NSG 4060 Comprehensive ATI Practice B

A nurse is assessing a client who received 2 units of packed RBCs 48 hrs ago. Which of the following findings should indicate to the nurse that the therapy has been effective?

Hemoglobin 14.9 g/dL

The nurse should identify that packed RBCs a re administered to clients who have a decreased level of hemoglobin or hematocrit. This h emoglobin level is within the expected reference range of 14 to 18 g/dL for males and 12 to 16 g/dL for females, indicating the therapy has been effective.

A nurse working in a n emergency department is triaging four clients. Which of the following clients should the nurse recommend for treatment first?

A middle adult client who has unstable vital signs.

Using the stable vs unstable approach t o client care, the nurse should recommend priority treatment for the client who has u nstable vital signs because this client requires immediate treatment to reduce the risk of further injury o r possible death.

A nurse is caring for a c lient who has fluid volume overload. Which of the following tasks should the nurse delegate t o the CNA?

Measure the client's daily weight

It is within the CNAs range of function to measure a client's daily weight, so the nurse should delegate this task to them.

A nurse is preparing t o administer mannitol 0.2g/kg IV bolus over 5 min as a test dose to a client who has severe oliguria. The client weighs 198lb. What is t he amount in grams the nurse should administer?

18 g

A nurse is conduction a physical examination for an adolescent and is assessing the range of motion of the legs. W hich of the following images indicates the adolescent is abducting the hip joint?

In the correct image, the adolescent is abduction the hip joint by moving the leg away from the midline of the body.

A nurse is caring for a c lient who has hyperthyroidism. Which of the following findings should the nurse expect?

Tremors

Tremors are a manifestation of hyperthyroidism, along with tachycardia, diaphoresis, weight loss, insomnia, and exophthalmia.

A nurse is assessing a school-aged child who has bacterial meningitis. Which of the following findings should the n urse expect?

Nuchal rigidity

This is a manifestation of bacterial meningitis.

A nurse is assessing a newborn's heart rate. Which of the following actions should the nurse take?

Auscultate the apical pulse at least 1 min.

The nurse should auscultate the apical pulse to obtain an accurate assessment of heart rate and rhythm. Auscultation of a newborn's heart sounds can be difficult because of the rapid rate and the transmission of respiratory sounds.

A nurse is preparing t o assist with a thoracentesis for a client who has pleurisy. The nurse should plan to perform which of the following actions?

Instruct the client to avoid coughing during the procedure.

It is important for the nurse to remind the client to avoid coughing and to lie still during a thoracentesis to avoid puncturing the pleura.

A nurse in the ED is a ssessing a preschooler who has a facial laceration. The nurse should identify which of the f ollowing findings as a potential indication of child sexual abuse?

The child exhibits discomfort while walking.

The nurse should identify this finding as a potential indication of child sexual abuse.

A nurse is preparing t o teach about dietary management to a client who has Crohn's disease and an enteroenteric f istula. Which of the following nutrients should the nurse instruct the client to decrease in their d iet?

Fiber

The nurse should instruct the client to consume a low-fiber diet to reduce diarrhea and inflammation.

A nurse is caring for a c lient who has a prescription for a continuous passive motion (CPM) machine following a total knee arthroplasty. Which of the following actions should the nurse take?

Turn off the CPM machine during mealtime.

This promotes client comfort and dietary intake.

A nurse is preparing t o initiate IV access for an older adult client. Which of the following sites should the nurse select when initiating the IV for the client?

Radial vein of the inner arm.

This site will have adequate subcutaneous t issue.

A nurse is developing a client education program a bout osteoporosis for older adult clients. The nurse should include which of the following variables as a risk factor for osteoporosis?

Sedentary lifestyle.

This is a risk factor for osteoporosis. The nurse should encourage older adult clients to engage in weight-bearing exercises because t hey will promote bone health by increasing calcium and phosphorus levels.

A nurse in an ED is caring for a child who has a fever and fluid-filled vesicles on the trunk and extremities. Which of t he following interventions should the nurse identify as the priority?

Initiate transmission-based precautions

When using the urgent vs nonurgent approach to client care, the nurse should determine that the priority action is to initiate transmission-based precautions for the child. The child most likely has varicella. Therefore, the nurse should isolate the child to prevent the spread of the infection.

A nurse is caring for a c lient who has a clogged percutaneous gastrostomy feeding tube. Which of the following actions should the nurse take first?

Change the position of the client.

When providing client care, the nurse should use the least restrictive intervention first. Therefore, the nurse should reposition the client to remove any kinks in the tube, which can lead to clogging. If this method is unsuccessful, t he nurse should attempt to flush or aspirate the client's tube to remove the clog.

A home health care nurse is developing a teaching plan for a client who has a new ileostomy. Which of the following i nstructions should the nurse include?

Empty the appliance when it is one-third t o one-half full.

The ileostomy pouch should be emptied when it is o ne-third to one-half full to prevent stool leakage and skin irritation.

A nurse is reviewing the laboratory report of a client who has end-stage kidney disease and received hemodialysis 24 yr ago. Which of the following lab values should the nurse report to the provider?

Sodium 148 mEq/L

The nurse should report this sodium level because it is a bove the expected reference range of 136 to 145 mEq/L, indicating hypernatremia. Clients who have kidney disease often retain sodium and require sodium-restricted diets.

A nurse is caring for four clients. Which of the following tasks should the nurse delegate to a CNA?

Arrange the lunch tray for a client who has a hip fracture.

Assisting a client with meals is within the range of function of the CNA.

A nurse is preparing a client for a paracentesis. Which of the following actions should the nurse take?

Instruct the client to void.

The nurse should instruct the client to void prior to the procedure because an empty bladder decreases the risk of a bladder puncture and minimizes the client's discomfort during the procedure.

A nurse has received change of shift report on four assigned clients. For which of the following clients should the nurse intervene to prevent a potential food and medication interaction?

A client who is receiving an MAOI and is requesting a cheeseburger for dinner. This client's food selection contains tyramine. Clients prescribed an MAOI must restrict the intake of foods that contain tyramine due to adverse effects, such as hypertension.

A nurse is planning care for a client who has rheumatoid arthritis and has moderate to severe pain in multiple joints. W hich of the following actions should the nurse plan to take?

Allow for frequent rest periods throughout the day.

The nurse should encourage the client to balance rest with exercise to maintain muscle strength, joint function, and range of motion.

A nurse is caring for a c lient who is receiving continuous bladder irrigation following a transurethral resection of the prostate. The client reports bladder spasms, and the nurse observes a decreased u rinary output. Which of the following action should the nurse take?

Irrigate the catheter with 0.9% sodium chloride irrigation.

Decreased urine output and bladder spasms indicate internal obstruction of the catheter. Therefore, the nurse should irrigate the catheter with 0.9% sodium chloride irrigation and notify the provider if the obstruction does n ot clear.

A nurse is assessing a client who has COPD. Which of the following findings should the nurse expect?

pH 7.31

Respiratory acidosis is an expected finding for a client who has COPD. The expected reference range of pH is 7.35-7.45. A pH level of less than 7.35 indicates acidosis. For a client who has COPD, a decrease in pH w ill be accompanied by an increase in the level of carbon dioxide over the expected reference range of 35 to 45 mm Hg, indicating respiratory acidosis.

A nurse in a community center is providing an educational session to a group of clients about ovarian cancer. Which of the following manifestations of ovarian cancer should the nurse include in the teaching?

Abdominal bloating

The nurse should include the presence of abdominal bloating as an early manifestation of ovarian cancer. Other manifestations include an increase in abdominal girth, pelvic or abdominal pain, early satiety, and urinary frequency or urgency.

A nurse is caring for a c lient who has active TB. Which of the following actions should the nurse plan to take to prevent the transmission of the disease?

Have the client wear a surgical mask while being transported outside the room. This will prevent the transmission of the disease.

A nurse is caring for a g roup of clients. Which of the following clients should the nurse attend to first?

An older adult client who is anxious and attempting to pull out an IV line. This client is at greater risk of injury.

An RN is observing an LPN and a CNA move a client up in bed. For which of the following situations should the nurse intervene?

The LPN and the CNA grasp the client under his arms to lift him up in bed. They should not grasp the client under the arms when lifting, as this can result in shoulder dislocation or other injuries to the client. The RN should intervene and instruct the nurses to use a draw sheet or friction-reducing device to lift the client.

A nurse is preparing t o administer insulin to a client via a pen device. Which of the following actions should the nurse take?

Hold the insulin pen device perpendicular to the client's skin to inject the medication. This ensures the insulin enters the subQ tissue.

A nurse is caring for a c lient who has immunosuppression and a continuous IV infusion. Which of the following actions should the nurse take?

Monitor the client's mouth every 8 hr.

Check for manifestations of infection, such as sores or lesions.

A nurse is providing t eaching about advance directives to a middle-aged adult client. Which of the following client responses indicates an understanding of the teaching?

"I can designate my partner as my health care surrogate."

This statement indicates that the client recognizes that designating a health care surrogate is part of advance directives.

A nurse is assessing a client following a vaginal delivery and notes heavy lochia and a boggy fundus. Which of t he following medications should the nurse expect to administer?

Oxytocin

This is a hormone that stimulates uterine contractions, to decrease vaginal bleeding.

A nurse manager is planning to use a democratic l eadership style with the nurses on the unit. Which of the following a ctions by the nurse manager demonstrates a democratic leadership style?

Seeks input from the other nurses.

This includes members of the team when making decisions and encourages staff members to participate in the decision-making process.

A nurse is assigning t ask roles for a group of clients in a community mental health clinic. Which of the following tasks should the nurse a ssign to the member of the group functioning as the orienteer?

Noting the progress of the group toward assigned goals. This is the task of the orienteer.

A nurse is creating a plan of care for a newly admitted child. Which of the following actions should the nurse include in the plan? See Exhibit button Administer high-dose antibiotic therapy.

Children who have cystic fibrosis metabolize antibiotics more rapidly and require higher doses of antibiotics to help fight aggressive i nfections such as Burkholderia cepacia.

A nurse is caring for a n ewborn immediately after delivery. Which of the following interventions should the nurse implement to prevent heat l oss by conduction?

Use a protective cover on the scale when weighing the infant.

Heat loss by conduction is a loss of heat between the newborn's skin and the cooler surface beneath it.

A nurse is caring for a c lient who had abdominal surgery 24 hr ago. Which of the following actions is the nurse's priority?

Assist with deep breathing and coughing.

The priority action the nurse should take when using the airway, breathing, circulation approach to client care is to assist the client with deep breathing and coughing, which reduces the risk of postop pneumonia.

A nurse in an outpatient mental health clinic is caring for four clients. The nurse should recognize that which o f the following clients is effectively using sublimation as a defense mechanism?

A client who channels their energy into a new hobby following the loss of their job.

Channeling negative feelings over the loss of their job into a new hobby is using the defense mechanism of sublimation.

A nurse is assessing f or correct placement of a client's NG feeding tube prior to administering a bolus feeding. Which o f the following actions should the nurse t ake?

Aspirate contents from the tube and verify the pH level.

The nurse should verify that the pH l evel of the client's gastric aspirate is less than 5 to determine proper placement.

An antepartum nurse i s caring for four clients. For which of the following clients should the nurse initiate seizure precautions?

A client who is at 33 weeks gestation and has severe gestational hypertension. The nurse should initiate seizure precautions for a client who has severe gestational because extremely elevated blood pressure in an antepartum client can trigger seizure activity. The nurse should provide the client with a quiet, darkened environment, place suction equipment and oxygen at the bedside, and position the call light within the client's reach.

A nurse is providing d ischarge teaching to a client who is to receive home oxygen therapy. Which of the following i nstructions should the nurse include in the teaching?

Wear clothing made with cotton fabrics while oxygen is in use.

Woolen and synthetic fabrics can generate static e lectricity, which increases the risk of a fire.

A nurse is providing t eaching for a client who has a fracture of the right fibula with a short-leg cast in place and a n ew prescription for c rutches. The client is non-weight bearing for 6 weeks. Which of the following i nstructions should the nurse include in the teaching?

Use the three-point gait.

This allows the client to be mobile without bearing weight on the affected extremity.

A nurse is preparing t o transfer a client from the ICU to the medical floor. The client was recently weaned from mechanical ventilation following a pneumonectomy. Which of the following information should the n urse include in the change-of-shift report?

The time of the client's last dose of pain medication.

The nurse should recognize than an effective handoff report provides a baseline of the client's status for comparison and should include any recent changes or priority situations affecting the client's condition. The time of the client's last dose of pain meds is important to include so the receiving nurse can anticipate what time to give the next dose.

A nurse is assessing a n infant who has hydrocephalus and is 6 hr postop following placement of a ventriculoperitoneal (VP) shunt. Which of the following findings should the nurse report to the provider?

Irritability when being held.

This is a manifestation of increased intracranial pressure, which is an indication that the VP shunt is malfunctioning. This finding should be reported to the provider immediately.

A nurse is caring for a c lient who has a prescription for chlorpromazine. Which of the following finding should the n urse identify as an indication that the medication is effective?

Decreased hallucinations.

This is an antipsychotic medication administered to decrease hallucinations and other manifestations of schizophrenia.

A nurse is providing t eaching about lithium to a client who has bipolar disorder. Which of the following statements s hould the nurse include in the teaching? “Notify your provider if you experience increased thirst”

Increased thirst is a manifestation of lithium toxicity. The nurse should instruct the client to report increased thirst, vomiting, diarrhea, or tremors to the provider.

A nurse caring for a client who has a fecal impaction. Which of the following actions should the nurse take when digitally evacuating the stool?

Insert a lubricated gloved finger and advance along the rectal wall. This is the correct way of doing this.

A nurse is planning to delegate client care tasks to a CNA. Which of the following tasks should the nurse plan to delegate to the CNA?

Perform gastrostomy feedings through a client’s established gastrostomy tube. This task is within their range of function.

A nurse manager is preparing an educational session for nursing staff about how to provide cost-effective care. Which of the following methods should the nurse include in the teaching?

Delegate non-nursing tasks to ancillary staff.

It is an effective method of providing high-quality, cost-effective care because this will allow additional time for nurses to focus on skilled tasks.

A nurse on an inpatient m ental health unit is monitoring a visit between a client who has a history of aggressive b ehavior and the client’s partner. Which of the following should the nurse identify as an indication of potential violence?

The client is pacing around the chair in which their partner is sitting.

Hyperactivity and pacing indicate that this client is at risk for violent behavior. The nurse should assess the situation further and attempt to de-escalate the situation by speaking to the client in a low, calm voice using short sentences.

A nurse is caring for a c lient who has signed an informed consent form to receive electroconvulsive therapy (ECT). The client states to the nurse, “I’m not sure about this now. I’m afraid it’s too risky.” Which of the following responses s hould the nurse make?

“You have the right to change your mind about this p rocedure at any time.”

The client can refuse to consent at any time for a procedure. The nurse is demonstrating advocacy by respecting the client’s wishes r egarding care.

A rural community health nurse is developing a plan to improve health care delivery for migrant farmworkers. To identify health services d ata for this minority group, the nurse should gather information from which of the following sources?

Agency for Healthcare Research and Quality

The goal of the Agency for Healthcare Research and Quality (AHRQ) is to improve the quality of health care services for all populations, including low-income groups and minorities. This data should help the nurse to develop an evidence-based plan to improve health care services for specific populations.

A nurse is assessing a newborn following a vaginal delivery. Which of the following findings should the nurse report to the provider?

Nasal flaring.

This indicates respiratory distress. Signs are nasal flaring, retractions, and grunting.

A charge nurse is speaking with the partner of a client. The partner states that the client is not receiving adequate care. Which of the following actions should the charge nurse take first to resolve the situation?

Ask the partner to list specific concerns.

The first action the nurse should take u sing the nursing process is to assess the situation by asking the partner to list specific concerns.

A nurse is providing i nformation to a client immediately before his scheduled Romberg test. Which of the following s tatements should the nurse make?

“I will be checking you once with your eyes open and once with them closed.” The Romberg test will be performed once with eyes o pen and once with eyes closed. This is performed to assess balance and motor function.

A nurse is teaching a client who is at 20 weeks of gestation about common discomforts associated with pregnancy. Which of the following statements by the client indicates an understanding of the teaching?

“I will wear a supportive bra overnight.”

Wearing a supportive bra even while sleeping can promote comfort by providing support to enlarged breasts during pregnancy.

A nurse is caring for a c lient who is taking valproic acid for seizure control. For which of the following adverse effects should the nurse monitor and report?

Jaundice.

Monitor the client for jaundice and report any indications to the provider. Clients who take valproic acid are at risk for liver damage, w hich can lead to jaundice.

A nurse is providing d ischarge instructions about newborn care to a client who is postpartum. Which of the following s tatements indicates to the nurse that the client understands the teaching?

“I will cover my baby’s body when I wash her”

“I will use the bulb syringe first in her mouth and then in her nose”

Newborns are highly susceptible to heat loss. The client should wrap the newborn in a towel when washing the hair to minimize heat loss.

The client should suction the newborn’s mouth first to remove secretions that the newborn could aspirate when suctioning the nares.

A nurse on a mental h ealth unit is conducting a mental status e xamination (MSE) on a newly admitted client. Which o f the following components of the MSE is the priority for the nurse to assess?

Ideas of self-harm.

The greatest risk to this client is injury from ideas of self-harm. The priority assessment the nurse should make is to determine whether the client has had suicidal or homicidal ideas.

A nurse is preparing t o administer lactated Ringer’s 1500 mL to infuse at 50 mL/hr. The drop factor of the manual I V tubing is 15 gtt/min. The nurse should set the manual IV infusion to deliver how many g tt/min? 13 gtt/min

A nurse is providing t eaching to a client who has a new diagnosis of type 1 diabetes mellitus. The nurse should i nstruct the client to monitor for which of the following findings as a manifestation of hypoglycemia?

Irritability

The nurse should instruct the client to monitor for irritability, which can indicate decreased blood glucose levels.

A nurse is providing t eaching to a client who is scheduled for ECT. The nurse should inform the client that which of the following is an adverse effect of ECT?

Short-term memory loss

This is a common adverse effect of ECT.

A charge nurse notices t hat one of the nurses on the shift frequently violates unit policies by taking an extended amount of time for a break. Which of the following statements should the charge nurse make t o address this conflict?

"I would like to talk to you about the unit policies r egarding break time."

The charge nurse is dealing with the conflict i n a cooperative, positive manner by using this statement to open the conversation in a nonthreatening way. The focus is on the length of the break time and is not a personal affront.

A nurse in an emergency department is caring for a client who is at 9 weeks of gestation and reports nausea and v omiting for the past 2 days. Which of the following findings should the nurse expect?

Urine specific gravity 1.052

The nurse should recognize this urine specific gravity is significantly elevated above the expected reference range of 1.005 to 1.030. An increased urine specific gravity indicates dehydration from vomiting.

A nurse is caring for an o lder adult client who is experiencing chronic anorexia and is receiving enteral tube feedings. Which of the following laboratory values indicates that the client needs additional nutrients a dded to the feeding?

Albumin 2.8 g/dL

The nurse should recognize that an albumin level of less than 3.5 g/dL indicates malnutrition and a need for additional nutritional supplementation. The expected reference range for albumin is 3.5 to 5 g/dL.

A nurse is conducting g roup therapy with clients who have breast cancer. The nurse should recognize which of t he following statements by a client as an example of altruism?

"I told my doctor that I would like to start a support group for other women who are sick in my community."

This statement indicates that the client is demonstrating altruism by reaching out and helping others.

A nurse is providing d ietary teaching to a client who has a new prescription for phenelzine. Which of the following f ood recommendations should the nurse make?

Broccoli, yogurt, cream cheese

Clients taking an MAOI should not eat foods that contain tyramine. Fermented meat such as pepperoni and bologna are high in tyramine.

A nurse is assessing a client for compartment syndrome. Which of the following findings should the nurse expect?

Edema

Compartment syndrome causes increased pain, pallor, a nd paresthesias from increased edema in the compartment involved.

A nurse is providing d ischarge teaching about disease management for a client who has a new diagnosis of type 1 diabetes mellitus. Which of the following activities is the nurse's priority?

Ensure that the client understands the medication regimen.

The priority action the nurse should take when using the safety vs risk reduction approach to client care is to ensure the client understands the medication regimen. The greatest risk to the client is the potential to develop hypoglycemia or hyperglycemia, which can be life-threatening if treated incorrectly.

A nurse at an urgent c are clinic is assessing a client who reports impaired vision in one eye. Which of the following r eports by the client should indicate to the nurse that the client has a detached retina?

Floating dark spots

These are a manifestation of a detached retina due to bulges, folds, or holes in the affected retina.

A nurse on a med-surg u nit is assessing a client who has had a stroke. For which of the following findings should the nurse initiate a referral for occupational therapy?

Difficulty performing ADLs

A referral for occupational therapy to teach the client the skills necessary to become independent in performing ADLs such as bathing, dressing, and eating.

A nurse is assessing a client following a colonoscopy. Which of the following findings should indicate to the nurse t hat the client is hemorrhaging?

Rapid decrease in blood pressure

This is an indication of hemorrhage.

A nurse is caring for a c lient who recently signed an informed consent form to donate a kidney to her sibling who had end-stage kidney d isease. The donor states to the nurse, "I don't want my brother to die, but what if I need this kidney one day?" Which of the following responses should the nurse make?

"You're afraid that your other kidney will fail at some point after the organ donation?" The nurse is restating the client's statement, w hich lets the client know that the nurse is listening and paying attention to what the client is communicating.

A nurse is assessing a client who has pulmonary edema. Which of the following findings should the nurse expect?

Pink, frothy sputum

A client who has manifestations of pulmonary edema can have pink, frothy sputum due to fluid leaking across the pulmonary c apillaries and into the lung tissue.

A nurse administers an incorrect dose of medication to a client. The nurse recognizes the error immediately and completes an incident r eport. Which of the following facts related to the incident should the n urse document in the client's medical record?

Time the medication was given

The nurse should document the time, the name of the med, the dose, and the route in which the med was given on the client's MAR immediately after it was administered. The nurse should also document the time that the incorrect med was administered to the client in the incident report, as this is a fact directly related to the occurrence.

A nurse is caring for a c lient who is post-op after receiving moderate (conscious) sedation. The client suddenly becomes restless and reports f eeling lightheaded. Which of the following actions should the nurse take?

Check the client's oxygen saturation level.

Restlessness and lightheadedness are indications of hypoxia. The nurse should check the client's oxygen saturation level.

A nurse in an ED is assessing a school-aged child who was brought in by their p arents and has scald burns to both hands and wrists. The nurse suspects physical abuse. Which of the following actions should the nurse take?

Contact Child Protective Services

The nurse has a legal responsibility to report suspected physical abuse to Child Protective Services.

A nurse is caring for a 2-month-old infant who has Hirschsprung disease (HD). Which of the following areas should t he nurse assess for manifestations of HD?

The nurse should assess the infant's abdomen for distention and visible peristalsis, which are manifestations of HD.

A nurse is admitting a client to the psychiatric unit after attempting suicide. The client states, "My family does not care whether I live or die." Which of the following responses should the nurse make?

"How does this make you feel?"

This response encourages the client to evaluate their feelings.

A nurse is providing d ischarge teaching for the parents of a preschool-age child who has a new prescription for amoxicillin/clavulanate suspension. Which of the following instructions should the nurse include in the teaching?

Shake the medication bottle well before each dose is given.

Store the medication in the refrigerator
Report diarrhea to the provider immediately

A nurse on a med surg unit is caring for a client who has a new diagnosis of terminal cancer. The client tells the nurse that they would like to go home to be with family and loved ones. Which of the following a ctions should the nurse take?

Make a referral for social services
As a client advocate, the nurse should support the client's decisions and obtain a referral for social services to ensure that the client's needs a t home are met. Social services can set up home care or hospice care services for the client i f needed.

A nurse is assessing a client who has a chest tube. Which of the following findings should the nurse expect?

Occlusive dressing on the insertion site.
This prevents air from leaking and is an expected finding.

A nurse is preparing t o transfer a client who has had a stroke to a rehabilitation facility. The client's family tells the n urse they are concerned about the level of care the client will receive. Which of the following a ctions should the nurse take?

Facilitate an interdisciplinary conference at the new facility for the family.
This will address the family's concerns about providing optimal care for the client.

A nurse is assessing a client who has major depressive disorder and is taking amitriptyline. Which of the following s hould the nurse identify as an adverse effect of the medication?

Blurred vision
This is an adverse effect of amitriptyline and the provider should be notified.

A charge nurse is providing an educational session about infection control for a group of staff nurses. Which of the following statements b y one of the staff nurses indicates an understanding of isolation precautions?

"A client who requires airborne precautions should be placed in a negative-pressure airflow room."
Airborne precautions require a negative-pressure airflow room that has at least 6-12 air exchanges each hour using a HEPA filtration system.

A nurse is preparing t o administer a blood transfusion to a client. Which of the following procedures should t he nurse follow to ensure proper client identification?

Verify the client and blood product information with another licensed nurse.

The nurse should compare the blood product label against the medical record and the client's identification number with another nurse to ensure the correct blood product is administered to the correct client.

A nurse in a mental h ealth clinic is assessing a client who h as a history of seeking counseling for relationship problems. The client shows the nurse multiple superficial self-inflicted lacerations on their f orearms. The nurse should identify these behaviors as characteristics of which of the following personality disorders?

Borderline

The nurse should identify that clients who have borderline personality disorder tend to be emotionally unstable, have troubled interpersonal relationships, and often engage in harmful behaviors such as cutting, substance use, and suicidal ideation.

A nurse is caring for a c lient who has type 1 diabetes mellitus and reports severe ankle pain after falling off a step stool at home. Which of the following prescriptions should the nurse clarify with the provider?

Apply a cold pack to the client's ankle for 30 min/hr

The nurse should clarify a prescription for a cold pack to the client's ankle because type 1 diabetes mellitus is a contradiction for receiving cold therapy. A client who has type 1 diabetes mellitus can have impaired circulation due to arteriosclerosis and a loss of sensory perception due to neuropathy. Ice can further impair circulation.

A nurse is teaching a bout adverse effects with a client who is s tarting to take captopril. Which of the following findings should the nurse identify a s an adverse effect of the medication to report to the provider?

Cough

This is due to the buildup of bradykinin in the lungs. The client should report this to the provider.

A nurse is reviewing the ABG values of a client. The client has a pH of 7.2, $PaCO_2$ of 60 mm Hg. and HCO_3 of 25 mEq/L. The nurse should identify that the client has which of the following acid-base imbalances?

Respiratory acidosis

A client who has respiratory acidosis will have decreased pH below the expected reference range of 7.35-7.45, an increased $PaCO_2$ above the expected reference range of 35-45 mm Hg, and an HCO_3 within the expected reference range of 22-26 mEq/L.

A nurse in a provider's office is assessing an adolescent who has been taking ibuprofen for 6 months to treat juvenile i diopathic arthritis. Which of the following questions should the nurse ask to assess for an a dverse effect of this med?

"Have you had any stomach pain or bloody stools?"

These are an indication of gastrointestinal bleeding, an adverse effect of ibuprofen.

A nurse in a pediatric unit has received a change-of-shift report for four children. Which of the following children should the nurse assess first?

A 10-year-old child who is awaiting surgery f or an appendectomy and experienced sudden relief from pain.

Using the urgent vs nonurgent approach to client care, the nurse should determine that the client to assess first is the child awaiting an appendectomy who suddenly experiences pain relief as this can be an i ndication of peritonitis from a ruptured appendix. The nurse should notify the provider immediately.

A nurse on an inpatient u nit is caring for a client who has schizophrenia and recently started taking risperidone. Which of the following actions should the nurse take?

Implement fall precautions for the client.

Risperidone can cause orthostatic hypotension and dizziness, which can lead to falls. The nurse should initiate fall precautions for the client.

A nurse is assessing a client who has decreased visual acuity due to cataracts. The nurse should identify which o f the following physiological changes is the cause of the client's visual loss?

Increased opacity of the lens

A cataract is a cloudy or opaque area in the lens o f the eye that inhibits light penetration.

A nurse is caring for a c lient following a vacuum-assisted birth. The nurse should monitor the client for which of the following complications related to vacuum-assisted birth?

Cervical laceration

Complications are perineal, vaginal, or cervical lacerations.

A nurse is updating the plan of care for a client who is 48 hr. post-op following a laryngectomy and is unable to speak. W hich of the following actions should the nurse plan to take first?

Determine the client's reading skills

Using the nursing process to assess the client, determine the client's level of reading skills and cognition. The nurse can best provide the client with a variety of customized techniques to practice and use after verbal skills are lost.

A nurse is caring for a s chool-aged child who has dehydration and is receiving an oral rehydration solution. Which of the following lab results indicates that the treatment regimen is effective?

Serum sodium 138 mEq/L

Sodium level of 138 mEq/L, is within the expected reference range of 136-145 mEq/L and is an indication that the child is responding to the oral rehydration solution.

A school nurse is notified of an emergency in which several children were injured following the collapse of playground e quipment. Upon arrival at the playground, which of the following actions should the nurse take f irst?

Survey the scene for potential hazards to staff and children.

Using the nursing process, assess the situation. By s urveying the scene, the nurse can identify potential hazards to staff and children. These findings allow the nurse and staff to enter the scene and safely provide care to injured children and help decrease the risk of further injury.

A nurse in an ED is caring for a client who is unconscious and requires emergency medical procedures. The nurse is unable to locate members of the client's family to obtain consent. Which of the following a ctions should the nurse take?

Proceed with provision for medical care.

When a client is unable to give informed consent in an emergency, health care personnel can proceed with necessary life-saving care because the law considers this implied consent.

A nurse is caring for a s chool-aged child who is taking valproic acid. The nurse should expect the provider to order w hich of the following diagnostic tests?

Serum liver enzyme levels.

Valproic acid can cause hepatic toxicity. The nurse should expect the provider to prescribe lab tests to assess the child's liver function prior to and periodically during therapy.

A nurse manager is preparing to teach a group of newly licensed nurses about effective time management. Which o f the following steps of the time management process should the nurse manager include as t he priority?

Making a list of activities to complete.

According to evidence-based practice, p lanning is the most important step in managing time effectively. The nurse manager should include making a list of activities to complete as the priority. Other planning activities include setting goals, establishing priorities, and scheduling activities.

A nurse is caring for a c lient who has a pulmonary embolism. The client is receiving heparin via continuous IV infusion at 1200 units/hr and warfarin 5 mg PO daily. The morning lab values for the client are aPTT 98 seconds and INR 1.8. Which of the following actions should the nurse take?

Withhold the heparin infusion.

The expected value for aPTT is 40 seconds. A therapeutic level of heparin increases the aPTT by a factor of 1.5-2, making the aPTT 60-80 seconds. An aPTT level of 98 is above the expected reference range, indicating that the dosage should be reduced, or the infusion withheld until the aPTT returns to the therapeutic range.

A nurse is providing t eaching to a school-age child who has asthma about using an albuterol metered-dose inhaler. W hich of the following instructions should the nurse include?

Take the medication 15 mins before playing sports.

Take 5-20 min prior to exercise to promote bronchodilation. The meds effects begin immediately, peak in 30-60 min, and can last for up to 5 hr.

A home health nurse is evaluating a school aged child who has cystic fibrosis. The nurse should initiate a request for a h igh-frequency chest compression vest in response to which of the following parent statements?

“My child has only a small amount of mucus after percussion therapy.”

The nurse should recommend a high-frequency chest compression vest for a child who has inadequate results from other airway clearance therapy techniques. Older children often require other techniques in addition to percussion and postural drainage to achieve adequate mucus expectoration.

A nurse is planning care for a patient who is receiving chemotherapy and has neutropenia. Which of the following i nterventions should the nurse include in the plan?

Avoid including raw fruits in the client’s diet. This

reduces the risk of bacterial infections.

A nurse is caring for a c lient who is in the fourth stage of labor and is receiving oxytocin via continuous IV infusion. W hich of the following assessments is the nurse’s priority?

Amount of vaginal bleeding.

The first action the nurse should take u sing the nursing process is assessing the amount of vaginal bleeding. A client who is in the f ourth stage of labor is at risk for hemorrhage, so assessing the amount of vaginal bleeding is the nurse’s priority.

A nurse is caring for a c lient who is in the resuscitation phase of burn injury. Which of the following findings should the nurse expect?

Hyponatremia

The nurse should expect a decrease i n sodium levels because sodium is drawn to the edematous burn areas and lost through plasma leakage.

A nurse is teaching a client who has a new prescription for total parenteral nutrition through a central line. Which of t he following information should the nurse include in the teaching?

“I will need to measure your weight daily.”

The nurse should instruct the client that daily w eight measurement is a necessary part of administering nutrition through a central l ine to avoid fluid overload and monitor for adequate weight gain.

A nurse is assessing a client who has bipolar disorder. Which of the following alterations in speech is the client u sing?

Flight of ideas.

Flight of ideas is an alteration in speech in which the speaker talks continuously with sudden, frequent topic changes.

A home health nurse is caring for a group of older adult clients. The nurse should initiate a referral to the Program o f All-Inclusive Care for the Elderly (PACE) for which of the following clients?

A client whose caregiver requests adult daycare services.

The nurse should initiate a referral for PACE for this client because PACE provides adult day care services along with in-home assessments and supportive services.

A nurse at a mental h ealth clinic is caring for four clients. The nurse should recognize that which of the following clients i s using dissociation as a defense mechanism?

A client who was abused as a child describes the abuse as if it happened to someone else.

The nurse should identify that this client i s using the defense mechanism of dissociation because they are separating painful events from t he conscious mind and describing the events as if they happened to another person.

A nurse is caring for a c lient who has active pulmonary tuberculosis. Which of the following actions should the nurse take?

Assign the client to a private room with negative air pressure.

To control the spread of active TB, the nurse should assign the client to a private room with negative air pressure.

A nurse is providing t eaching to a client who is at 24 weeks of gestation and is scheduled for a 3 hr oral glucose tolerance test. Which of the following instructions should the nurse include in the teaching?

“You will need to fast the night before the test.”

The nurse should instruct the client that they w ill need to fast the night before the test to prevent inaccurate test results.

A nurse is providing e ducation to the parent of a school-age child who has asthma. Which of the following statements b y the parent indicates an understanding of the teaching?

“I will make sure my child receives a yearly influenza i mmunization.”

Children who have asthma should be immunized and protected from infections. The nurse should educate the parent to ensure the child receives a yearly influenza immunization.

A nurse is caring for a c lient who is receiving a continuous heparin infusion. Which of the following lab tests should the nurse review p rior to adjusting the client's heparin?

aPTT

Prior to adjusting the client's continuous heparin infusion, the nurse should review the client's activated partial thromboplastin (aPTT). T he expected reference range for the aPTT is 40 secs. Clients who are receiving continuous h eparin therapy should have an aPTT of 60-80 secs, which is 1.5-2 times the expected aPTT level. The nurse should increase or decrease the heparin infusion according to this value.

A nurse is assessing a client who is taking propranolol. Which of the following findings should indicate to the nurse t hat this client is experiencing an adverse r eaction to propranolol?

Wheezing

The nurse should recognize that wheezing can indicate the client is experiencing an adverse reaction to the med.

A client is receiving IV fluids at 150 m L/hr. Which of the following findings i ndicates that the client is experiencing f luid overload?

Dyspnea

The nurse should recognize that dyspnea indicates t he client could be experiencing fluid overload. Fluid overload can lead to the backup of fluid in the pulmonary system resulting in shortness of breath.

A nurse is assessing a client whose partner recently died. The client states, "I don't know what to do without my partner. Life is just not worth living." Which of the following responses should the nurse make?

"You seem to be having a difficult time right now."

This statement makes an observation, which is a therapeutic response by the nurse. It encourages the client to express their thoughts and feelings.

A nurse must recommend clients for discharge in order to make room for several critically injured clients from a local disaster. Which of the following clients should the nurse recommend discharge?

A client who has cellulitis and is receiving oral antibiotics every 8 hr. This client can safely continue this treatment at h ome.

A nurse is performing an admission assessment on a client who had a recent positive pregnancy test. The f irst day of her last menstrual period (LMP) was May 8. According to

Nagele's rule, which of the following dates should the nurse document as the client's estimated date of birth (EDB)?

February 15.

Add 7 days to the first day of the client's LMP and then subtract 3 months.

A nurse is providing t eaching about home care to the parents of a child who has autism spectrum disorder. Which of the following instructions should the nurse include? Use a rewards system to modify the child's behavior.

Children who have autism spectrum disorder respond well to a reward system, which can provide structure and expectations for behavior.

A nurse in a provider's office is caring for an 18-month-old toddler who has a blood level of 3 mcg/dL. Which of the following actions should the nurse take?

Recommend rescreening in 1 year.

This level is within the expected reference range.

A nurse is caring for a c lient who has cancer and is deciding between two treatment plans. The client asks the nurse for assistance in making the decision. Which of the following responses should the nurse make?

"Tell me more about your understanding of the options."

This is therapeutic because it is offering a general lead that facilitates communication between the nurse and the client and will help the nurse to explore the client's feelings about the treatment options.

A nurse is caring for a c lient who has a new prescription for clonidine. The nurse should inform the client that which o f the following findings is an adverse effect of this med?

Dry mouth.

Clonidine is an indirect-acting antiadrenergic agent used for HTN, severe pain, and ADD.

The nurse should inform the client that dry m outh, or xerostomia, is a common adverse effect of this med.

A nurse is creating a plan of care for a client who has left-sided weakness following a stroke. Which of the following i nterventions should the nurse include in the plan?

Support the client's left arm on a pillow while sitting.

This prevents the extremity from hanging freely because this can cause shoulder subluxation.

A nurse is caring for a c lient who has acute blood loss following a trauma. The client refuses a blood transfusion that m ight potentially save their life. Which of the following actions should the nurse take first?

Explore the client's reasons for refusing the treatment.

This is assessment. The nurse should gather more data regarding the client's decision to refuse the blood transfusion.

A nurse is performing an abdominal assessment on a client. Identify the sequence of actions the nurse should take.

Inspection, auscultation, percussion, palpation

Inspect to assess skin integrity and symmetry. Auscultate. Percuss for tympany, dullness, absence or flatness of resonance. P alpate for tenderness, pain, or the presence of a mass.

A nurse is providing t eaching to the guardians of a newborn about measures to prevent sudden infant death syndrome (SIDS). Which of the following guardian statements indicates an understanding of the teaching?

"I will not allow anyone to smoke near my baby."

Research indicates a strong correlation between exposure to cigarette smoke and the occurrence of SIDS.

A nurse is preparing a sterile field to perform a sterile dressing change. Which of the following interventions should the nurse use to maintain surgical aseptic t echnique?

Maintain sterile objects with the line of vision.

Objects out of the line of vision are not considered sterile. Keep sterile items at least 1 inch (2.5cm) away from the border of a sterile drape. Hold gloved hands away from the body and above waist level to prevent contamination.

A nurse is caring for a c lient who has a magnesium level of 2.7 mEq/L. Which of the following interventions should the nurse plan to take?

Initiate continuous cardiac monitoring.

This client is at risk for cardiac dysrhythmias a nd cardiac arrest.

A nurse is assessing a client who is at 11 weeks of gestation and reports drinking ginger tea. Which of the following f indings indicates the client's use of ginger tea is effective?

The client reports a decrease in episodes of nausea.

The client can also use ginger ale and ginger snaps to alleviate nausea associated with pregnancy.

A nurse is caring for a c lient who has a deep vein thrombosis. Which of the following actions should the nurse take?

Instruct the client to elevate the affected extremity when sitting. Reduce edema and facilitate venous r eturn.

A nurse is preparing t o replace a client's transdermal fentanyl patch after 72 hours of use. After the nurse opens the packet containing the new patch, the client declines to accept it. Which of the following actions should the nurse take?

Ask another nurse to witness the disposal of the new patch.

Place the med in a secure receptacle, according to agency policy, when disposing of any unused portion of a controlled substance.

A nurse is assessing a n older adult client who has pneumonia. Which of the following findings should the nurse expect?

Acute confusion.

Will have acute confusion, fatigue, lethargy, and anorexia.

A nurse is providing c lient teaching about the basal body temp method of birth control. Which of the following information should the nurse include in the teaching?

"Your body temp might decrease slightly just prior to ovulation."

A decrease of 1° F commonly occurs immediately p rior to ovulation.

A nurse manager in a long term facility is having difficulty with staffing for weekend shifts and is planning to implement some changes to the scheduling procedure. Which of the following actions should the nurse manager take first?

Form a committee of staff members to investigate current staffing issues.

Assess the staffing issue. The first stage o f change is the "unfreezing stage," in which information is gathered about the problem. The first action the nurse manager should take is to form a committee to investigate the problem.

A nurse is preparing t o administer an IM injection to a client who is obese. Which of the following actions should the nurse plan to take?

Use the ventrogluteal site.

It has a thick area of muscle and contains no large nerves or blood vessels.

A hospice nurse is consulting with a client and her family about receiving home services. Which of the following statements should the nurse i dentify as an indication that the family understands home hospice care?

"We can expect the hospice nurse to provide support for us after our mother's death."

Hospice care includes bereavement services a fter a family member's death.

A nurse is caring for a c lient who is receiving positive end-expiratory pressure (PEEP) via mechanical ventilation. T he nurse should monitor the client for which of the following adverse effects of PEEP?

Tension pneumothorax

The nurse should identify that tension pneumothorax is a possible adverse effect of PEEP. The nurse should monitor the client's l ung sounds hourly for indications of a tension pneumothorax, such as tracheal deviation, absent breath sounds, and distended neck veins.

A nurse manager is reviewing the client's r ights with the nurses on the unit. The nurse manager should tell the nurses that informed consent promotes which of the following ethical principles?
Autonomy

Autonomy refers to a client's ability to make their own decisions about treatment. Informed consent promotes autonomy by providing clients with complete information about treatment.

A nurse preceptor is evaluating the performance of a newly l icensed nurse. Which of the following actions by the n ewly licensed nurse requires intervention by the preceptor?
Starts a task then determine what supplies a re needed.

The preceptor should intervene and instruct the newly licensed nurse to gather supplies before performing client tasks to practice effective time management.

A nurse manager is preparing an educational session about advocacy for a group of nurses. The nurse manager s hould include which of the following i nformation in the teaching?

Advocacy is a leadership role that helps others to self-actualize.
The nurse manager should teach that advocacy is a leadership role that can help others to grow personally and professionally through self-actualization.

A nurse is admitting a client who has pneumonia. The nurse should initiate which of the following isolation precautions for the client?

Droplet
The nurse should initiate droplet precautions for this client by placing the client in a private room and wearing a surgical mask when caring for the client. Pneumonia is transmitted by droplet particles.

A nurse has just received change of shift report on four clients. Which of the following clients should the nurse assess first?

A client who is postoperative with abdominal distention and no bowel sounds.
Using the acute vs chronic approach to client care, the nurse should first assess the client who is postoperative with abdominal distention and no bowel sounds because these manifestations are an indication of paralytic i leus.

During a change of shift report, a night shift nurse informs the day shift nurse that a newly admitted client was d isoriented and combative during the night. Which of the following actions should the day shift nurse take?

Move the client to a room near the nurses' station.

The day shift nurse should move the client to a room near the nurses' station to enhance the staff's ability to keep the client under frequent observation.

A nurse is reviewing the laboratory results of a toddler who has hemophilia A. Which of the aPTT values should the nurse expect?

45 seconds

This value is above the expected reference r ange of 30-40 seconds and indicates a risk for spontaneous bleeding, which is a manifestation of hemophilia A.

A nurse is planning care for a client who has rheumatoid arthritis. Which of the following interventions should the nurse include in the plan?

Increase the client's dietary iron intake.

Clients who have rheumatoid arthritis require foods h igh in protein, vitamins, and iron to promote tissue repair. The nurse should encourage the client to increase their intake of dietary iron.

A nurse is an outpatient mental health facility i s assessing a child who has autism spectrum disorder. Which of t he following manifestations should the nurse expect?

Strict adherence to routines

The nurse should identify that a child who has autism spectrum disorder can exhibit strict adherence to routines or rituals, a fixation to specific objects, and resistance to change.

A nurse is caring for a c lient who had a stroke 6 hr ago. Which of the following interventions should the nurse implement to reduce the risk of increased intracranial pressure (ICP)?

Place the client in a quiet environment.

The nurse should keep the client's environment quiet to minimize the risk of increasing ICP.