurse in the operatingroom about the components of Universal Protocol, one of The Joint Commission's National Patient Safety Goals. What specific component should the nurse include in the instructions?

✓ A time-out should be performed in theoperating room before the procedure.

687) The nurse prepares a client 1 hour prior to surgery. Which assessment finding does the nurse need to communicateto the health care provider (HCP) at this time?

✓ Daily garlic capsules, last dose yesterdaymorning

688) The nurse cares for a client immediately following alumbar laminectomy procedure. The client reports numbness

and tingling down the left lateral thigh and knee. What isthe **next** action for the nurse to take?

✓ Question the client about preoperativesymptoms.

689) The nurse is teaching a client who had a lumbar laminectomy how to perform activities of daily living without causing strain on the back. Which action performedby the client indicates a **need for further instruction?**

✓ Bends over to tie shoes

690) A client preparing to go home 2 days following a rightmastectomy with dissection of axillary lymph nodes asks thenurse, "What should I do to minimize my chance for complications from this surgery?" Which response should thenurse make?

✓ "Avoid having blood pressures taken on yourright arm."

691) The nurse is caring for a client who sustained an openfracture and is diagnosed with acute osteomyelitis of the right lower extremity. Which intervention should the nurse plan to perform?

✓ Perform sterile dressing changes.

692) The nurse is counseling the young mother of a smallchild recently diagnosed with impetigo. The nurse shouldmake which statement that provides the **best** information about impetigo?

✓ "You will need to prevent any of the fluid from the blisters from coming into contact withyour other children."

693) Nursing care of the infant with eczema should focus onwhich action as a **priority** nursing intervention?

✓ Preventing secondary infection of the lesions694) The nurse is estimating the body surface area of a child with a burn injury using the West nomogram. After noting the child's height (45 inches [114 cm]) and weight (65 lb [29.5 kg]), the nurse reads the nomogram and determines that the body surface area is approximately whichnumber? **Refer to Figure.**

View Figure

✓ 1.0

695) The nurse is verifying that a mother understands how tocare for her infant who has thrush. Which comment by the mother would indicate that **further teaching is indicated?**

✓ "I can put the medication in my son's bottlefor him to drink."

696) The nurse is collecting data on a child with a 1-week-old cat scratch injury. While assessing the scratch the nurse notes redness, heat, swelling, and red streaking surrounding the area. The child states that the scratch hurts. Cellulitis is diagnosed. When providing home care instructions, which statement by the mother indicates a **needfor further teaching?**

✓ "I will apply cool, moist soaks every 4hours."

697) The nurse reinforces instructions to the mother of a child diagnosed with pediculosis (head lice). Permethrin hasbeen prescribed. Which statement by the mother regarding theuse of the medication indicates a **need for further teaching?**

✓ "I need to shampoo my child's hair, apply themedication, and leave the medication on for 24 hours."

698) A pediatric nurse educator provides a teaching sessionto the nursing staff regarding phenylketonuria. Which statement should the nurse educator include in the session?

✓ "All 50 states require routine screening ofall newborn infants for phenylketonuria."

699) A home care nurse is teaching an adolescent with type 1diabetes mellitus about insulin administration and rotation sites. Which statement, if made by the adolescent, would indicate **effective** teaching?

✓ "I need to give 4 to 6 injections in onearea, about an inch apart, and then move to another area."

700) A 6-year-old child with diabetes mellitus and the child's mother come to the health care clinic for a routineexamination. The nurse evaluates the data collected during this visit to determine if the child has been euglycemic since the last visit. Which information is the **most** significant indicator of euglycemia?

✓ Glycosylated hemoglobin (hemoglobin A_{1c}) 701) A child's fasting blood glucose levels range between 100 and 120 mg/dL (5.7 and 6.9 mmol/L) daily. The before- dinner blood glucose levels are between 120 and 130 mg/dL (6.9 and 7.4 mmol/L), with no reported episodes of hypoglycemia. Mixed insulin is administered before breakfastand before dinner. The nurse should make which interpretation about these findings?

✓ Insulin doses are appropriate for foodingested and activity level.

702) The home care nurse is visiting a child newly diagnosedwith diabetes mellitus. The nurse is instructing the child and parents regarding actions to take if hypoglycemic reactions occur. The nurse should tell the child to take which action?

✓ Carry hard candies whenever leaving home incase a hypoglycemic reaction occurs.

703) The nurse is teaching the parents of a child with growth hormone deficiency about preparing synthetic growth hormone and administering it to the child. Which statement,if made by the parents, would indicate an understanding of the procedure?

✓ "We will rotate injection sites." 704) An adolescent with diabetes receives 30 units of Humulin N insulin at 7:00 a.m. The nurse would monitor for ahypoglycemic episode at what time?

✓ Before supper

705) The nurse is teaching the parent of a preschool childhow to administer the child's insulin injection. The child will be receiving 2 units of Humulin R insulin and 12 unitsof Humulin N insulin every morning. How should the nurse instruct the parents to prepare the insulin?

✓ Draw the Humulin R insulin first and then theHumulin N insulin into the same syringe.

706) The clinic nurse is assessing a child for dehydration. The nurse determines that the child is moderately dehydratedif which finding is noted on assessment?

✓ Oliguria

707) An adolescent is examined in the hospital emergency department after taking an overdose of acetylsalicylic acid.The adolescent has rapid breathing, nausea and vomiting, andlethargy. The health care provider prescribes arterial bloodspecimens for blood gas analysis to be drawn. Aspirin toxicity is suspected when the blood gas results are reported as which value?

✓ pH 7.29, Pco_2 29 mmHg, HCO_3 19 mEq/L (19mmol/L)

708) An adolescent with type 1 diabetes mellitus is attending a dance in the school gym. The adolescent suddenlybecomes flushed and complains of hunger and dizziness. The school nurse, who is present at the dance, takes the child to the nurse's office and performs a blood glucose level test that shows 60 mg/dL (3.4 mmol/L). Which is the **initial** nursing intervention?

✓ Give the child ½ cup (120 ml) of a sugar-sweetened carbonated beverage.

709) A nurse is caring for an infant with a respiratory infection and is monitoring the infant for signs of dehydration. What is the nurse's **best** action to determinefluid loss in the infant?

✓ Monitor body weight.

710) The nurse is caring for a hospitalized child who is receiving a continuous infusion of intravenous potassium forthe treatment of dehydration. Which assessment finding requires the need to notify the health care provider?

✓ A decrease in urine output to 0.5 mL/kg/hr711) An adolescent

with type 1 diabetes mellitus has been
chosen for the school's cheerleading squad. The adolescentvisits the school nurse to obtain information regarding

adjustments needed in the treatment plan for diabetes. Whatshould the school nurse instruct the student to do?

✓ Eat six graham crackers or drink a cup oforange juice prior to practice or game time.

712) The nurse provides instructions to the adolescent regarding the administration of insulin. The nurse shouldinclude which instruction?

✓ Check the blood glucose before administeringinsulin.

713) A nurse is caring for a hospitalized child who has hypotonic dehydration. Which serum sodium level would thisstudent expect to observe?

✓ 125 mEq/L (125 mmol/L)

714) The nurse is caring for an infant with gastroenteritiswho is being treated for dehydration. The nurse reviews thehealth record and notes that the health care provider has documented that the infant is mildly dehydrated. Which assessment finding should the nurse expect to note in mild dehydration?

✓ Pale skin color

715) The nurse is talking to the parents of a child newlydiagnosed with diabetes mellitus. Which statement by the parents indicates an understanding of preventing and managing hyperglycemia?

✓ "I will check for ketones when my child issuffering from an illness."

716) An alert child, who is crying loudly, is brought to thehospital emergency department for a simple fracture to the lower right arm that occurred after a fall off a bicycle.
What is the nurse's **priority** assessment?

✓ Neurovascular

717) A neighborhood nurse is attending a soccer game at a local middle school. One of the students falls off the bleachers and sustains an injury to the left arm. The nurse quickly attends to the child and suspects that the child's arm may be broken. Which nursing action would be the

priority before transferring the child to the hospitalemergency department?

✓ Immobilize the arm.

718) A child sustains a fall at home and is brought to the hospital emergency department by the child's mother. After aradiographic examination, the child is determined to have a fractured arm, and a plaster cast is applied. The nurse provides instructions to the mother regarding neurocirculatory assessment and function. Which statement bythe mother indicates a **need for further instruction?**

✓ "If her hand gets real cool and pale, I canapply the heating pad to it."

719) A child who sustained a fractured ankle has a short legcast applied, and the nurse provides home care instructions to the mother. The mother returns to the emergency department 16 hours later because the child is complaining of severe pain. The nurse notes that the child's toes are cool, pale, and puffy and that the child is agitated and crying loudly. The mother states, "I gave her the pain medication you sent with us just like you told us, and I have kept her foot up on two pillows since we left, except when she gets up to go to the bathroom. I don't understand why she hurts so much. Do something!" What is the **most likely**

✓ Compartment syndrome

720) A child must wear a brace for correction of scoliosis. The nurse creates a plan of care knowing the child is atrisk for which problem?

✓ Breaks in skin integrity

721) The pediatric nurse educator provides a teaching session to the nursing staff regarding juvenile idiopathicarthritis (JIA). Which action by a nursing staff member in the care of a child with JIA indicates a **need for further education?**

✓ Emphasizes the importance of rising quicklyin the mornings

722) The nurse in the pediatric unit is preparing for theadmission of a child with a dislocated hip. The child will

be placed in Buck's extension traction preoperatively for short-term immobilization. The nurse prepares to place the child in which type of traction setup? **Click on the image to indicate your answer.**

(Figures from Hockenberry Wilson: *Wong's essentials ofpediatric nursing*, ed 9, St. Louis, 2013, Mosby.)

✓ 1 Correct Answer Indication: ✓

723) The mother of a 5-year-old child brings the child to the hospital emergency department and tells the nurse that the child fell. A fracture is suspected, and a radiograph istaken. The results indicate that the child has a comminuted fracture. The mother asks the nurse to describe this type offracture, and the nurse draws a picture for the mother. Which picture identifies this type of fracture? **Click on theimage to indicate your answer.**

(From Price D, Gwin J: *Pediatric nursing: An introductorytext*, ed 11, St. Louis, 2012,

✓ 2 Correct Answer Indication: ✓

724) An infant is brought to the child care clinic for a follow-up visit. The nurse notes that the infant is wearingthis apparatus. The nurse documents that the infant is wearing which device? **Refer to Figure.**

View Figure

✓ A Pavlik harness for the treatment ofcongenital hip dislocation

725) A child with cerebral palsy is in a management programto achieve maximum potential for locomotion, self-care, andsocialization in school. The nurse works with the child to meet these goals by performing which action?

✓ Placing the child on a wheeled scooter board726) The nurse has reinforced teaching for a school-age child who was given a brace to wear for the treatment of scoliosis. The nurse determines that the child **needs furtherteaching** if the child makes which statement?

✓ "This brace will correct my curve."

727) A 9-year-old child fractures the left tibia along anepiphyseal line while using a skateboard. What is the nurse's **priority** concern during future growth?

✓ Uneven leg growth

728) A child has just returned from surgery and has a hipspica cast. What is the nurse's **priority** action for this client?

✓ Assess the circulatory status.

729) Russell's traction is prescribed for a child with a lower leg fracture. The mother of the child asks the nurse about the purpose of the traction. The nurse explains to themother that which is the **primary** action of this type of traction?

✓ Reduces or realigns a fracture site 730) A child with developmental dysplasia of the hip is placed in a Pavlik harness. The nurse should demonstrate tothe parents how to place the child in this harness by placing the child's legs in which position?

✓ Abduction

731) The nurse is reviewing the health care record of an infant suspected of having unilateral hip dysplasia. Which assessment finding should the nurse expect to note documented in the infant's record regarding this condition?

✓ Asymmetry of the gluteal skin folds when theinfant is placed prone and the legs are extended against the examining table

732) The nurse is implementing a teaching plan for a 4- month-old child who has been diagnosed with developmental dysplasia of the hip. The child will be placed in the Pavlik harness. Which statement by the family indicates that they understand the care of their child while placed in the Pavlik harness?

✓ "I will watch for any redness or skin irritation where the straps are applied and callthe health care provider for red areas."

733) The nurse is caring for a child who fractured the ulnabone and had a cast applied 24 hours ago. The child tells

the nurse that the arm feels like it is falling asleep.Which nursing action is appropriate?

✓ Report the findings to the health careprovider.

734) An adolescent is seen in the emergency department for asuspected sprain of the ankle. X-rays have been obtained, and a fracture has been ruled out. Which instruction should the nurse provide to the adolescent regarding home care for treatment of the sprain?

✓ Apply ice to the injured area for a period of 30 minutes every 4 to 6 hours for the first 24 to 48 hours.

735) The nurse is reinforcing instructions to the mother ofa child who has a plaster cast applied to the left arm.
Which statement by the mother indicates a **need for furtherteaching?**

✓ "I will have to use a heat lamp to help thecast dry."

736) The nurse is assisting a health care provider (HCP) during the examination of an infant with developmental hip dysplasia. The HCP performs the Ortolani maneuver. The nursedetermines that the infant exhibits a positive response to this maneuver if which finding is noted?

✓ A palpable click during abduction of theaffected hip

737) The nurse provides instructions to the parents of an infant with hip dysplasia regarding care of the Pavlik harness. Which statement by one of the parents indicates an understanding of the use of the harness?

✓ "I can remove the harness to bathe myinfant."

738) The nurse is providing instructions to the parents of achild with scoliosis regarding the use of a brace. Which statement by a parent indicates a **need for further teaching?**

✓ "I need to be sure to apply lotion on theskin under the brace."

739) The nurse is caring for a child with a fracture who isplaced in skeletal traction. The nurse should monitor for which sign of a serious complication associated with this type of traction?

✓ Elevated temperature

740) A child is brought to the emergency department, and diagnostic x-rays of the child reveal that a fracture is present. The mother states that the child was rollerblading and attempted to break a fall with an outstretched arm. A plaster of Paris cast is applied to the arm. Which instructions should the nurse provide the mother? **Select allthat apply.**

✓ The cast will mold to the body part.

✓ Keep the cast elevated on pillows for thefirst day.

✓ Make sure that the child can frequentlywiggle the fingers.

✓ The cast needs to be kept dry because it willbegin to disintegrate when wet.

741) The clinic nurse is assessing a child suspected of having juvenile rheumatoid arthritis (JRA). Which assessmentfindings should the nurse expect to note in a child who has been diagnosed with JRA? **Select all that apply.**

✓ Morning stiffness

✓ Painful, stiff, and swollen joints

✓ Limited range of motion of the joints

✓ History of late-afternoon temperature

742) The nurse enters a child's room and discovers that thechild is having a seizure. Which actions should the nurse take? **Select all that apply.**

✓ Turn the child on her side.

✓ Loosen any restrictive clothing.

✓ Check the child's respiratory status.

743) The nurse is caring for a child after surgical removalof a brain tumor. The nurse should assess the child for which sign that would indicate that brainstem involvement occurred during the surgical procedure?

✓ Elevated temperature

744) The nurse is performing an assessment of a 7-year-oldchild who is suspected of having episodes of absence seizures. Which assessment question to the mother will assist in providing information that will identify the symptoms associated with this type of seizure?

✓ "Does the child have a blank expressionduring these episodes?"

745) The nurse is caring for a newborn infant with spina bifida (myelomeningocele) who is scheduled for surgical closure of the sac. In the preoperative period, which is the **priority** problem?

✓ Infection

746) The nurse is creating a plan of care for a newborn infant with spina bifida (myelomeningocele type). The nurse includes assessment measures in the plan to monitor for increased intracranial pressure. Which assessment technique should be performed that will **best** detect the presence of anincrease in intracranial pressure?

✓ Assess anterior fontanel for bulging. 747) A nursing student is assisting a school nurse in performing scoliosis screening on the children in the school. The nurse assesses the student's preparation for conducting the screening. The nurse determines that the student demonstrates understanding of the disorder when thestudent states that scoliosis is characterized by which finding?

✓ Abnormal lateral curvature of the spine 748) The community health nurse is providing information to parents of children in a local school regarding the signs ofmeningitis. The nurse informs the parents that the classic signs/symptoms of meningitis include which findings?

✓ Severe headache, fever, and a change in thelevel of consciousness

749) The nursing student is writing a plan of care for a child who presents with an acute head injury. The nursing instructor reviews the plan of care and praises the student for identifying which assessment as a **priority?**

✓ Airway and breathing

750) The nurse is reviewing a chart for a child with a headinjury. The nurse notes that the level of consciousness hasbeen documented as obtunded. Which finding should the nurseexpect to note on assessment of the child?

✓ Not easily arousable and limited interaction 751) The nurse is performing an assessment on a child with a head injury. The nurse notes an abnormal flexion of the upper extremities and an extension of the lower extremities.What should the nurse document that the child is experiencing?

✓ Decorticate posturing

752) The nurse is caring for a child with a head injury. Thenurse observes decerebrate posturing. What is the nurse's **best** action?

✓ Notify the health care provider.

753) The nurse is monitoring a child with a brain tumor forcomplications associated with increased intracranial pressure. Which finding, if noted by the nurse, would indicate the presence of diabetes insipidus?

✓ High urine output

754) The nurse should plan to place a child who had a medulloblastoma brain tumor (infratentorial) removed inwhich position postoperatively?

✓ Flat, on either side

755) The nurse is caring for a child who sustained a head injury after falling from a tree. On assessment of the child, the nurse notes the presence of a watery discharge from the child's nose. The nurse should **immediately** test thedischarge for the presence of which substance?

✓ Glucose

756) The nurse is assigned to care for a child with a brain injury who has a temporal lobe herniation and increasing intracranial pressure. Which signs should the nurse identify as indicative of this type of injury? **Select all that apply.**

✓ Flaccid paralysis

✓ Ipsilateral pupil dilation

✓ Shifting of the temporal lobe laterallyacross the tentorial notch

757) The nurse assists a health care provider in performinga lumbar puncture on a 3-year-old child with leukemia in whom central nervous system disease is suspected. In which position will the nurse place the child during this procedure?

✓ Lateral recumbent position with the kneesflexed and chin resting on the chest

758) A school-age child with Down syndrome is brought to theambulatory care center by the mother. The child has bruisingall over the body. To work **most effectively** with this child,the nurse **first** addresses which complication associated withDown syndrome?

✓ Children with Down syndrome are more likely to develop acute leukemia than the average child.

759) The nurse is assessing a child with increased intracranial pressure. On assessment, the nurse notes that the child is now exhibiting decerebrate posturing. The nurseshould modify the client's plan of care based on which interpretation of the client's change?

✓ Deteriorating neurological function

760) The nurse is caring for an infant with spina bifida (myelomeningocele type) who had the sac on the back containing cerebrospinal fluid, the meninges, and the nerves (gibbus) surgically removed. The nursing plan of care for the postoperative period should include which action to maintain the infant's safety?

✓ Elevating the head with the infant in theprone position

761) The nurse is caring for a child diagnosed with Downsyndrome. Which explanation of this syndrome should the nurse provide the parents?

✓ Moderate to severe intellectual disabilityand linkage to an extra chromosome 21, group G

762) The nurse is providing home care instructions to the parents of a child with a seizure disorder. Which statementindicates to the nurse that the teaching regarding seizure disorders has been **effective?**

✓ "We will make appointments for follow-upblood work and care as directed."

763) The nurse is assessing for Kernig's sign in a childwith a suspected diagnosis of meningitis. Which action should the nurse perform for this test?

✓ Raise the child's leg with the knee flexed and then extend the leg at the knee and assess forpain.

764) The nurse notes that an infant with the diagnosis ofhydrocephalus has a head that is heavier than that of theaverage infant. The nurse should determine that special safety precautions are needed when moving the infant withhydrocephalus. Which statement should the nurse plan to include in the discharge teaching with the parents to reflect this safety need?

✓ "When picking up your infant, support the infant's neck and head with the open palm of yourhand."

765) The nurse is performing an admission assessment on a child with a seizure disorder. The nurse is interviewing thechild's parents to determine their adjustment to caring for their child, who has a chronic illness. Which statement, if made by the parents, would indicate a **need for further teaching?**

✓ "Our child sleeps in our bedroom at night."766) The nurse is assessing a client with fragile X
syndrome. The nurse anticipates noting which physicalassessment finding?

✓ Long, narrow face with a prominent jaw

767) A child is admitted to the hospital with a diagnosis ofacute bacterial meningitis. In reviewing the health care provider's prescriptions, which would the nurse question as appropriate for a child with this diagnosis?

✓ Administer an oral antibiotic.

768) A girl who is playing in the playroom experiences a tonic-clonic seizure. During the seizure, the nurse shouldtake which actions? **Select all that apply.**

✓ Remain calm.

✓ Time the seizure.

✓ Ease the child to the floor.

✓ Loosen restrictive clothing.

769) The nurse is monitoring an infant for signs of increased intracranial pressure. On assessment of the fontanelles, the nurse notes that the anterior fontanelle bulges when the infant is sleeping. Based on this finding,which is the **priority** nursing action?

✓ Notify the health care provider.

770) The nurse receives a telephone call from the admissionsoffice and is told that a child with acute bacterial meningitis will be admitted to the pediatric unit. The nurse prepares for the child's arrival and plans to implement which type of precautions?

✓ Droplet

771) The nurse is monitoring a 7-year-old child who sustained a head injury in a motor vehicle crash for signsof increased intracranial pressure (ICP). The nurse should assess the child frequently for which **early** sign of increased ICP?

✓ Nausea

772) The nurse caring for an infant with a diagnosis of hydrocephalus should monitor the infant for which sign ofincreased intracranial pressure?

✓ A bulging anterior fontanel

773) The nurse caring for a child who has sustained a headinjury in an automobile crash is monitoring the child for signs of increased intracranial pressure (ICP). For which **early** sign of increased ICP should the nurse monitor?

✓ Changes in level of consciousness

774) The nurse is providing instructions to the parents ofan infant with a ventriculoperitoneal shunt. The nurse should include which instruction?

✓ Call the health care provider if the infanthas a high-pitched cry.

775) The nurse creates a plan of care for a child with Reye's syndrome. Which **priority** intervention should thenurse include in the plan of care?

✓ Monitor for signs of increased intracranialpressure.

776) The nurse is providing home care instructions to themother of a child who is recovering from Reye's syndrome. Which instruction should the nurse provide to the mother?

✓ Check the skin and eyes every day for a yellow discoloration.

777) The nurse caring for a child with suspected absence seizures is collecting data from the parents on how to manage the disorder. Which statement, if made by the parents, indicates the presence of signs congruent with thisdisorder?

✓ "My child's teacher mentioned that he seemsto daydream a lot."

778) The nurse is reviewing the record of a child with increased intracranial pressure and notes that the child hasexhibited signs of decerebrate posturing. Which assessment finding should the nurse expect if this type of posturing ispresent?

✓ Abnormal extension of the upper and lowerextremities with some internal rotation.

779) Cerebral palsy (CP) is suspected in a child and the parents ask the nurse about the potential warning signs of

CP. The nurse should provide which information? **Select allthat apply.**

- ✓ The infant's arms or legs are stiff or rigid.
- ✓ A high risk factor for CP is very low birthweight.
- ✓ The infant has feeding difficulties, such aspoor sucking and swallowing.
- ✓ If the infant is able to crawl, only one sideis used to propel himself or herself.

780) The mother of a 4-year-old child tells the pediatric nurse that the child's abdomen seems to be swollen. During further assessment of subjective data, the mother tells thenurse that the child is eating well and that the activity level of the child is unchanged. The nurse, suspecting the possibility of Wilms' tumor, should avoid which during the physical assessment?

- ✓ Palpating the abdomen for a mass

781) The pediatric nurse specialist provides a teaching session to the nursing staff regarding osteosarcoma. Which statement by a member of the nursing staff indicates a **needfor information?**

- ✓ "The child does not experience pain at theprimary tumor site."

782) A 13-year-old child is diagnosed with Ewing's sarcomaof the femur. After a course of radiation and chemotherapy,it was decided that leg amputation is necessary. After the amputation, the child becomes very frightened because of aching and cramping felt in the missing limb. Which nursingstatement is **most appropriate** to assist in alleviating the child's fear?

- ✓ "This aching and cramping is normal andtemporary and will subside."

783) A 9-year-old child with leukemia is in remission and has returned to school. The school nurse calls the mother ofthe child and tells the mother that a classmate has just been diagnosed with chickenpox. The mother immediately callsthe clinic nurse because the leukemic child has never had

chickenpox. Which is an appropriate response by the clinicnurse to the mother?

✓ "Bring the child into the clinic for avaccine."

784) The nurse instructs the parents of a child with leukemia regarding measures related to monitoring for infection. Which statement, if made by the parent, indicatesa **need for further instructions?**

✓ "I will take a rectal temperature daily."785) The nurse is caring for a 3-year-old boy with a diagnosis of acute lymphocytic leukemia. The child is cryingand complaining that his knees hurt. Which nursing intervention is **most appropriate?**

✓ Administer acetaminophen to the child.

786) A 14-year-old child is admitted to the hospital with adiagnosis of acute lymphocytic leukemia. She is receiving acombination chemotherapeutic regimen that includes cyclophosphamide. The nurse plans care understanding that which are associated with this medication? **Select all that apply.**

✓ It is platelet sparing.

✓ It causes hemorrhagic cystitis.

✓ It causes bone marrow depression.

✓ Increased fluid intake is necessary.

787) Nursing care of the child with myelosuppression fromleukemia or chemotherapeutic agents should include which intervention?

✓ Use good hand washing technique

788) The pediatric nurse clinician is discussing the pathophysiology related to childhood leukemia with a classof nursing students. Which statement made by a nursing student indicates a **need for further teaching** of the pathophysiology of this disease?

✓ Reed-Sternberg cells are found on biopsy.

789) The nurse is caring for a 9-year-old child with leukemia who is hospitalized for the administration of chemotherapy. The nurse would monitor the child specificallyfor central nervous system involvement by checking which item?

✓ Level of consciousness

790) The pediatric nurse assists the health care provider inperforming a lumbar puncture on a 3-year-old child with leukemia and suspected central nervous system metastasis.
The nurse should place the child in which position for thisprocedure?

✓ Lateral recumbent, knees flexed to theabdomen and the head bent, chin down

791) In caring for a child diagnosed with Hodgkin's disease. Which oncologic emergency should the nurse be **most** concernedabout?

✓ Superior vena cava syndrome

792) A diagnostic workup is being performed on a 1-year-oldchild with suspected neuroblastoma. The nurse reviews the results of the diagnostic tests and understands that which finding is **most** specifically related to this type of tumor?

✓ Elevated vanillylmandelic acid urinary levels793) The nurse is collecting data on a 9-year-old child
suspected of having a brain tumor. Which question should thenurse ask to elicit data related to the classic symptoms of a brain tumor?

✓ "Do you throw up in the morning?"

794) The nurse has reviewed the health care provider's prescriptions for a child suspected of a diagnosis of neuroblastoma and is preparing to implement diagnostic procedures that will confirm the diagnosis. What should thenurse expect to do **next** to assist in confirming the diagnosis?

✓ Collect a 24-hour urine sample.

795) The nurse is asked to prepare for the admission of achild to the pediatric unit with a diagnosis of Wilms'

tumor. The nurse is creating a plan of care for the childand should include which intervention in the plan?

✓ Inspect the urine for the presence ofhematuria at each voiding.

796) The nurse is providing home care instructions to themother of a child receiving radiation therapy. Which statement by the mother indicates a **need for further teaching?**

✓ "I won't need to limit the amount of sun thatmy child gets."

797) The nurse is reviewing the record of a 10-year-old child suspected of having Hodgkin's disease. Which characteristic manifestation should the nurse anticipate tobe documented in the assessment notes?

✓ Painless and movable lymph nodes in thecervical area

798) The nurse is reviewing the laboratory and diagnostic test results of a 5-year-old child scheduled to be seen in the clinic. The nurse notes that the health care provider documented that diagnostic studies revealed the presence of Reed-Sternberg cells. The nurse prepares to assist the health care provider to discuss which initial procedure withthe parents?

✓ Surgical biopsy

799) The nurse is monitoring for bleeding in a child following surgery for removal of a brain tumor. The nurse checks the head dressing and notes the presence of dried blood on the back of the dressing. The child is alert and oriented, and the vital signs and neurological signs are stable. Which nursing action is **most appropriate initially?**

✓ Check the operative record to determinewhether a drain is in place.

800) A child is scheduled for allogeneic bone marrow transplantation (BMT). The parent of the child asks the nurse about the procedure. The nurse should provide whichdescription about the BMT?

✓ Obtaining bone marrow from a donor whomatches the child's tissue type

801) The nurse reviews the record of a child who is suspected to have glomerulonephritis and expects to notewhich finding that is associated with this diagnosis?

✓ Brown-colored urine

802) The nurse performing an admission assessment on a 2-year-old child who has been diagnosed with nephrotic syndrome notes that which **most** common characteristic is associated with this syndrome?

✓ Generalized edema

803) The nurse is planning care for a child with hemolytic-uremic syndrome who has been anuric and will be receiving peritoneal dialysis treatment. The nurse should plan to implement which measure?

✓ Restrict fluids as prescribed.

804) A 7-year-old child is seen in a clinic, and the primaryhealth care provider documents a diagnosis of primary nocturnal enuresis. Which statement made by the parents indicates understanding of this condition?

✓ "Most children outgrow the bed-wettingproblem without therapeutic intervention."

805) The nurse provided discharge instructions to theparents of a 2-year-old child who had an orchiopexy tocorrect cryptorchidism. Which statement by the parentsindicates that **further teaching is necessary?**

✓ "I'll let him decide when to return to hisplay activities."

806) The nurse is reviewing a treatment plan with the parents of a newborn with hypospadias. Which statement bythe parents indicates their understanding of the plan?

✓ "Circumcision has been delayed to save tissuefor surgical repair."

807) The nurse is caring for an infant with a diagnosis ofbladder exstrophy. To protect the exposed bladder tissue, the nurse should plan which intervention?

✓ Cover the bladder with a nonadhering plasticwrap.

808) When collecting the history about a child who presentswith signs of glomerulonephritis, the nurse should report which **most** important finding to the health care provider?

✓ Streptococcal throat infection 2 weeks beforediagnosis

809) The nurse collects a urine specimen preoperatively froma child with epispadias who is scheduled for surgical repair. When analyzing the results of the urinalysis, which should the nurse **most likely** expect to note?

✓ Bacteriuria

810) The nurse is performing an assessment on a child admitted to the hospital with a probable diagnosis of nephrotic syndrome. Which assessment findings should thenurse expect to observe? **Select all that apply.**

✓ Pallor

✓ Edema

✓ Anorexia

✓ Proteinuria

811) The nurse is developing a plan of care for a 6-year-oldchild diagnosed with acute glomerulonephritis. The nurse should include which **priority** intervention in the plan of care?

✓ Encourage limited activity and provide safetymeasures.

812) Which is a **priority** problem for a child with severeedema caused from nephrotic syndrome?

✓ Risk for skin breakdown

813) After performing an assessment of an infant with bladder exstrophy, the nurse prepares a plan of care. Thenurse identifies which problem as the **priority** for the infant?

✓ Impaired tissue integrity

814) The nurse is caring for an infant with cryptorchidism.The nurse anticipates that the **most likely** diagnostic studyto be prescribed would be the one that assesses which item?

✓ Urinary function

815) The nurse is caring for a 7-year-old child with glomerulonephritis and is preparing to discuss the plan of care with the parents. In anticipating this encounter, the nurse recognizes that which is a common reaction of parentsto the diagnosis of glomerulonephritis?

✓ Guilt that they did not seek treatment morequickly

816) An 18-month-old child is being discharged after surgical repair of hypospadias. Which postoperative nursingcare measure should the nurse stress to the parents as they prepare to take their child home?

✓ Avoid tub baths until the stent has beenremoved.

817) The parents of a newborn have been told that their child was born with bladder exstrophy, and the parents ask the nurse about this condition. Which explanation, given bythe parents, indicates understanding of this condition?

✓ "It's an extrusion of the urinary bladder tothe outside of the body through a defect in the lower abdominal wall."

818) The nurse recognizes that clinical manifestations ofnephrotic syndrome include which findings?

✓ Massive proteinuria, hypoalbuminemia, edema819) A 4-year-old child with acute glomerulonephritis is admitted to the hospital. The nurse identifies which clientproblem in the plan of care as the **priority?**

✓ Excessive fluid volume related to decreasedplasma filtration

820) The nurse is reviewing the health care provider's prescriptions for a child hospitalized with nephrotic syndrome. Which food should the nurse tell the unlicensedassistive personnel to remove from the child's food tray?

✓ Pickle

821) A nursing student caring for a 6-month-old infant isasked to collect a sample for urinalysis from the infant.How should the student collect the specimen?

✓ Attaching a urinary collection device to theinfant's perineum for collection

822) The nurse is collecting data on a child recently diagnosed with glomerulonephritis. Which question to the mother should elicit data associated with the cause of thisdisease?

✓ "Did your child recently complain of a sorethroat?"

823) The nurse is reviewing the record of a child diagnosedwith nephrotic syndrome. The nurse should expect to note which finding documented in the child's record?

✓ Weight gain

824) The nurse is planning discharge instructions for the mother of a child following orchiopexy, which was performedon an outpatient basis. Which is a **priority** in the plan of care?

✓ Wound care

825) The nurse is assigned to care for a child following surgery to correct cryptorchidism. Which **priority** action should the nurse include in the plan of care following thistype of surgery?

✓ Prevent tension on the suture.

826) The mother of a newborn infant with hypospadias asks the nurse why circumcision cannot be performed. Which is the**most appropriate** response by the nurse?

✓ "Circumcision has been delayed to save tissuefor surgical repair."

827) The nurse is providing discharge instructions to the parents of an infant who underwent surgical repair of bladder exstrophy. The parents ask if the infant will be able to control their bladder as they get older. How shouldthe nurse respond?

✓ "Your child will not have a sphincter mechanism for the first 3 to 5 years, so urinewill drain freely."

828) The nurse is creating a plan of care for a 10-year-oldchild diagnosed with acute glomerulonephritis. What is the **priority** nursing intervention?

✓ Promoting bed rest

829) A child is scheduled for a tonsillectomy. The nurse plans care, knowing that which condition would be a **priority**because it presents the highest risk of aspiration during surgery?

✓ Presence of loose teeth

830) A child is scheduled for a tonsillectomy in a day surgical unit. On the day after surgery, the mother callsthe surgical unit and expresses concern because the childhas a bad mouth odor. Which response is **most appropriate?**

✓ "Bad mouth odor is normal and may be relievedby drinking more liquids."

831) An ambulatory care nurse is preparing a list of instructions for the parents of a child who is being discharged after a tonsillectomy. The nurse should place which instructions on the list? **Select all that apply.**

✓ Avoid hot fluids.

✓ Avoid raw vegetables.

✓ Rest in bed or on a couch for 24 hours. 832) The nurse in the ambulatory care unit is caring for a child after a tonsillectomy. The child's mother tells thenurse that the child is complaining of a dry throat and would like something to relieve the dryness. Which item should the nurse provide for the mother to give to the child?Yellow noncitrus Jell-O

✓ Yellow noncitrus Jell-O

833) A mother arrives at the hospital emergency departmentwith her child, in whom a diagnosis of epiglottitis is documented. Which prescription, if written by the health care provider, should the nurse question?

✓ Obtain a throat culture.

834) The student nurse is caring for an infant with a tracheostomy and is preparing to suction the infant. The nursing instructor should intervene if the nursing student stated she would take which action to perform this procedure?

✓ Limit insertion and suctioning time to 15seconds to prevent hypoxia.

835) Breathing exercises and postural drainage are prescribed for a hospitalized child with cystic fibrosis.What instruction should the nurse include in the client's teaching plan?

✓ Perform the postural drainage first and thenthe breathing exercises.

836) A school nurse is teaching parents about emergency treatment for epistaxis. Which **best** action should the nursetake to assist the parents in understanding the emergency treatment?

✓ Ask the parents to demonstrate, on a mannequin, where to apply continuous pressure if anosebleed occurs.

837) A mother arrives at the clinic with her 3-year-old child. The mother tells the nurse that the child has had a fever and a cough for the past 2 days and that this morning the child began to wheeze. Viral pneumonia is diagnosed.
Based on the diagnosis, the nurse anticipates that whichwill be a component of the treatment plan?

✓ Supportive treatment

838) The mother of a child with cystic fibrosis (CF) asksthe clinic nurse about the disease. What should the nursetell the mother about CF?

✓ A chronic multisystem disorder affecting theexocrine glands

839) A mother calls the health care provider's office requesting an appointment for her 8-year-old child. She states he has asthma and is telling her he had trouble breathing last night and does not want to go to school. In

triaging this child, which is the **most important** question to **initially** ask the mother?

✓ "Is your child telling you at this time he ishaving trouble breathing?"

840) After a tonsillectomy, a child is brought to the pediatric unit. The nurse should appropriately place thechild in which position?

✓ Prone

841) The nurse is caring for a child following a tonsillectomy. The nurse should reposition the child onreturn from the operating room if the child is in which position?

✓ Supine

842) A pediatric nurse in the ambulatory surgery unit is caring for a child following a tonsillectomy. The child iscomplaining of a dry throat. Which item should the nurse offer to the child?

✓ Green gelatin

843) The nurse is reviewing the health care provider's prescriptions for a child following a tonsillectomy. Whichprescription should the nurse question?

✓ Suction the child frequently if coughing.844) During clinical conference, a nursing student is discussing care for a child with a diagnosis of cystic fibrosis (CF). Which comment by a student indicates the **needfor further review** of information about CF?

✓ This disease causes dilation of thepassageways of many organs.

845) The nurse reviews the health record of a 2-year-old child. The health care provider has documented that the results of a tuberculin skin test have indicated an area ofinduration measuring 5 mm. How should the nurse interpret these results?

✓ Negative

846) The nurse has provided instructions to the mother of achild with cystic fibrosis about appropriate dietary

measures. Which statement by the mother indicates anunderstanding of these dietary measures?

✓ "The diet needs to be high in calories." 847) The nurse is caring for a hospitalized infant with a diagnosis of bronchiolitis. In which position should thenurse place the infant?

✓ Head and chest at a 30-degree angle with theneck slightly extended

848) The nurse is providing instructions to the mother of achild with croup regarding treatment measures if an acute spasmodic episode occurs. Which statement made by the motherindicates a **need for further teaching?**

✓ "I should place a steam vaporizer in mychild's room."

849) The nurse employed in an emergency department is monitoring a child diagnosed with epiglottitis. The nurse notes that the child is leaning forward with the chin thrustout. How should the nurse interpret this finding?

✓ An airway obstruction

850) A nursing student is conducting a clinical conference about measures that assist in preventing sudden infant deathsyndrome. The student plans to write on a handout that it is **best** to place an infant in which position for sleep?

✓ On the back, or supine

851) The nurse is caring for an infant with a diagnosis oftetralogy of Fallot. The infant suddenly becomes cyanotic,and the nurse recognizes that the infant is experiencing ahypercyanotic spell (blue or tet spell). The nurse **immediately** places the infant in what position?

✓ Knee-chest position

852) The nurse is monitoring an infant with heart failure.Which sign alerts the nurse to suspect fluid accumulation and the need to call the health care provider?

✓ A weight gain of 1 lb (0.5 kg) in 1 day853) A child with a diagnosis of tetralogy of Fallot exhibits an increased depth and rate of respirations. On

further assessment, the nurse notes increased hypoxemia. Thenurse interprets these findings as indicating which situation?

✓ A hypercyanotic episode

854) The mother of a child being discharged after heart surgery asks the nurse when the child will be able to returnto school. Which is the **most appropriate** response to the mother?

✓ "The child may return to school in 3 weeks but needs to go half-days for the first few days."

855) A child has been tentatively diagnosed with rheumaticfever. The nurse interprets that this diagnosis is consistent with which laboratory result obtained for this child?

✓ Elevated antistreptolysin O titer

856) A 12-year-old is admitted to the hospital with a low-grade fever and joint pain. Which diagnostic test finding will assist to determine a diagnosis of rheumatic fever?

✓ Elevated erythrocyte sedimentation rate 857) The nurse reviews the laboratory results for a child with rheumatic fever and would expect to note whichfindings? **Select all that apply.**

✓ Elevated C-reactive protein

✓ Elevated antistreptolysin O titer

✓ Presence of group A beta-hemolytic strep 858) Prostaglandin E1 is prescribed for a child with transposition of the great arteries. The mother of the childis a registered nurse and asks the nurse why the child needsthe medication. What is the **most appropriate** response to themother about the action of the medication?

✓ Maintains adequate cardiac output

859) A 1-year-old infant with a diagnosis of heart failureis prescribed digoxin. The nurse takes the apical pulse for 1 minute before administering the medication and obtains a result of 102 beats/minute. What is the nurse's **best** action?

✓ Administer the medication.

860) The nurse is assessing a newborn with heart failure before administering the prescribed digoxin. In reviewing the laboratory data, the nurse notes that the newborn has a digoxin blood level of 1.6 ng/mL (2.05 mmol/L) and an apicalheart rate of 90 beats/min. The mother also tells the nurse that the newborn just vomited her formula. Which intervention should the nurse take?

✓ Withhold the medication and notify the healthcare provider.

861) The nurse is preparing to administer digoxin to an infant with heart failure. Before administering the medication, the nurse double-checks the dose, counts the apical heart rate for 1 full minute, and obtains a rate of 80 beats/minute. Based on this finding, which is theappropriate nursing action?

✓ Withhold the medication.

862) The nurse is creating a plan of care for a child admitted with a diagnosis of Kawasaki disease. In developingthe **initial** plan of care, the nurse should include monitoring the child for signs of which condition?

✓ Heart failure

863) The nurse is reviewing the health care provider's prescriptions for a child with rheumatic fever who is suspected of having a viral infection. The nurse notes that aspirin is prescribed for the child. Which nursing action is**most appropriate?**

✓ Consult with the health care provider toverify the prescription.

864) The nurse is assigned to care for an infant with tetralogy of Fallot. The mother of the infant calls the nurse to the room because the infant suddenly seems to be having difficulty breathing. The nurse enters the room andnotes that the infant is experiencing a hypercyanotic episode. What is the **priority** action by the nurse?

✓ Place the infant in a knee-chest position.

865) The nurse is caring for an infant with congenital heartdisease. Which, if noted in the infant, should alert the nurse to the **early** development of heart failure?

✓ Diaphoresis during feeding

866) The nurse is caring for a child with a diagnosis of aright-to-left cardiac shunt. On review of the child's record, the nurse should expect to note documentation of which **most** common assessment finding?

✓ Bluish discoloration of the skin 867) The nurse is collecting data on a child with a diagnosis of rheumatic fever. Which question should thenurse **initially** ask the mother of the child?

✓ "Has the child complained of a sore throatwithin the past few months?"

868) The nurse is caring for an infant with a diagnosis ofcongenital heart disease. Which finding, on physical assessment, does the nurse attribute to chronic hypoxia?

✓ Clubbing of the fingers

869) A child is being discharged from the hospital followingheart surgery. Prior to discharge, the nurse reviews the discharge instructions with the mother. Which statement by the mother indicates a **need for further teaching?**

✓ "Visitors are not allowed for 1 month."870) The nurse in the health care clinic receives a telephone call from the mother of a child who reports that an insect has somehow flown into the child's ear. The motherreports that the child is complaining of a buzzing sound in the ear. Which **priority** instruction should the nurse provideto the mother?

✓ Use a flashlight to coax the insect out ofthe ear.

871) A 10-year-old child complains of ear pain that is aggravated by palpation of the auricle. A foul-smelling, tenacious yellow discharge is noted in the ear canal, and the child is diagnosed with acute otitis externa. In providing information to the child and parent, the nurse emphasizes which information?

✓ Nothing smaller than the child's elbow shouldbe placed in the ear.

872) The nurse is providing care to a child admitted for acute otitis media. What is the nurse's **priority** concern forthis child?

✓ Acute pain

873) A 4-year-old child is diagnosed with otitis media. Themother asks the nurse about the causes of this illness.
Which risk factors should the nurse include in response tothis mother? **Select all that apply.**

✓ Bottle-feeding

✓ Household smoking

✓ Exposure to illness in other children

✓ Congenital conditions such as cleft palate874) The mother arrives at a well-baby clinic with her 1-
month-old infant. She expresses concern because one of theinfant's eyes appears to be crossed. What is the nurse's **best** response?

✓ "This is normal in the young infant but should not be present after the age of about 4months."

875) The health care provider prescribes patching for a child with strabismus of the right eye, and the nurse instructs the mother regarding this procedure. What shouldthe nurse include in the instructions?

✓ Place the patch on the left eye.

876) The mother of a child who has undergone a myringotomy,with insertion of tympanoplasty tubes, telephones and tellsthe nurse that the tubes have fallen out. Which is the appropriate response to the mother?

✓ "This is not an emergency. I will speak to the health care provider and call you right back."

877) The nurse provides discharge instructions to the motherof a child following a myringotomy with insertion of tympanoplasty tubes. Which statement by the mother indicatesthe **need for further teaching?**

✓ "My child can swim in the lake or pool aslong as the water is not too deep."

878) The nurse is providing home care instructions to the mother of a 9-year-old child diagnosed with viral conjunctivitis. Antibiotic eyedrops are prescribed for the child. Which statement by the mother indicates the teachinghas been **effective?**

✓ "My child will need to stay home until my child has received the antibiotic eyedrops for 24hours."

879) On assessment during a well-baby visit, the nurse notesthat a 6-month-old infant has crossed eyes. Which interpretation would the nurse make based on this finding?

✓ Surgical intervention may be necessary torealign weak eye muscles.

880) The nurse is caring for a 2-year-old child with an earinfection who requires the administration of antibiotic eardrops. The nurse observes the mother administering the eardrops to the child. Which observation by the nurse indicates that the mother is performing the procedure correctly?

✓ The mother pulls the earlobe down and back.881) An ambulatory care nurse makes a follow-up telephone call to the mother of a child who underwent a myringotomy with insertion of tympanoplasty tubes on the previous day.The mother of the child tells the nurse that the child is complaining of discomfort. What should the nurse instruct the mother to do?

✓ Administer acetaminophen.

882) The nurse is assisting in providing an educational session to new mothers regarding the methods that will decrease the risk of recurrent otitis media in infants. Which statement by a mother in the group indicates a **needfor further teaching?**

✓ "I need to stop breast-feeding as soon aspossible."

883) The nurse has a prescription to give eardrops to a 5-year-old child. Which position should the nurse use to pullthe pinna of the ear?

✓ Upward and backward

884) The parents of a newborn with a cleft lip are concernedand ask the nurse when the lip will be repaired. With which statement should the nurse respond?

✓ Cleft-lip repair is usually performed duringthe first weeks of life.

885) A 1-year-old child is diagnosed with intussusception,and the mother of the child asks the student nurse to describe the disorder. Which statement by the student nurse indicates correct understanding of this disorder?

✓ "It is a condition in which a proximal segment of the bowel prolapses into a distalsegment of the bowel."

886) A 3-year-old child is seen in the health care clinic,and a diagnosis of encopresis is made. The nurse expects toprovide teaching about which client problem?

✓ Odor

887) A home care nurse instructs the mother of a 5-year-oldchild with lactose intolerance about dietary measures for her child. The nurse should tell the mother that it is necessary to provide which dietary supplement in the child'sdiet?

✓ Calcium

888) The nurse has been assigned to care for a neonate justdelivered who has gastroschisis. Which concern should the nurse address in the client's plan of care?

✓ Infection

889) The nurse is assigned to care for a child who is scheduled for an appendectomy. Select the prescriptions thatthe nurse anticipates will be prescribed. **Select all that apply.**

✓ Initiate an IV line.

✓ Maintain an NPO status.

✓ Administer intravenous antibiotics.

✓ Administer preoperative medications.

890) The nurse is developing a plan of care for an infant after surgical intervention for imperforate anus. The nurseshould include in the plan that which position is the **most appropriate** one for the infant in the postoperative period?

✓ Prone position

891) The nurse is providing discharge instructions to themother of a child who had a cleft palate repair. Which statement should the nurse make to the mother?

✓ "You need to use an orthodontic nipple on thechild's bottle."

892) A mother brings her 5-week-old infant to the health care clinic and tells the nurse that the child has been vomiting after meals. The mother reports that the vomitingis becoming more frequent and forceful. The nurse suspectspyloric stenosis and asks the mother which assessment question to elicit data specific to this condition?

✓ "Does the vomit contain sour, undigested foodwithout bile, and is the infant constipated?"

893) The nurse is caring for an infant after repair of aninguinal hernia. Which of these assessment findings indicates that the surgical repair was **effective?**

✓ Absence of inguinal swelling with crying 894) After

hydrostatic reduction for intussusception, the
nurse should expect to observe which client response?

✓ Passage of barium or water-soluble contrastwith stools

895) The nurse is writing out discharge instructions for theparents of a child diagnosed with celiac disease. The nurse should focus **primarily** on which aspect of care?

✓ Following a gluten-free diet

896) Parents bring their child to the emergency departmentand tell the nurse that the child has been complaining of colicky abdominal pain located in the lower right quadrant

of the abdomen. The nurse suspects that the child has whichdisorder?

✓ Appendicitis

897) The nurse is providing instructions to the parents of achild with a hernia regarding measures that will promote reducing the hernia. The nurse determines that the parents understand care for their child if they make which statement?

✓ "We will provide comfort measures to reduceany crying periods by our child."

898) An emergency department nurse is performing an assessment on a child with a suspected diagnosis of intussusception. Which assessment question for the parents will elicit the **most** specific data related to this disorder?

✓ "Can you describe the type of pain that thechild is experiencing?"

899) The nurse is caring for a newborn infant after surgicalintervention for imperforate anus. The nurse should place the infant in which position in the postoperative period?

✓ Side-lying with the legs flexed

900) The mother of a child with hepatitis A tells the homecare nurse that she is concerned because the child's jaundice seems worse. What is the nurse's **best** response?

✓ "The jaundice may worsen before it resolves."901) The mother of an 18-month-old child tells the clinic nurse that the child has been having some mild diarrhea and describes the child's stools as "mushy." The mother tells the nurse that the child is tolerating fluids and solid foods. The **most appropriate** suggestion regarding the child'sdiet would be to give the child which items?

✓ Mashed potatoes with baked chicken

902) The nurse provides home care instructions to the motherof a child who had a cleft palate repair 4 days ago. Which statement by the mother indicates the **need for further instruction?**

✓ "I need to buy some straws for drinking."

903) The nurse is preparing to care for an infant who has esophageal atresia with tracheoesophageal fistula. Surgery is scheduled to be performed in 1 hour. Intravenous fluids have been initiated, and a nasogastric (NG) tube has been inserted by the health care provider. The nurse plans care,knowing that which intervention is of **highest priority** during this preoperative period?

✓ Aspirate the NG tube every 5 to 10 minutes 904) A mother brings her child to the well-child clinic and expresses concern to the nurse because the child has beenplaying with another child diagnosed with hepatitis. The nurse prepares to perform an assessment on the child, knowing that which finding would be of least concern for hepatitis?

✓ Left upper abdominal quadrant pain

905) A child is diagnosed with Hirschsprung's disease. Thenurse is teaching the parents about the cause of the disease. Which statement, if made by the parent, supports that teaching was successful?

✓ "Special cells are not present in the rectum,which caused the disease."

906) The parents of a child with a cleft palate are concerned and ask the nurse when the palate will be repaired. The nurse should plan to base the response on which information about cleft palate repair?

✓ Repair usually is performed between 6 monthsand 2 years.

907) During a home care visit, an adult client complains ofchronic constipation. What should the nurse tell the clientto do?

✓ Increase fluid and dietary fiber intake. 908) The clinic nurse is obtaining data about a child with a diagnosis of lactose intolerance. Which data should thenurse expect to obtain on assessment?

✓ Reports of frothy stools and diarrhea 909) The nurse has provided dietary instructions to the mother of a child with celiac disease. The nurse determines

that **further instruction is needed** if the mother states thatshe will include which food item in the child's nutritional plan?

✓ Oatmeal

910) A child is suspected of suffering from intussusception.The nurse should be alert to which clinical manifestation ofthis condition?

✓ Tender, distended abdomen

911) The nurse is caring for a 1-year-old child after cleftpalate repair. On completion of feeding, the nurse should plan for which appropriate nursing action?

✓ Rinsing the mouth with water

912) The nurse is reviewing the laboratory results for an infant with suspected hypertrophic pyloric stenosis. What should the nurse expect to note as the **most likely** findingin this infant?

✓ Metabolic alkalosis

913) A 12-year-old girl is admitted to the hospital with suspected appendicitis. What nursing interventions should beimplemented preoperatively?

✓ Placing the adolescent in a fetal position,side-lying with legs drawn up to chest

914) The nurse is reviewing the laboratory test results foran infant suspected of having hypertrophic pyloric stenosis.The nurse should expect to note which value as the **most likely** laboratory finding in this infant?

✓ Blood pH of 7.50

915) A preschooler with a history of cleft palate repair comes to the clinic for a routine well-child checkup. To determine if this child is experiencing a long-term effectof cleft palate, which question should the nurse ask?

✓ "Is the child unresponsive when givendirections?"

916) The nurse is preparing an infant for surgery to treat Hirschsprung's disease. Which assessment finding is **priority**to identify and treat?

✓ Decreased blood pressure and tachycardia

917) The nurse is assisting the pediatrician in performing an assessment on a newborn suspected of having imperforate anus. Which finding would be noted in this disorder?

✓ Presence of an anal membrane

918) A nurse is assessing the status of jaundice in a childwith hepatitis. Which anatomical areas will provide the **best**data regarding the presence of jaundice? **Select all that apply.**

✓ The sclera

✓ The nail beds

✓ The mucous membranes

919) The nurse is reviewing the plan of care for a child with a diagnosis of suspected appendicitis. The nurse wouldquestion which intervention if noted in the plan of care?

✓ Applying a heating pad to abdomen to promotepain relief

920) The nurse in the hospital is giving at-home feeding instructions to a family whose child is being discharged after being born with a cleft lip. Which statement by themother would indicate that **further teaching is indicated?**

✓ "I must always feed my baby with a syringeand not use a nipple."

921) An infant is seen in the health care provider's office for complaints of frequent vomiting and spitting up after feedings. Findings indicate that the infant is not gaining weight, and gastroesophageal reflux is suspected. Which would the nurse anticipate being prescribed **initially** in thecare of this child?

✓ Administer predigested formula and feedsmall, frequent feedings.

922) An infant is seen in the health care provider's officefor complaints of projectile vomiting after feeding.
Findings indicate that the child is fussy and is gaining weight but seems never to get enough to eat. Pyloric stenosis is suspected. Which prescription would the nurse

anticipate having the **highest priority** in the care of thischild?

✓ Prepare the family for surgery for the child.923) A 2-year-old child with acute diarrhea has been diagnosed with mild dehydration. Which rehydration methodswould the nurse expect the health care provider to prescribe?

✓ Consume oral rehydration fluid, advancing toa regular diet.

924) A child admitted to the hospital with a diagnosis of gastroenteritis and dehydration weighs 17 pounds 2 ounces (7.8 kg). The parents state that his preadmission weight was 18 pounds 4 ounces (8.3 kg). Based on weight alone, whattype of dehydration does the nurse expect?

✓ Moderate dehydration

925) The nurse is initiating nasogastric tube feedings in achild. What is the nurse's **best** action?

✓ Position the child with the head slightlyhyperflexed.

926) The mother of a child with an umbilical hernia calls the clinic and reports to the nurse that the child has beenvomiting and is complaining of pain in the abdominal area. Which instruction to the mother is **most appropriate?**

✓ Contact the health care provider

927) The nurse is reviewing the health care provider's documentation in the record of a child admitted with a diagnosis of intussusception. The nurse expects to note thatthe health care provider has documented which manifestation?

✓ Currant jelly stools

928) The nurse is preparing to care for a newborn infant following creation of a colostomy for the treatment of imperforate anus. In the immediate postoperative period, thenurse plans to inspect the stoma and expects to note which finding in the colostomy?

✓ Red and edematous

929) The nurse is collecting data on an infant with adiagnosis of suspected Hirschsprung's disease. Which question to the mother will **most** specifically elicit information regarding this disorder?

✓ "Does your infant have foul-smelling, ribbon-like stools?"

930) The nurse is caring for a child who was brought to theclinic complaining of severe abdominal pain and is suspectedof having acute appendicitis. The child is lying on the examining table, with the knees pulled up toward the chest. What is the **priority** nursing action?

✓ Perform a pain assessment using the FACESscale

931) The nurse has provided dietary instructions to the mother of a child with celiac disease. The nurse determines that the mother understands the instructions when the motherstates to include which food in the child's diet?

✓ Corn

932) The nurse is developing a plan of care for a 5-week-oldinfant being admitted with hypertrophic pyloric stenosis whois scheduled for pyloromyotomy. In the preoperative period, the nurse should place the infant in which **best** position?

✓ In an infant seat placed in the crib

933) The nurse is preparing a plan of care for an infant whowill be returning from the recovery room following the surgical repair of a cleft lip located on the right side of the lip. On return from the recovery room, the nurse should plan to place the infant in which position?

✓ On the left side

934) The nurse is providing discharge instructions to themother of a child with herpetic gingivostomatitis. Which response by the mother indicates the **need for further teaching?**

✓ "I will not give my child anything to eat for 2 days to allow healing."

935) Oral iron supplements are prescribed for a 6-year-oldchild with iron deficiency anemia. Which beverage is the **best** option to recommend with iron administration?

✓ Orange juice

936) The pediatric nursing instructor asks a nursing studentto prioritize care for a child diagnosed with sickle cell disease. Which student response correctly identifies the **priority** of care?

✓ Hypoxia

937) The nurse is caring for a child with a diagnosis of hemophilia, and hemarthrosis is suspected because the childis complaining of pain in the joints. Which measure should the nurse expect to be prescribed for the child?

✓ Application of a bivalved cast for jointimmobilization

938) The home care nurse is providing safety instructions tothe mother of a child with hemophilia. Which instruction should the nurse include to promote a safe environment for the child?

✓ Eliminate any toys with sharp edges from thechild's play area.

939) The nurse on the pediatric unit is caring for a child with hemophilia who has been in a motor vehicle crash. Whichassessment finding, if noted in the child, indicates the **need for follow-up?**

✓ The child is drowsy and difficult to arouse;previously the child was able to respond to questions effectively.

940) The nurse provides instructions regarding home care tothe parents of a 3-year-old child hospitalized with hemophilia. Which statement, if made by the parent, indicates a **need for further instructions?**

✓ "We will avoid having our child receiveimmunizations."

941) A child is brought to the emergency department afterbeing accidentally struck in the lower back region with a baseball bat. When gathering assessment data, the nurse

discovers that the child has hemophilia. The nurse should **immediately** assess for which data?

✓ Presence of hematuria

942) A child in whom sickle cell anemia is suspected is seenin a clinic, and laboratory studies are performed. The nursechecks the laboratory results, knowing that which value would be increased in this disease?

✓ Reticulocyte count

943) The pediatric nurse educator provides a teaching session to the nursing staff regarding hemophilia. Which statement regarding this disorder should the nurse plan to include in the discussion?

✓ Hemophilia A results from deficiency offactor VIII.

944) A child arrives at the emergency department with a nosebleed. On assessment, the nurse is told by the motherthat the nosebleed began suddenly and for no apparent reason. What is the **initial** nursing action?

✓ Ask the child to sit down and lean forward,and apply pressure to the nose.

945) A 12-year-old child with newly diagnosed thalassemia isbrought to the clinic exhibiting delayed sexual maturation, fatigue, anorexia, pallor, and complaints of headache. The child seems listless and small for age and has frontal bossing. What should the nurse expect to note on review of the results of the laboratory tests?

✓ Deficient production of functional hemoglobin946) The pediatric nurse educator is providing a teaching session to nursing staff about hemophilia. Which statementshould the nurse educator include?

✓ "Affected prepubescent girls should be counseled concerning menorrhagia, which may belife-threatening."

947) An 11-year-old child is admitted to the hospital in vaso-occlusive sickle cell crisis. The nurse plans for which**priority** treatments in the care of the child?

✓ Adequate hydration, pain management

948) A 2-year-old boy with a diagnosis of hemophilia is admitted to the hospital with bleeding into the joint of theright knee. Which intervention should the nurse plan to implement with this child?

✓ Measure the injured knee joint every shift.949) A child with sickle cell anemia who is in vaso-occlusive crisis is admitted to the hospital. Which healthcare provider prescription would assist in reversing the vaso-occlusive crisis?

✓ Begin intravenous fluids.

950) A child with a diagnosis of sickle cell anemia and vaso-occlusive crisis is complaining of severe pain, selecting number 8 on the 1 to 10 pain scale. Which medication would the nurse expect to be prescribed for paincontrol?

✓ Morphine sulfate

951) The nurse is providing home care instructions to themother of an infant who has just been found to have hemophilia. The nurse should tell the mother that care of the infant should include which appropriate measure?

✓ Pad crib rails and table corners.

952) The nurse is collecting data on a 12-month-old child with iron deficiency anemia. Which finding should the nurseexpect to note in this child?

✓ Tachycardia

953) Oral iron is prescribed for a child with iron deficiency anemia. The nurse provides instructions to the mother regarding the administration of the iron. The nurse should instruct the mother to administer the medication inwhich way?

✓ Between meals

954) The nurse provides instructions to the mother of achild with sickle cell disease. Which statement by the mother indicates a **need for further teaching?**

✓ "I know my child must spend as much time aspossible in the sun."

955) The nurse is reviewing the laboratory results of a child with aplastic anemia and notes that the white bloodcell count is 2000 mm^3 (2×10^9/L) and that the platelet count is 150,000 mm^3 (150×10^9/L). Which intervention should the nurse incorporate into the plan of care?

✓ Maintain strict neutropenic precautions. 956) The nursing student is assigned to care for a child with hemophilia. The nursing instructor reviews the plan ofcare with the student. Which intervention on the student written plan of care requires correction?

✓ Blood transfusion of packed red blood cells.957) The nurse is providing instructions to the mother of a 3- year-old child with hemophilia regarding care of the child. Which statement by the mother indicates a **need forfurther teaching?**

✓ "I need to cancel the upcoming dentalappointment that I made for my child."

958) A child is brought to the emergency department after falling from a high swing and landing on the back. The nursenotes that the client also has hemophilia. Based on the client's history and the nature of the injury, which should the nurse assess for **first?**

✓ Blood in the urine

959) A child with a diagnosis of sickle cell disease is being admitted for the treatment of vaso-occlusive crisis.The nurse prepares for the admission anticipating which prescription for the child?

✓ Intravenous fluids

960) A nursing student is assigned to care for a child with sickle cell disease (SCD). The nursing instructor asks the student to describe the causative factors related to this disease. Which statement by the student indicates a **need forfurther research?**

✓ If each parent carries the trait, the child will carry the trait, and the probability of the child having the disease is 75%.

961) The nurse is caring for a child with hemophilia and is reviewing the results that were sent from the laboratory.
Which result should the nurse expect in this child?

✓ Prolonged PTT

962) A child is seen in the health care clinic for complaints of fever. On data collection, the nurse notes that the child is pale, tachycardic, and has petechiae. Aplastic anemia is suspected. The nurse should prepare the child to obtain which specimen that will confirm the diagnosis?

✓ Bone marrow biopsy

963) The nurse is monitoring the laboratory values of a child with leukemia who is receiving chemotherapy. The nurse prepares to implement bleeding precautions if the child becomes thrombocytopenic and the platelet count is less than how many cells/mm^3?

✓ 150,000 mm^3 (150 × 10^9/L)

964) A child is admitted to the pediatric unit with a diagnosis of acute stage Kawasaki disease. Which assessment findings by the nurse are characteristic of this disorder? **Select all that apply.**

✓ Red throat

✓ Conjunctival hyperemia

✓ Enlargement of the cervical lymph nodes 965) The student nurse is presenting a clinical conference regarding human immunodeficiency virus (HIV) in children. Which information should the student include?

✓ HIV cannot be spread by hugging, holding, or touching other people.

966) The nurse is reviewing the laboratory results of studies on a 4-month-old infant and notes that the human immunodeficiency virus (HIV) antibody test is positive. How should the nurse interpret this test result?

✓ The mother is infected with the HIV virus.

967) The nurse is caring for a child with acquired immunodeficiency syndrome (AIDS) and notes the presence ofmouth sores. The nurse provides instructions to the motherregarding maintaining adequate nutritional intake in the child. Which statement by the mother indicates a **need for further teaching?**

✓ "Salty foods are very important to maintainan appropriate sodium level in the child."

968) The nurse is reviewing the immunization schedule for achild with human immunodeficiency virus (HIV) infection withthe mother. Which instruction should the nurse provide to the mother?

✓ The child and the siblings will need toreceive inactivated polio vaccine.

969) A $CD4^+$ count has been prescribed for a child with humanimmunodeficiency virus (HIV) infection. The nurse has explained to the mother the purpose of the blood test. Whichcomment by the mother indicates the **need for further explanation?**

✓ "This test identifies the specific diagnosisof HIV infection."

970) The nurse is providing instructions to the mother of achild who has been exposed to human immunodeficiency virus infection. The nurse should include notifying the health care provider if which symptom occurs in the child?

✓ Coughing

971) A 3-year-old child with human immunodeficiency virus infection is being discharged from the hospital. The nurse is providing discharge instructions to the mother regarding home care and infection control measures. Which statement bythe mother indicates a **need for further teaching?**

✓ "I should discard any unused food and formulaimmediately."

972) The nurse is providing instructions to the mother of achild with human immunodeficiency virus infection regardingimmunizations. Which statement by the mother indicates an understanding of the immunization schedule?

✓ "Family members in the household need toreceive the influenza vaccine."

973) A child was seen in the health care clinic and receivedan immunization of DPT (diphtheria, pertussis, tetanus) vaccine. One hour later, the mother calls the clinic and tells the nurse that the injection site is painful and red. Which instruction should the nurse provide to the mother?

✓ Apply cold compresses for 24 hours for 20minutes at a time

974) The nurse is preparing to administer an MMR (measles,mumps, and rubella) vaccine to a 15-month-old child. Beforeadministering the vaccine, which question should the nurse ask the mother of the child?

✓ "Is the child allergic to any antibiotics?"975) The nurse is caring for a child with a diagnosis of neutropenia. Which nursing interventions are **most appropriate** for a child placed in protective isolation forneutropenia? **Select all that apply.**

✓ Place the child on a low-bacteria diet.

✓ Change dressings using sterile technique.

✓ Peel fruits and vegetables before allowingthe child to eat them

976) The mother of a preschooler who attends day care callsa clinic nurse and tells the nurse that the child is constantly scratching the perianal area and that the area isirritated. The nurse suspects the possibility of pinworm infection (enterobiasis) and instructs the mother to obtain a rectal specimen by a tape test. At what time should the nurse tell the mother to obtain the specimen?

✓ In the morning, when the child awakens

977) Several children have contracted rubeola (measles) in alocal school, and the school nurse conducts a teaching session for the parents of the schoolchildren. Which statement made by a parent indicates a **need for further teaching** regarding this communicable disease?

✓ "The disease can be spread to others from 10days before any sign of the disease appears to 15days after the rash appears."

978) The nurse provides instructions to the mother of a child with mumps regarding respiratory precautions, and themother asks the nurse about the length of time required forthe respiratory precautions. The nurse should make which statement to the mother?

✓ "Precautions are indicated during the periodof communicability."

979) A mother brings her 6-year-old child to the clinic because the child has developed a rash on the trunk and scalp. The mother reports that the child has had a low-gradefever, has not felt like eating, and has been tired. The child is diagnosed with chickenpox. The mother inquires about the communicable period associated with chickenpox, and the nurse bases the response on which statement?

✓ The communicable period is 1 to 2 days beforethe onset of the rash to 6 days, when crusts have formed.

980) A child diagnosed with scarlet fever is being cared forat home. The home health nurse performs an assessment on thechild and checks for which clinical manifestations of this disease? **Select all that apply.**

✓ Pastia's sign

✓ White strawberry tongue

✓ Edematous and beefy-red pharynx

981) A child with acquired immunodeficiency syndrome is hospitalized for the treatment of *Pneumocystis jiroveci* pneumonia. The child will be receiving nebulizer treatmentsat home when discharged. The nurse instructs the mother regarding the maintenance of the nebulizer equipment. What should the nurse tell the mother to do?

✓ Clean the nebulizer pieces with warm waterafter each treatment and allow to air dry.

982) A 12-month-old child with human immunodeficiency virusinfection is currently immunocompromised. The nurse

determines that the immunization needs of this child includewhich action?

✓ Delaying the administration of the varicellavirus vaccine until the child is not immunocompromised

983) The nursing student is assigned to administer immunizations to children in a clinic. The student should question whether to administer immunizations to a child with which condition?

✓ A severe febrile illness

984) The nurse is providing anticipatory guidance to the mother of a 10-month-old child. The mother asks how soon herdaughter will be able to receive the chickenpox (varicella) vaccine. What is the **best** nursing response?

✓ "She can receive it when she is 12 monthsold."

985) A child is scheduled to receive immunizations. The child's mother reports to the nurse that the child has beenreceiving long-term immunosuppressive therapy. The nurse prepares the scheduled immunizations knowing that which vaccine is contraindicated?

✓ MMR (measles-mumps-rubella)

986) A child is sent to the school nurse by the teacher. Onassessment of the child the nurse notes the presence of a rash. The nurse suspects that the child has erythema infectiosum (fifth disease) based on which assessment finding?

✓ Erythema on the face, giving a "slappedcheeks" appearance

987) An infant is brought to the clinic for his third diphtheria–tetanus toxoid–acellular pertussis vaccination(DTaP). The mother reports that the infant developed a 99.4°F (37.4°C) temperature after the last DTaP. Which action is **most appropriate?**

✓ Administer the vaccination.

988) The nurse should expect to administer the first dose ofthe measles, mumps, and rubella (MMR) vaccine at which age?

✓ 12 months

989) A school-age child is seen in the health care provider's office for complaints of intense itching mostly at night. The health care provider makes a diagnosis of scabies and prescribes permethrin for treatment of the skincondition. Which at-home instruction should the nurse provide to the mother?

✓ Apply the lotion liberally to the body andhead, avoiding the eyes and mouth.

990) A child who is 4 years old is seen for a well-child checkup. He has been regularly receiving immunizations. Which immunizations should the child receive at this visit?**Select all that apply.**

✓ Varicella vaccine

✓ Inactivated polio vaccine

✓ Measles, mumps, rubella (MMR) vaccine 991) A child seen

in the clinic is found to have rubeola
(measles), and the mother asks the nurse how to care for thechild. The nurse should tell the mother to implement which action?

✓ Keep the child in a room with dim lights.992) A child is

seen in the health care clinic, and the
nurse suspects the presence of pinworm infection (enterobiasis). The nurse instructs the mother as to how to obtain a cellophane tape rectal specimen. Which statement bythe mother indicates an understanding of the correct procedure to obtain the specimen?

✓ "I need to place a piece of transparent cellophane tape lightly over the anal area as soonas my child awakens and bring it to the clinic for examination."

993) An adolescent is seen in the health care clinic with complaints of chronic fatigue. On physical examination, the nurse notes swollen lymph nodes, and laboratory test results indicate the presence of Epstein-Barr virus (mononucleosis).The nurse provides instruction regarding care of the

adolescent. Which statement made by the mother indicates anunderstanding of the care measures?

✓ "I will call the doctor if my child hasabdominal or left shoulder pain."

994) The nurse is caring for a hospitalized child with a diagnosis of measles (rubeola). In preparing to care for thechild, which supplies should the nurse bring to the child's room to prevent transmission of the virus?

✓ Mask and gloves

995) The nurse is caring for a child with a diagnosis of roseola. The nurse provides instructions to the mother regarding prevention of the transmission to siblings and other household members. Which instruction should the nurseprovide?

✓ Avoid allowing the children to share drinkingglasses or eating utensils because the disease is transmitted through saliva.

996) A child hospitalized with pertussis is in the convalescent stage, and the nurse is preparing the child fordischarge. The nurse has provided instructions to the parents for home care of the child. Which statement by a parent indicates a **need for further teaching?**

✓ "I need to make sure that the child is isolated from the other children for at least 2 weeks to prevent the spread of the virus to them."

997) A child is seen in a health care clinic, and a diagnosis of chickenpox is confirmed. The mother expresses concern for two other children at home and asks the nurse ifthe child is infectious to the other children. Which response by the nurse is **most appropriate?**

✓ "The infectious period begins 1 to 2 days before the onset of the rash and ends about 5 daysafter the onset of the lesions and crusting of the lesions."

998) The nurse is developing a plan of care for a 10-year-old girl with an exacerbation of eczema. Which problem should be addressed in the care for this child?

✓ The client is at risk for infection relatedto scratching of pruritic lesions.

999) The nurse is providing a yearly summer educational session to parents in a local community. The topic of the session is prevention and treatment measures for poison ivy. The nurse instructs the parents that if the child comes intocontact with poison ivy to take which action?

✓ Shower the child immediately, lathering andrinsing the exposed skin several times.

1000) A 2-year-old child is admitted to a hospital burn unitwith partial- and full-thickness burns involving 35% of bodysurface area. After admission assessment and review of the health care provider's prescriptions, the **priority** nursing intervention should focus on which action?

✓ Inserting an indwelling urinary catheter