Herzing University -NU 216 FINAL EXAMS 1 & 2: Revised and Updated All Answers Are correct.

written by

Congratulations

3. A patient is diagnosed with heart failure after being admitted to the hospital for shortness of breath and fatigue. Which teaching strategy, if implemented by the nurse, is **most** likely to be effective?

a. Assure the patient that the nurse is an expert on management of heart failure.

b. Teach the patient at each meal about the amounts of sodium in various foods.

c. Discuss the importance of medication control in maintenance of long-term health.

d. Refer the patient to a home health nurse for instructions on diet and fluid restrictions.

ANS: B

4. A patient who was admitted to the hospital with hyperglycemia and newly diagnosed diabetes mellitus is scheduled for discharge the second day after admission. When implementing patient teaching, what is the **priority** action for the nurse?

a. Instruct about the increased risk for cardiovascular disease.

b. Provide detailed information about dietary control of glucose.

c. Teach glucose self-monitoring and medication administration.

d. Give information about the effects of exercise on glucose control.

ANS: C

5. A patient states, “I told my husband I wouldn’t buy as much prepared food snacks, so I will go the grocery store to buy fresh fruit, vegetables, and whole grains.” When using the Transtheoretical Model of Health Behavior Change, the nurse identifies that this patient is in which stage of change?

a. Preparation

b. Termination

c. Maintenance

d. Contemplation

ANS: A

6. While admitting a patient to the medical unit, the nurse determines that the patient is hard of hearing. How should the nurse use this information to plan teaching and learning strategies?

a. Motivation and readiness to learn will be affected.

b. The family must be included in the teaching process.

c. The patient will have problems understanding information.

d. Written materials should be provided with verbal instructions.

ANS: D

7. A patient who is morbidly obese states, “I’ve recently made some changes in my life. I’ve decreased my fat intake and I’ve stopped smoking.” Which statement, if made by the nurse, is the **best** initial response?

a. "Although those are important, it is essential that you make other changes, too."

b. "Are you having any difficulty in maintaining the changes you have already made?"

c. "Which additional changes in your lifestyle would you like to implement at this time?"

d. "You have already accomplished changes that are important for the health of your heart."

ANS: D

8. The nurse is planning a teaching session with a patient newly diagnosed with migraine headaches. To assess a patient's readiness to learn, which question should the nurse ask?

a. "What kind of work and leisure activities do you do?"

b. **"What information do you think you need right now?"**

c. "Can you describe the types of activities that help you learn new information?"

d. "Do you have any religious beliefs that are inconsistent with the planned treatment?"

ANS: B

10. A patient with diabetic neuropathy requires teaching about foot care. Which learning goal should the nurse include in the teaching plan?

a. The nurse will demonstrate the proper technique for trimming toenails.

b. **The patient will list three ways to protect the feet from injury by discharge.**

c. The nurse will instruct the patient on appropriate foot care before discharge.

d. The patient will understand the rationale for proper foot care after instruction.

ANS: B

12. The nurse and the patient who is diagnosed with hypertension develop this goal: "The patient will select a 2-gram sodium diet from the hospital menu for the next 3 days." Which evaluation method will be **best** for the nurse to use when determining whether teaching was effective?

a. Have the patient list substitutes for favorite foods that are high in sodium.

b. Check the sodium content of the patient's menu choices over the next 3 days.

c. Ask the patient to identify which foods on the hospital menus are high in sodium.

d. Compare the patient's sodium intake before and after the teaching was implemented.

ANS: B

14. The hospital nurse implements a teaching plan to assist an older patient who lives alone to independently accomplish daily activities. How would the nurse **best** evaluate the patient's long-term response to the teaching?

a. Make a referral to the home health nursing department for home visits.

b. Have the patient demonstrate the learned skills at the end of the teaching session.

c. Arrange a physical therapy visit before the patient is discharged from the hospital.

d. Check the patient's ability to bathe and get dressed without any assistance the next day.

ANS: A

15. A patient who smokes a pack of cigarettes per day tells the nurse, "I enjoy smoking and have no plans to quit." Which nursing diagnosis is **most**appropriate?

a. Health seeking behaviors related to cigarette use

b. Ineffective health maintenance related to tobacco use

c. Readiness for enhanced self-health management related to smoking

d. Deficient knowledge related to long-term effects of cigarette smoking

ANS: B

18. The nurse plans to teach a patient and the caregiver how to manage high blood pressure (BP). Which action should the nurse take **first**?

a. Give written information about hypertension to the patient and caregiver.

b. Have the dietitian meet with the patient and caregiver to discuss a low sodium diet.

c. Teach the caregiver how to take the patient's BP using a manual blood pressure cuff.

d. Ask the patient and caregiver to select information from a list of high BP teaching topics.

ANS: D

1. The nurse plans to provide instructions about diabetes to a patient who has a low literacy level. Which teaching strategies should the nurse use (*select all that apply*)?

a. Discourage use of the Internet as a source of health information.

b. Avoid asking the patient about reading abilities and level of education.

c. Provide illustrations and photographs showing various types of insulin.

d. Schedule one-to-one teaching sessions to practice insulin administration.

e. Obtain CDs and DVDs that illustrate how to perform blood glucose testing.

ANS: C, D, E

Chapter 5: Chronic Illness and Older Adults

1. When caring for an older patient with hypertension who has been hospitalized after a transient ischemic (TIA), which topic is the **most** important for the nurse to include in the discharge teaching?

a. Effect of atherosclerosis on blood vessels

b. Mechanism of action of anticoagulant drug therapy

c. Symptoms indicating that the patient should contact the health care provider

d. Impact of the patient's family history on likelihood of developing a serious stroke

ANS: C

2. The nurse performs a comprehensive geriatric assessment of a patient who is being assessed for admission to an assisted living facility. Which question is the **most** important for the nurse to ask?

a. "Have you had any recent infections?"

b. "How frequently do you see a doctor?"

c. "Do you have a history of heart disease?"

d. "Are you able to prepare your own meals?"

ANS: D

5. An older patient is hospitalized with pneumonia. Which intervention should the nurse implement to provide optimal care for this patient?

a. Use a standardized geriatric nursing care plan.

b. Minimize activity level during hospitalization.

c. Plan for transfer to a long-term care facility upon discharge.

d. Consider the preadmission functional abilities when setting patient goals.

ANS: D

6. The nurse cares for an older adult patient who lives in a rural area. Which intervention should the nurse plan to implement to **best** meet this patient's needs?

a. Suggest that the patient move to an urban area.

b. Assess the patient for chronic diseases that are unique to rural areas.

c. Ensure transportation to appointments with the health care provider.

d. Obtain adequate medications for the patient to last for 4 to 6 months.

ANS: C

7. Which nursing action will be **most** helpful in decreasing the risk for drug-drug interactions in an older adult?

a. Teach the patient to have all prescriptions filled at the same pharmacy.

b. Instruct the patient to avoid taking over-the-counter (OTC) medications.

c. Make a schedule for the patient as a reminder of when to take each medication.

d. Have the patient bring all medications, supplements, and herbs to each appointment.

ANS: D

10. The nurse admits an acutely ill, older patient to the hospital. Which action should the nurse take **first**?

a. Speak slowly and loudly while facing the patient.

b. Obtain a detailed medical history from the patient.

c. Perform the physical assessment before interviewing the patient.

d. Ask a family member to go home and retrieve the patient's cane.

ANS: C

11. The nurse cares for an alert, homeless older adult patient who was admitted to the hospital with a chronic foot infection. Which intervention is the**most** appropriate for the nurse to include in the discharge plan for this patient?

a. Refer the patient to social services for further assessment.

b. Teach the patient how to assess and care for the foot infection.

c. Schedule the patient to return to outpatient services for foot care.

d. Give the patient written information about shelters and meal sites.

ANS: A

14. Which statement, if made by an older adult patient, would be of **most** concern to the nurse?

a. "I prefer to manage my life without much help from other people."

b. "I take three different medications for my heart and joint problems."

c. "I don't go on daily walks anymore since I had pneumonia 3 months ago."

d. "I set up my medications in a marked pillbox so I don't forget to take them."

ANS: C

19. The family of an older patient with chronic health problems and increasing weakness is considering placement in a long-term care (LTC) facility. Which action by the nurse will be **most** helpful in assisting the patient to make this transition?

a. Have the family select a LTC facility that is relatively new.

b. Obtain the patient's input about the choice of a LTC facility.

c. Ask that the patient be placed in a private room at the facility.

d. Explain the reasons for the need to live in LTC to the patient.

ANS: B

20. The nurse manages the care of older adults in an adult health day care center. Which action can the nurse delegate to unlicensed assistive personnel (UAP)?

a. Obtain information about food and medication allergies from patients.

b. Take blood pressures daily and document in individual patient records.

c. Choose social activities based on the individual patient needs and desires.

d. Teach family members how to cope with patients who are cognitively impaired.

ANS: B

MULTIPLE RESPONSE

1. Which nursing actions will the nurse take to assess for possible malnutrition in an older adult patient (*select all that apply*)?

a. Observe for depression.

b. Review laboratory results.

c. Assess teeth and oral mucosa.

d. Ask about transportation needs.

e. Determine food likes and dislikes.

ANS: A, B, C, D

1. The nurse assesses a patient's surgical wound on the first postoperative day and notes redness and warmth around the incision. Which action by the nurse is **most** appropriate?

a. Obtain wound cultures.

b. Document the assessment.

c. Notify the health care provider.

d. Assess the wound every 2 hours.

ANS: B

6. A patient has an open surgical wound on the abdomen that contains deep pink granulation tissue. How would the nurse document this wound?

a. Red wound

b. Yellow wound

c. Full-thickness wound

d. Stage III pressure ulcer

ANS: A

7. A patient with rheumatoid arthritis has been taking corticosteroids for 11 months. Which nursing action is **most** likely to detect early signs of infection in this patient?

a. Monitor white blood cell count.

b. Check the skin for areas of redness.

c. Check the temperature every 2 hours.

d. Ask about fatigue or feelings of malaise.

ANS: D

9. A patient from a long-term care facility is admitted to the hospital with a sacral pressure ulcer. The base of the wound is yellow and involves subcutaneous tissue. How should the nurse classify this pressure ulcer?

a. Stage I

b. Stage II

c. Stage III

d. Stage IV

ANS: C

10. A young male patient who is a paraplegic has a stage II sacral pressure ulcer and is being cared for at home by his mother. To prevent further tissue damage, what instructions are **most** important for the nurse to teach the mother?

a. Change the patient's bedding frequently.

b. Use a hydrocolloid dressing over the ulcer.

c. Record the size and appearance of the ulcer weekly.

d. Change the patient's position at least every 2 hours.

ANS: D

11. The nurse will perform which action when doing a wet-to-dry dressing change on a patient's stage III sacral pressure ulcer?

a. Soak the old dressings with sterile saline 30 minutes before removing them.

b. Pour sterile saline onto the new dry dressings after the wound has been packed.

c. Apply antimicrobial ointment before repacking the wound with moist dressings.

d. Administer the ordered PRN hydrocodone (Lortab) 30 minutes before the dressing change.

ANS: D

18. A patient who has diabetes is admitted for an exploratory laparotomy for abdominal pain. When planning interventions to promote wound healing, what is the nurse's **highest** priority?

a. Maintaining the patient's blood glucose within a normal range

b. Ensuring that the patient has an adequate dietary protein intake

c. Giving antipyretics to keep the temperature less than 102° F (38.9° C)

d. Redressing the surgical incision with a dry, sterile dressing twice daily

ANS: A

20. After the home health nurse teaches a patient's family member about how to care for a sacral pressure ulcer, which finding indicates that additional teaching is needed?

a. The family member uses a lift sheet to reposition the patient.

b. The family member uses clean tap water to clean the wound.

c. The family member places contaminated dressings in a plastic grocery bag.

d. The family member dries the wound using a hair dryer set on a low setting.

ANS: D

SHORT ANSWER

1. A patient's temperature has been 101° F (38.3° C) for several days. The patient's normal caloric intake to meet nutritional needs is 2000 calories per day. Knowing that the metabolic rate increases 7% for each Fahrenheit degree above 100° in body temperature, how many total calories should the patient receive each day?

ANS:

2140 calories

OTHER

1. A patient who has an infected abdominal wound develops a temperature of 104° F (40° C). All the following interventions are included in the patient's plan of care. In which order should the

nurse perform the following actions?*(Put a comma and a space between each answer choice [A, B, C, D]).*

a. Administer IV antibiotics.

b. Sponge patient with cool water.

c. Perform wet-to-dry dressing change.

d. Administer acetaminophen (Tylenol).

ANS:

A, D, B, C

2. A new mother expresses concern about her baby developing allergies and asks what the health care provider meant by "passive immunity." Which example should the nurse use to explain this type of immunity?

a. Early immunization

b. Bone marrow donation

c. Breastfeeding her infant

d. Exposure to communicable diseases

ANS: C

3. A patient is being evaluated for possible atopic dermatitis. The nurse expects elevation of which laboratory value?

a. IgE

b. IgA

c. Basophils

d. Neutrophils

ANS: A

6. Which teaching should the nurse provide about intradermal skin testing to a patient with possible allergies?

a. "Do not eat anything for about 6 hours before the testing."

b. "Take an oral antihistamine about an hour before the testing."

c. "Plan to wait in the clinic for 20 to 30 minutes after the testing."

d. "Reaction to the testing will take about 48 to 72 hours to occur."

ANS: C

12. Which patient should the nurse assess **first**?

a. Patient with urticaria after receiving an IV antibiotic

b. Patient who has graft-versus-host disease and severe diarrhea

c. Patient who is sneezing after having subcutaneous immunotherapy

d. Patient with multiple chemical sensitivities who has muscle stiffness

ANS: C

13. Ten days after receiving a bone marrow transplant, a patient develops a skin rash. What would the nurse suspect is the cause of this patient's skin rash?

a. The donor T cells are attacking the patient's skin cells.

b. The patient's antibodies are rejecting the donor bone marrow.

c. The patient is experiencing a delayed hypersensitivity reaction.

d. The patient will need treatment to prevent hyperacute rejection.

ANS: A

15. The nurse teaches a patient about drug therapy after a kidney transplant. Which statement by the patient would indicate a need for further instructions?

a. "After a couple of years, it is likely that I will be able to stop taking the cyclosporine."

b. "If I develop an acute rejection episode, I will need to have other types of drugs given IV."

c. "I need to be monitored closely because I have a greater chance of developing malignant tumors."

d. "The drugs are given in combination because they inhibit different ways the kidney can be rejected."

ANS: A

18. The charge nurse is assigning rooms for new admissions. Which patient would be the **most** appropriate roommate for a patient who has acute rejection of an organ transplant?

a. A patient who has viral pneumonia

b. A patient with second-degree burns

c. A patient who is recovering from an anaphylactic reaction to a bee sting

d. A patient with graft-versus-host disease after a recent bone marrow transplant

ANS: C

19. A patient who has received allergen testing using the cutaneous scratch method has developed itching and swelling at the skin site. Which action should the nurse take **first**?

a. Administer epinephrine.

b. Apply topical hydrocortisone.

c. Monitor the patient for lower extremity edema.

d. Ask the patient about exposure to any new lotions or soaps.

ANS: A

20. A patient who is anxious and has difficulty breathing seeks treatment after being stung by a wasp. What is the nurse's **priority** action?

a. Have the patient lie down.

b. Assess the patient's airway.

c. Administer high-flow oxygen.

d. Remove the stinger from the site.

ANS: B

23. The health care provider asks the nurse whether a patient's angioedema has responded to prescribed therapies. Which assessment should the nurse perform?

a. Ask the patient about any clear nasal discharge.

b. Obtain the patient's blood pressure and heart rate.

c. Check for swelling of the patient's lips and tongue.

d. Assess the patient's extremities for wheal and flare lesions.

ANS: C

24. A nurse has obtained donor tissue typing information about a patient who is waiting for a kidney transplant. Which results should be reported to the transplant surgeon?

a. Patient is Rh positive and donor is Rh negative

b. Six antigen matches are present in HLA typing

c. Results of patient-donor cross matching are positive

d. Panel of reactive antibodies (PRA) percentage is low

ANS: C

1. A patient who is receiving an IV antibiotic develops wheezes and dyspnea. In which order should the nurse implement these prescribed actions?*(Put a comma and a space between each answer choice [A, B, C, D, E]).*

a. Discontinue the antibiotic infusion.

b. Give diphenhydramine (Benadryl) IV.

c. Inject epinephrine (Adrenalin) IM or IV.

d. Prepare an infusion of dopamine (Intropin).

e. Start 100% oxygen using a nonrebreather mask.

ANS:

A, E, C, B, D

1. The nurse is caring for a patient with a massive burn injury and possible hypovolemia. Which assessment data will be of **most** concern to the nurse?

a. Blood pressure is 90/40 mm Hg.

b. Urine output is 30 mL over the last hour.

c. Oral fluid intake is 100 mL for the last 8 hours.

d. There is prolonged skin tenting over the sternum.

ANS: A

3. A patient is admitted for hypovolemia associated with multiple draining wounds. Which assessment would be the **most** accurate way for the nurse to evaluate fluid balance?

a. Skin turgor

b. Daily weight

c. Presence of edema

d. Hourly urine output

ANS: B

4. The home health nurse cares for an alert and oriented older adult patient with a history of dehydration. Which instructions should the nurse give to this patient related to fluid intake?

a. "Increase fluids if your mouth feels dry.

b. "More fluids are needed if you feel thirsty."

c. "Drink more fluids in the late evening hours."

d. "If you feel lethargic or confused, you need more to drink."

ANS: A

6. Spironolactone (Aldactone), an aldosterone antagonist, is prescribed for a patient. Which statement by the patient indicates that the teaching about this medication has been effective?

a. "I will try to drink at least 8 glasses of water every day."

b. "I will use a salt substitute to decrease my sodium intake."

c. "I will increase my intake of potassium-containing foods."

d. "I will drink apple juice instead of orange juice for breakfast."

ANS: D

7. A newly admitted patient is diagnosed with hyponatremia. When making room assignments, the charge nurse should take which action?

a. Assign the patient to a room near the nurse's station.

b. Place the patient in a room nearest to the water fountain.

c. Place the patient on telemetry to monitor for peaked T waves.

d. Assign the patient to a semi-private room and place an order for a low-salt diet.

ANS: A

8. IV potassium chloride (KCl) 60 mEq is prescribed for treatment of a patient with severe hypokalemia. Which action should the nurse take?

a. Administer the KCl as a rapid IV bolus.

b. Infuse the KCl at a rate of 10 mEq/hour.

c. Only give the KCl through a central venous line.

d. Discontinue cardiac monitoring during the infusion.

ANS: B

9. A postoperative patient who had surgery for a perforated gastric ulcer has been receiving nasogastric suction for 3 days. The patient now has a serum sodium level of 127 mEq/L (127 mmol/L). Which prescribed therapy should the nurse question?

a. Infuse 5% dextrose in water at 125 mL/hr.

b. Administer IV morphine sulfate 4 mg every 2 hours PRN.

c. Give IV metoclopramide (Reglan) 10 mg every 6 hours PRN for nausea.

d. Administer 3% saline if serum sodium decreases to less than 128 mEq/L.

ANS: A

10. A patient who was involved in a motor vehicle crash has had a tracheostomy placed to allow for continued mechanical ventilation. How should the nurse interpret the following arterial blood gas results: pH 7.48, PaO2 85 mm Hg, PaCO2 32 mm Hg, and HCO3 25 mEq/L?

a. Metabolic acidosis

b. Metabolic alkalosis

c. Respiratory acidosis

d. Respiratory alkalosis

ANS: D

12. An older adult patient who is malnourished presents to the emergency department with a serum protein level of 5.2 g/dL. The nurse would expect which clinical manifestation?

a. Pallor

b. Edema

c. Confusion

d. Restlessness

ANS: B

13. A patient receives 3% NaCl solution for correction of hyponatremia. Which assessment is **most** important for the nurse to monitor for while the patient is receiving this infusion?

a. Lung sounds

b. Urinary output

c. Peripheral pulses

d. Peripheral edema

ANS: A

14. The long-term care nurse is evaluating the effectiveness of protein supplements for an older resident who has a low serum total protein level. Which assessment finding indicates that the patient's condition has improved?

a. Hematocrit 28%

b. Absence of skin tenting

c. Decreased peripheral edema

d. Blood pressure 110/72 mm Hg

ANS: C

15. A patient who is lethargic and exhibits deep, rapid respirations has the following arterial blood gas (ABG) results: pH 7.32, PaO2 88 mm Hg, PaCO2 37 mm Hg, and HCO3 16 mEq/L. How should the nurse interpret these results?

a. Metabolic acidosis

b. Metabolic alkalosis

c. Respiratory acidosis

d. Respiratory alkalosis

ANS: A

17. The nurse is caring for a patient who has a calcium level of 12.1 mg/dL. Which nursing action should the nurse include on the care plan?

a. Maintain the patient on bed rest.

b. Auscultate lung sounds every 4 hours.

c. Monitor for Trousseau's and Chvostek's signs.

d. Encourage fluid intake up to 4000 mL every day.

ANS: D

24. A nurse is assessing a newly admitted patient with chronic heart failure who forgot to take prescribed medications and seems confused. The patient complains of "just blowing up" and has peripheral edema and shortness of breath. Which assessment should the nurse complete **first**?

a. Skin turgor

b. Heart sounds

c. Mental status

d. Capillary refill

ANS: C

26. A patient who had a transverse colectomy for diverticulosis 18 hours ago has nasogastric suction and is complaining of anxiety and incisional pain. The patient's respiratory rate is 32 breaths/minute and the arterial blood gases (ABGs) indicate respiratory alkalosis. Which action should the nurse take **first**?

a. Discontinue the nasogastric suction.

b. Give the patient the PRN IV morphine sulfate 4 mg.

c. Notify the health care provider about the ABG results.

d. Teach the patient how to take slow, deep breaths when anxious.

ANS: B

27. Which action can the registered nurse (RN) who is caring for a critically ill patient with multiple IV lines delegate to an experienced licensed practical/vocational nurse (LPN/LVN)?

a. Administer IV antibiotics through the implantable port.

b. Monitor the IV sites for redness, swelling, or tenderness.

c. Remove the patient's nontunneled subclavian central venous catheter.

d. Adjust the flow rate of the 0.9% normal saline in the peripheral IV line.

ANS: B

28. A patient has a serum calcium level of 7.0 mEq/L. Which assessment finding is **most** important for the nurse to report to the health care provider?

a. The patient is experiencing laryngeal stridor.

b. The patient complains of generalized fatigue.

c. The patient's bowels have not moved for 4 days.

d. The patient has numbness and tingling of the lips.

ANS: A

29. Following a thyroidectomy, a patient complains of "a tingling feeling around my mouth." Which assessment should the nurse complete**immediately**?

a. Presence of the Chvostek's sign

b. Abnormal serum potassium level

c. Decreased thyroid hormone level

d. Bleeding on the patient's dressing

ANS: A

33. The nurse notes a serum calcium level of 7.9 mg/dL for a patient who has chronic malnutrition. Which action should the nurse take **next**?

a. Monitor ionized calcium level.

b. Give oral calcium citrate tablets.

c. Check parathyroid hormone level.

d. Administer vitamin D supplements.

ANS: A

37. During the admission process, the nurse obtains information about a patient through the physical assessment and diagnostic testing. Based on the data shown in the accompanying figure, which nursing diagnosis is appropriate?

a. Deficient fluid volume

b. Impaired gas exchange

c. Risk for injury: Seizures

d. Risk for impaired skin integrity

ANS: C

TEST 2

Question 1

After teaching a client with type 2 diabetes mellitus, the nurse assesses the client's understanding. Which statement made by the client indicates a need for additional teaching? Since my diabetes is controlled with diet and exercise , I must be seen only if an sick

•Question 2

When doing a skin assessment, the nurse applies the ABCDE rule to examine the skin. The "C" stands for: **color changes**

•Question 3

A nurse teaches a client with diabetes mellitus about foot care. Which statements should the nurse include in this client's teaching? **(Select all that apply.)**

a.Do not walk around barefoot."

b.Soak your feet in a tub each evening."

c."Trim toenails straight across with a nail clipper."

d.Treat any blisters or sores with Epsom salts."

e.Wash your feet every other day.

•Question 4

A nurse collaborates with the interdisciplinary team to develop a plan of care for a client who is newly diagnosed with diabetes mellitus. Which team members should the nurse include in this interdisciplinary team meeting? **(Select all that apply.)**

a.Registered dietitian

b.Clinical pharmacist

c.Occupational therapist

d.Health care provider

e.Speech-language pathologist

•Question 5

A nurse assesses a client who is recovering from a total thyroidectomy and notes the development of stridor. Which action should the nurse take first?

a.Reassure the client that the voice change is temporary.
b.Document the finding and assess the client hourly.
c.Place the client in high-Fowler's position and apply oxygen.
d.Contact the provider and prepare for intubation

•Question 6

A nurse assesses a client who has a large abdomen and a rounded face. Which additional assessment finding would lead the nurse to suspect that this client has Cushing's syndrome rather than obesity related to an imbalance of food intake and metaboic needs?

A. large thighs and upper arms

B. pendulous abdomen and large hips

C. abdominal striae and ankle enlargement

D. posterior neck fat pad and thin extremities

•Question 7

A diabetic patient is admitted with a blood glucose level of 476 mg/dL and an order reads, " Insulin drip, Regular insulin 0.03 units per Kg. per hour."The patient weighs 176 pounds. How many units of insulin should the patient receive each hour?

2.4units/hr

•Question 8

A nurse cares for a client who presents with bradycardia secondary to hypothyroidism. Which medication should the nurse anticipate being prescribed to the client?

a. Atropine sulfate

b. Levothyroxine sodium (Synthroid)

c. Propranolol (Inderal)

d. Epinephrine (Adrenalin)

•Question 9

An emergency department nurse assesses a client with ketoacidosis. Which clinical manifestation should the nurse correlate with this condition?

a. Increased rate and depth of respiration
b. Extremity tremors followed by seizure activity
c. Oral temperature of 102° F (38.9° C)
d. Severe orthostatic hypotension

•Question 10

A nurse assesses clients who are at risk for diabetes mellitus. Which client is at greatest risk?

a.A 29-year-old Caucasian
b.A 32-year-old African-American
c.A 44-year-old Asian
d.A 48-year-old American Indian

•Question 11

A client is complaining of dry eyes that makes it difficult to wear his contact lenses. What question would you anticipate the nurse would ask the patient?

Assess for contact lenses
Suggest saline eye drops
Check the medication list
Ask about eyeglass usage

•Question 12

After change-of-shift report, which patient should the nurse assess **first**?

a. A 23-year-old patient with cystic fibrosis who has pulmonary function testing scheduled
b. A 46-year-old patient on bed rest who is complaining of sudden onset of shortness of breath
c. A 77-year-old patient with tuberculosis (TB) who has four antitubercular medications due in 15 minutes
d. A 35-year-old patient who was admitted the previous day with pneumonia and has a temperature of 100.2° F (37.8° C)

•Question 13

When assisting a blind person with his meals, it is most important for the nurse to:

Go in clock wise direction or motion

•Question 14

What instructions should be given to the patient with a hordeolum?

hordeolum (stye) Management includes applying warm compresses four times a day and an antibacterial ointment. When the lesion opens, the pus drains and the pain subsides.

Apply a warm compress for 15 minutes four times daily

•Question 15

A nurse should include which instructions when teaching a patient with repeated hordeolum how to prevent further infection?

Discard all open or used cosmetics applied near the eyes.

•Question 16

A nurse cares for a client who has a family history of diabetes mellitus. The client states, “My father has type 1 diabetes mellitus. Will I develop this disease as well?” How should the nurse respond?

a. "Your risk of diabetes is higher than the general population, but it may not occur."
b. "No genetic risk is associated with the development of type 1 diabetes mellitus."
c. "The risk for becoming a diabetic is 50% because of how it is inherited."

d. "Female children do not inherit diabetes mellitus, but male children will."

•Question 17

After teaching a client who has diabetes mellitus and proliferative retinopathy, nephropathy, and peripheral neuropathy, the nurse assesses the client's understanding. Which statement made by the client indicates a correct understanding of the teaching?

a. "I have so many complications; exercising is not recommended."
b. "I will exercise more frequently because I have so many complications."
c. "I used to run for exercise; I will start training for a marathon."
d. "I should look into swimming or water aerobics to get my exercise."

•Question 18

A nurse cares for a client who has diabetes mellitus. The nurse administers 6 units of regular insulin and 10 units of NPH insulin at 0700. At which time should the nurse assess the client for potential problems related to the NPH insulin?

a. 0800
b. 1600
c. 2000
d. 2300

•Question 19

The nurse is caring for a patient who is 2 days post-op following the removal of a 3.6 cm. acoustic neuroma. The patient complains one side of his mouth is drooping. The most likely cause is:

nerve damage

•Question 20

A nurse cares for a client experiencing diabetic ketoacidosis who presents with

Kussmaul respirations. Which action should the nurse take?

a. Administration of oxygen via face mask
b. Intravenous administration of 10% glucose
c. Implementation of seizure precautions
d. Administration of intravenous insulin

•Question 21

After teaching a young adult client who is newly diagnosed with type 1 diabetes mellitus, the nurse assesses the client's understanding. Which statement made by the client indicates a correct understanding of the need for eye examinations?

Diabetes can cause blindness, so I should see the ophthalmologist yearly.

•Question 22

A nurse assesses a client who is recovering from a subtotal thyroidectomy. On the second postoperative day the client states, "I feel numbness and tingling around my mouth." What action should the nurse take?

a. Offer mouth care.
b. Loosen the dressing.
c. Assess for Chvostek's sign.
d. Ask the client orientation questions

•Question 23

A nurse cares for a client with excessive production of thyrocalcitonin (calcitonin). For which electrolyte imbalance should the nurse assess?

a. Potassium
b. Sodium
c. Calcium
d. Magnesium

•Question 24

A nurse assesses a client with diabetes mellitus who self-administers subcutaneous insulin. The nurse notes a spongy, swelling area at the site the client uses most frequently for insulin injection. Which action should the nurse take?

a. Apply ice to the site to reduce inflammation.
b. Consult the provider for a new administration route.
c. Assess the client for other signs of cellulitis.
d. Instruct the client to rotate sites for insulin injection.

•Question 25

A nurse cares for a client who has excessive catecholamine release. Which assessment finding should the nurse correlate with this condition?

a. Decreased blood pressure
b. Increased pulse
c. Decreased respiratory rate
d. Increased urine output

•Question 26

Simple aids the nurse can use to communicate with a hearing impaired patient include: (Select all that apply).

Review Table 22-14 p. 410

•Question 27

A nurse collaborates with an unlicensed assistive personnel (UAP) to provide care for a client who is prescribed a 24-hour urine specimen collection. Which statement should the nurse include when delegating this activity to the UAP?

a. "Note the time of the client's first void and collect urine for 24 hours."
b. "Add the preservative to the container at the end of the test."
c. "Start the collection by saving the first urine of the morning."
d. "It is okay if one urine sample during the 24 hours is not collected."

•Question 28

A nurse assesses a client who has diabetes mellitus and notes the client is awake and alert, but shaky, diaphoretic, and weak. Five minutes after administering a half-cup of orange juice, the client's clinical manifestations have not changed. Which action should the nurse take next?

Give the client another 1/2 cup of orange juice.

•Question 29

Which of the following hormones are affected in primary Cushings disease?

ACTH

Cortisol

•Question 30

After teaching a client with diabetes mellitus to inject insulin, the nurse assesses the client's understanding. Which statement made by the client indicates a need for additional teaching?

a. "The lower abdomen is the best location because it is closest to the pancreas."

b. "I can reach my thigh the best, so I will use the different areas of my thighs."

c. "By rotating the sites in one area, my chance of having a reaction is decreased."

d. “Changing injection sites from the thigh to the arm will change absorption rates.”

•Question 31

Hearing loss is a side effect of many different of drugs. Select all classes of drugs that can cause a hearing loss

- Aspirin
- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- antibiotics,
- Loop diuretics
- Medicines used to treat cancer.

•Question 32

Which of the following patients is most likely to have a recommendation to increase the sodium in her diet?

•Question 33

A client who is diagnosed with Addison's disease is admitted to the hospital. Which of the following would the nurse expect to find when assessing the client?

1. Moon face, buffalo hump, and hyperglycemia.
2. Hirsutism, fever, and irritability.
3. Bronze pigmentation, hypotension, and anorexia.
4. Tachycardia, bulging eyes, and goiter.

•Question 34

A nurse cares for a client with diabetes mellitus who asks, “Why do I need to administer more than one injection of insulin each day?” How should the nurse respond?

a. “You need to start with multiple injections until you become more proficient

at self-injection.”

b. “A single dose of insulin each day would not match your blood insulin levels and your food intake patterns.”

c. “A regimen of a single dose of insulin injected each day would require that you eat fewer carbohydrates.”

d. “A single dose of insulin would be too large to be absorbed, predictably putting you at risk for insulin shock.”

•Question 35

A nurse teaches a client about self-monitoring of blood glucose levels. Which statement should the nurse include in this client’s teaching to prevent bloodborne infections?

a. "Wash your hands after completing each test."
b. "Do not share your monitoring equipment."
c. "Blot excess blood from the strip with a cotton ball."
d. "Use gloves when monitoring your blood glucose."

•Question 36

A nurse teaches a client who is diagnosed with diabetes mellitus. Which statement should the nurse include in this client’s plan of care to delay the onset of microvascular and macrovascular complications?

a. "Maintain tight glycemic control and prevent hyperglycemia."
b. "Restrict your fluid intake to no more than 2 liters a day."
c. "Prevent hypoglycemia by eating a bedtime snack."
d. "Limit your intake of protein to prevent ketoacidosis."

•Question 37

A nurse teaches a client who has been prescribed a 24-hour urine collection to measure excreted hormones. The client asks, “Why do I need to collect urine for 24 hours instead of providing a random specimen?” How should the nurse respond?

A) “This test will assess for a hormone secreted on a circadian rhythm.”

B) “The hormone is diluted in urine; therefore, we need a large volume.”

C) “We are assessing when the hormone is secreted in large amounts.”

D) “To collect the correct hormone, you need to urinate multiple times.”

ANS: A

Some hormones are secreted in a pulsatile, or circadian, cycle. When testing for these substances, a collection that occurs over 24 hours will most accurately reflect hormone secretion. Dilution of hormones in urine, secretion of hormone amounts, and ability to collect the correct hormone are not reasons to complete a 24-hour urine test.

•Question 38

At 4:45 p.m., a nurse assesses a client with diabetes mellitus who is recovering from an abdominal hysterectomy 2 days ago. The nurse notes that the client is confused and diaphoretic. The nurse reviews the assessment data provided in the chart below:

Capillary Blood Glucose Testing (AC/HS)	Dietary Intake
At 0630: 95 At 1130: 70 At 1630: 47	Breakfast: 10% eaten – client states she is not hungry Lunch: 5% eaten – client is nauseous; vomits once

After reviewing the client’s assessment data, which action is appropriate at this time?

a.
Assess the client's oxygen saturation level and administer oxygen.
b.
Reorient the client and apply a cool washcloth to the client's forehead.

c.
Administer dextrose 50% intravenously and reassess the client.
d.
Provide a glass of orange juice and encourage the client to eat dinner.

ANS: C
The client's symptoms are related to hypoglycemia. Since the client has not been tolerating food, the nurse should administer dextrose intravenously. The client's oxygen level could be checked, but based on the information provided, this is not the priority. The client will not be reoriented until the glucose level rises.

•Question 39

The most common cause of central vision loss in older patients is:

Age-related macular degeneration

•Question 40

A nurse cares for a client with diabetes mellitus who is visually impaired. The client asks, “Can I ask my niece to prefill my syringes and then store them for later use when I need them?” How should the nurse respond?

A.) “Yes. Prefilled syringes can be stored for 3 weeks in the refrigerator in a vertical position with the needle pointing up.”

B) “Yes. Syringes can be filled with insulin and stored for a month in a location that is protected from light.”

C) “Insulin reacts with plastic, so prefilled syringes are okay, but you will need to use glass syringes.”

D) “No. Insulin syringes cannot be prefilled and stored for any length of time outside of the container.”

•Question 41

A nurse plans care for a client with hypothyroidism. Which priority problem should the nurse plan to address first for this client?

a. Heat intolerance
b. Body image problems
c. Depression and withdrawal
d. Obesity and water retention

Hypothyroidism causes many problems in psychosocial functioning. Depression is the most common reason for seeking medical attention. Memory and attention span may be impaired. The client's family may have great difficulty accepting and dealing with these changes. The client is often unmotivated to participate in self-care. Lapses in memory and attention require the nurse to ensure that the client's environment is safe. Heat intolerance is seen in hyperthyroidism. Body image problems and weight issues do not take priority over mental status and safety.

•Question 42

A nurse assesses a client with diabetes mellitus 3 hours after a surgical procedure and notes the client’s breath has a “fruity” odor. Which action should the nurse take?

a.	Encourage the client to use an incentive spirometer.
b.	Increase the client’s intravenous fluid flow rate.
c.	Consult the provider to test for ketoacidosis.
d.	Perform meticulous pulmonary hygiene care.

ANS: C The stress of surgery increases the action of counterregulatory hormones and suppresses the action of insulin, predisposing the client to ketoacidosis and metabolic acidosis. One manifestation of ketoacidosis is a "fruity" odor to the breath. Documentation should occur after all assessments have been completed. Using an incentive spirometer, increasing IV fluids, and performing pulmonary hygiene will not address this client's problem.

•Question 43

A nurse teaches a client with hyperthyroidism. Which dietary modifications should the nurse include in this client's teaching? **(Select all that apply.)**

a. Increased carbohydrates
b. Decreased fats
c. Increased calorie intake
d. Supplemental vitamins
e. Increased proteins
ANS: A, C, E

The client is hypermetabolic and has an increased need for carbohydrates, calories, and proteins. Proteins are especially important because the client is at risk for a negative nitrogen balance. There is no need to decrease fat intake or take supplemental vitamins.

•Question 44

A nurse assesses a client who has a 15-year history of diabetes and notes decreased tactile sensation in both feet. Which action should the nurse take first?

a. Document the finding in the client's chart.

b. Assess tactile sensation in the client's hands.

c. Examine the client's feet for signs of injury.

d. Notify the health care provider.

Diabetic neuropathy is common when the disease is of long duration. The client is at great risk for injury in any area with decreased sensation because he or she is less able to feel injurious events. Feet are common locations for neuropathy and injury, so the nurse should inspect them for any signs of injury. After assessment, the nurse should document findings in the client's chart. Testing sensory perception in the hands may or may not be needed. The health care provider can be notified after assessment and documentation have been

completed.

•Question 45

A nurse cares for a client who is recovering from a parathyroidectomy. When taking the client's blood pressure, the nurse notes that the client's hand has gone into flexion contractions. Which laboratory result does the nurse correlate with this condition?

a. Serum potassium: 2.9 mEq/L
b. Serum magnesium: 1.7 mEq/L
c. Serum sodium: 122 mEq/L
d. Serum calcium: 6.9 mg/dL
ANS: D Hypocalcemia destabilizes excitable membranes and can lead to muscle twitches, spasms, and tetany. This effect of hypocalcemia is enhanced in the presence of tissue hypoxia. The flexion contractions (Trousseau's sign) that occur during blood pressure measurement are indicative of hypocalcemia, not the other electrolyte imbalances, which include hypokalemia, hyponatremia, and hypomagnesemia.

•Question 46

During the early post operative period following surgery for Cushings disease, new nurse questioned the order for high dose IV steroids. Which explanation would the senior nurse most likely provide?

To ensure adequate response to the stress of the procedure

•Question 47

A nurse plans care for a client who has hypothyroidism and is admitted for pneumonia. Which priority intervention should the nurse include in this client's plan of care?

a. Monitor the client's intravenous site every shift.
b. Administer acetaminophen (Tylenol) for fever.
c. Ensure that working suction equipment is in the room.

d. Assess the client's vital signs every 4 hours.
ANS: C

•Question 48

A nurse cares for a client who is prescribed a drug that blocks a hormone's receptor site. Which therapeutic effect should the nurse expect?

a. Greater hormone metabolism

b. Decreased hormone activity

c. Increased hormone activity

d. Unchanged hormone response

ANS: B
Hormones cause activity in the target tissues by binding with their specific cellular receptor sites, thereby changing the activity of the cell. When receptor sites are occupied by other substances that block hormone binding, the cell's response is the same as when the level of the hormone is decreased.

•Question 49

A nurse is caring for a client who was prescribed high-dose corticosteroid therapy for 1 month to treat a severe inflammatory condition. The client's symptoms have now resolved and the client asks, "When can I stop taking these medications?" How should the nurse respond?

a. "It is possible for the inflammation to recur if you stop the medication."
b. "Once you start corticosteroids, you have to be weaned off them."
c. "You must decrease the dose slowly so your hormones will work again."
d. "The drug suppresses your immune system, which must be built back up."
ANS: B

•Question 50

A nurse assesses a client with Cushing's disease. Which assessment findings should the nurse correlate with this disorder? **(Select all that apply.)**

a. Moon face

b. Weight loss

c. Hypotension

d. Petechiae

e. Muscle atrophy

ANS: A, D, E Clinical manifestations of Cushing's disease include moon face, weight gain, hypertension, petechiae, and muscle atrophy.

•Question 51

A nurse assesses a client who is prescribed levothyroxine (Synthroid) for hypothyroidism. Which assessment finding should alert the nurse that the medication therapy is effective?

a. Thirst is recognized and fluid intake is appropriate.
b. Weight has been the same for 3 weeks.
c. Total white blood cell count is 6000 cells/mm3.
d. Heart rate is 70 beats/min and regular.
ANS: D Hypothyroidism decreases body functioning and can result in effects such as bradycardia, confusion, and constipation. If a client's heart rate is bradycardic while on thyroid hormone replacement, this is an indicator that the replacement may not be adequate. Conversely, a heart rate above 100 beats/min may indicate that the client is receiving too much of the thyroid hormone. Thirst, fluid intake, weight, and white blood cell count do not represent a therapeutic response to this medication.

•Question 52

A nurse assesses a client who has diabetes mellitus. Which arterial blood gas values should the nurse identify as potential ketoacidosis in this client?

a. pH 7.38, HCO3– 22 mEq/L, PCO2 38 mm Hg, PO2 98 mm Hg

b. pH 7.28, HCO3– 18 mEq/L, PCO2 28 mm Hg, PO2 98 mm Hg

c. pH 7.48, HCO3– 28 mEq/L, PCO2 38 mm Hg, PO2 98 mm Hg

d. pH 7.32, HCO3– 22 mEq/L, PCO2 58 mm Hg, PO2 88 mm Hg

ANS: B
When the lungs can no longer offset acidosis, the pH decreases to below normal. A client who has diabetic ketoacidosis would present with arterial blood gas values that show primary metabolic acidosis with decreased bicarbonate levels and a compensatory respiratory alkalosis with decreased carbon dioxide levels.

•Question 53

After teaching a client who is recovering from a complete thyroidectomy, the nurse assesses the client's understanding. Which statement made by the client indicates a need for additional instruction?

a. "I may need calcium replacement after surgery."
b. "After surgery, I won't need to take thyroid medication."
c. "I'll need to take thyroid hormones for the rest of my life."
d. "I can receive pain medication if I feel that I need it."
ANS: B After the client undergoes a thyroidectomy, the client must be given thyroid replacement medication for life. He or she may also need calcium if the parathyroid is damaged during surgery, and can receive pain medication postoperatively.

•Question 54

A nurse provides diabetic education at a public health fair. Which disorders should the nurse include as complications of diabetes mellitus? **(Select all that apply.)**

a. Stroke

b. Kidney failure

c. Blindness

d. Respiratory failure

e. Cirrhosis

ANS: A, B, C Complications of diabetes mellitus are caused by macrovascular and microvascular changes. Macrovascular complications include coronary artery disease, cerebrovascular disease, and peripheral vascular disease. Microvascular complications include nephropathy, retinopathy, and neuropathy. Respiratory failure and cirrhosis are not complications of diabetes mellitus.

•Question 55

A nurse prepares to administer prescribed regular and NPH insulin. Place the nurse's actions in the correct order to administer these medications.

a. Inspect bottles for expiration dates.
b. Gently roll the bottle of NPH between the hands.
c. Wash your hands.
d. Inject air into the regular insulin.
e. Withdraw the NPH insulin.
f. Withdraw the regular insulin.
g. Inject air into the NPH bottle.
h. Clean rubber stoppers with an alcohol swab.

ANS:

c, a, b, h, g, d, f, e After washing hands, it is important to inspect the bottles and then to roll the NPH to mix the insulin. Rubber stoppers should be cleaned with alcohol after rolling the NPH and before sticking a needle into either bottle. It is important to inject air into the NPH bottle before placing the needle in a regular insulin bottle to avoid mixing of regular and NPH insulin. The shorter-acting insulin is always drawn up first.

•Question 56

A nurse reviews laboratory results for a client with diabetes mellitus who is

prescribed an intensified insulin regimen:

- Fasting blood glucose: 75 mg/dL
- Postprandial blood glucose: 200 mg/dL
- Hemoglobin A_{1c} level: 5.5%

How should the nurse interpret these laboratory findings?

a. Increased risk for developing ketoacidosis

b. Good control of blood glucose

c. Increased risk for developing hyperglycemia

d. Signs of insulin resistance

The client is maintaining blood glucose levels within the defined ranges for goals in an intensified regimen. Because the client's glycemic control is good, he or she is not at higher risk for ketoacidosis or hyperglycemia and is not showing signs of insulin resistance.

EXAMS 3

Question 1

3 out of 3 points

A patient with an acute pharyngitis is seen at the clinic with fever and severe throat pain that affects swallowing. On inspection, the throat is reddened and edematous with patchy yellow exudates. The nurse anticipates that collaborative management will include:

Correct Answer: a throat culture or rapid strep antigen test.

Question 2

0 out of 3 points

During the assessment of the chest in a patient with pneumococcal pneumonia, the nurse would expect to find

Correct Answer: Dullness to percussion

Question 3

3 out of 3 points

The nurse receives change-of-shift report on the following four patients. Which patient should the nurse assess first?

Correct Answer: A 46-year-old patient on bed rest who is complaining of sudden onset of shortness of breath

Question 4

3 out of 3 points

Which information will the nurse include in the patient teaching plan for a patient who is receiving rifampin (Rifadin) for treatment of tuberculosis?

Correct Answer: “Your urine, sweat, and tears will be orange colored.”

Question 5

3 out of 3 points

Which initial physical assessment finding would the nurse expect to be present in a patient with acute left sided heart failure?

Correct Answer:

Correct Bubbling crackles and tachycardia

Question 6

0 out of 3 points

The nurse determines that which of the following blood pressures would meet the criteria for a diagnosis of stage 2 hypertension?

Correct Answer: 182/94 mmHg

Question 7

3 out of 3 points

The nurse is caring for a patient who has acute pharyngitis caused by Candida albicans. Which action is appropriate for the nurse to include in the plan of care?

Correct Answer: Teach patient to "swish and swallow" prescribed oral nystatin (Mycostatin).

Question 8

3 out of 3 points

Which medication should the nurse anticipate being used first in the emergency department for relief of severe respiratory distress related to asthma?

Correct Answer: Albuterol nebulizer

Question 9

3 out of 3 points

During an assessment of the patient with viral upper respiratory infection the nurse recognizes that

antibiotics may be indicated based on what finding?

Correct Answer: Dyspnea and severe sinus pain.

Question 10

3 out of 3 points

When admitting a patient with a myocardial infarction (MI) to the intensive care unit, which action should the nurse carry out first?

Correct Answer: Attach the cardiac monitor.

Response Feedback: Because dysrhythmias are the most common complication of MI, the first action should be to place the patient on a cardiac monitor. The other actions also are important and should be accomplished as quickly as possible.

Question 11

3 out of 3 points

An occupational health nurse works at a manufacturing plant where there is potential exposure to inhaled dust. Which action, if recommended by the nurse, will be most helpful in reducing the incidence of lung disease?

Correct Answer:Require the use of protective equipment.

Question 12

3 out of 3 points

The nurse determines that treatment of heart failure has been successful when the patient experiences:

Correct Answer: Correct clear lung sounds and a decreased HR.

Question 13

0 out of 3 points

Which of the following strategies would best assist the nurse in communicating with a patient who has a hearing loss (select all that apply)

Correct Answers: Write out names and difficult words

Speak normally but slowly

Question 14

3 out of 3 points

While teaching women about the risks and incidence of CAD, what does the nurse emphasis?

Correct Answer: CAD is the leading cause of death in women, with a higher mortality rate after MI

than men.

Question 15

3 out of 3 points

The nurse is caring for an HIV+ patient who was admitted with fever, productive cough and reports a recent 10 lb weight loss. A PPD skin test was done 2 days ago. Today the nurse notes a slight area of redness with a 5 mm induration on the patient's left forearm. The nurse would record the TB skin test as:

Correct Answer: Positive because the area of induration is greater than 5 mm.

Response Feedback: In patients with HIV+ or are immunocompromised, induration equal or greater than 5 mm is considered a positive test.

Question 16

3 out of 3 points

The nurse reviews the arterial blood gases of a patient. Which result would indicate the patient has later stage COPD?

Correct Answer: pH 7.32, PaCO2 58 mm Hg, HCO3 30 mEq/L

Question 17

3 out of 3 points

Mr. BJ experienced a major hearing loss as a child. He is able to communicate using speech reading. The nursing assistant complains about the patient not communicating with her when she takes his vital signs. Which of the follow statements made by the nurse would be the most helpful?

Correct Answer: Stand directly infront of the patient, speak normally, and maintain eye contact.

Response Feedback: Patients who communicate by speech reading need to have good eye contact to interpret speech. The speaker is best understood speaking slowly and normally.

Question 18

3 out of 3 points

What does the nurse teach the patient with intermittent allergic tinnitis is the most effective way to decrease allergic symptoms?

Correct Answer: Identify and avoid triggers of allergic reaction.

Question 19

0 out of 3 points

Which instructions are most appropriate for the nurse to provide to a patient who has an hordeolum (sty)?

Correct Answer: Application of warm and moist compresses at least four times per day.

Question 20

3 out of 3 points

A 52-year-old man is admitted to the emergency department with severe chest pain. On what basis would the nurse suspect an MI?

Correct Answer: He reports he has had no relief of the pain with rest or position change.

Question 21

3 out of 3 points

The nurse develops a teaching plan to help increase activity tolerance at home for an older adult with severe chronic obstructive pulmonary disease (COPD). Which instructions would be most appropriate for the nurse to include in the plan of care?

Correct Answer: Walk 15 to 20 minutes daily at least 3 times/week.

Question 22

3 out of 3 points

What causes the pain that occurs with myocardial ischemia?

Correct Answer: Lactic acid accumulation during anaerobic metabolism.

Question 23

3 out of 3 points

A patient with stage 2 hypertension who is taking hydrochlorothiazide (HydroDiuril) and lisinopril (Prinivil) has prazosin (Minipress) added to the medication regimen. What is most important fo the nurse to teach the patient to do?

Correct Answer: Change position slowly and avoid prolonged standing.

Question 24

0 out of 3 points

While obtaining patient histories, which patient does the nurse identify as having the highest risk for CAD?

Correct Answer: A white man, age 54, who is a smoker and has a stressful lifestyle.

Question 25

3 out of 3 points

Which initial physical assessment finding would the nurse expect to be present in a patient with

acute left sided heart failure?

Correct Answer: Bubbling crackles and tachycardia

Question 26

3 out of 3 points

What are the manifestations of acute coronary syndrome (ACS) (select all that apply)?

Correct Answers: Unstable angina

Non-ST-Segment-elevation myocardial infarction (NSTEMI)

ST-segment-elevation myocardial infarction (STEMI)

Question 27

3 out of 3 points

Which nursing action would be highest priority when suctioning a patient with a tracheostomy?

Correct Answer: Assessing the patient's oxygenation saturation before, during and after suctioning.

Question 28

3 out of 3 points

What causes the pain that occurs with myocardial ischemia?

Correct Answer: Lactic acid accumulation during anaerobic metabolism.

Question 29

2.25 out of 3 points

Which topics should the nurse include in the discharge teaching plan for a patient who has been hospitalized with chronic heart failure (select all that apply)?

Correct Answers:

a. How to take and record daily weight
b. Importance of limiting aerobic exercise
c. Date and time of follow-up appointment
d. Symptoms indicating worsening heart failure
e. Actions and side effects of prescribed medications

ANS: A, C, D, E
The Joint Commission Core Measures state that patients should be taught about prescribed medications, follow-up appointments, weight monitoring, and actions to take for worsening symptoms. Patients with heart failure are encouraged to begin or continue aerobic exercises such as walking, while self-monitoring to avoid excessive fatigue.

Question 30

0 out of 3 points

A patient is admitted to the emergency department with a severe exacerbation of asthma. Which finding is of most concern to the nurse?

Correct Answer: Unable to speak and sweating profusely.

Question 31

0 out of 3 points

In the United States, the most common cause of central vision loss in persons over 60 years of age is:

Correct Answer: Age-related macular degeneration

Response Feedback: Age-related macular degeneration is the number one cause of central vision loss in persons over age 60. Glaucoma is the number 2 cause of blindness in the USA. Cataracts can interfer with vision but and vision loss is reversible with surgery. Keratoconjunctivitis is not typically assoiciated with significant vision loss.

Question 32

3 out of 3 points

A patient's blood pressure has not responded to the prescribed drugs for hypertension. Which of the following should the nurse assess first?

Correct Answer: Patient's adherence to drug therapy.

Question 33

3 out of 3 points

A patient who is receiving dobutamine (Dobutrex) for the treatment of acute decompensated heart failure (ADHF) has the following nursing interventions included in the plan of care. Which action will be most appropriate for the registered nurse (RN) to delegate to an experienced licensed practical/ vocational nurse (LPN/LVN)?

Correct Answer: Monitor the patient's blood pressure and heart rate every hour.

Question 34

0 out of 3 points

When obtaining a health history form a patient suspected of having early TB, what manifestation should the nurse ask the patient about?

Correct Answer: Fatigue, low grad fever, and night sweats.

Question 35

3 out of 3 points

The nurse teaches a patient about pursed lip breathing. Which action by the patient would indicate to the nurse that further teaching is needed?

Correct Answer: The patient puffs up the cheeks while exhaling.

Question 36

3 out of 3 points

A patient with a history of chronic heart failure is admitted to the emergency department (ED) with severe dyspnea and a dry, hacking cough. Which action should the nurse do first?

Correct Answer: Auscultate the breath sounds.

Question 37

3 out of 3 points

After the nurse has finished teaching a patient about the use of sublingual nitroglycerin (Nitrostat), which patient statement indicates that the teaching has been effective?

Correct Answer: "I will call an ambulance if I still have pain after taking 3 nitroglycerin 5 minutes apart."

Question 38

0 out of 3 points

The nurse receives an evening report on a patient who underwent posterior nasal packing for epistaxis earlier in the day. What is the first patient assessment the nurse should make?

Correct Answer: Oxygen saturation by pulse oximetry.

Question 39

0 out of 3 points

Which statement by the patient with chronic heart failure should cause the nurse to determine that additional discharge teaching is needed?

Correct Answer: "I should weigh myself every morning and go on a diet if I gain more than 2 or 3 pounds in two days."

Question 40

0 out of 3 points

A 38 year old man is treated for hypertension with triamterene and hydrochlorothiazide (Maxzide) and metoprolol (Lopressor). Four months after his last clinic visit, his BP returns to pretreatment levels and he admits he has not been taking his medication regularly. What is the nurse's best response to this patient?

Correct Answer: "The drugs you are taking cause sexual dysfunction in many patients. Are you experiencing any problems in this area?"

Question 41

0 out of 3 points

The acronym FACES is used to help educate patients to identify symptoms of heart failure. What does this acronym mean?

Correct Answer: Fatigue, limitation of activities, chest congestion/cough, edema, shortness of breath.

Question 42

0 out of 3 points

Which manifestation is an indication that a patient is having a hypertensive emergency?

Correct Answer: A sudden rise in BP accompanied by neurologic impairment.

Question 43

0 out of 3 points

The nurse is caring for a patient who had surgery two days ago to remove a right acoustic neuroma. During the morning assessment, the nurse observes little movement on the right side of the patient's face and a slight drop to the right side of the mouth. The nurse should:

Correct Answer: Recognize the facial paralysis is permanent

Question 44

2 out of 3 points

Which of the following patients would be the most at risk for aspiration pneumonia (select all that apply)?

Correct Answers: Patient with seizures.

Patient who is receiving nasogastric tube feeding.

Patient with head injury.

Question 45

0 out of 3 points

Which manifestation is an indication that a patient is having a hypertensive emergency?

Correct Answer: A sudden rise in BP accompanied by neurologic impairment.

Question 46

0 out of 3 points

In planning care for a patient who has just returned to the unit following a PCI, the nurse may delegate which activity to a certified nursing assistant (CNA)?

Correct Answer: Check vital signs and report changes in HR, BP, or pulse oximetry.

Question 47

2.25 out of 3 points

What are nonmodifiable risk factors for primary hypertension (select all that apply)?

Correct Answers:

Genetic Link

Ethnicity

Gender

Age

Question 48

0 out of 3 points

A 21 year old college student was seen in the ER after an altercation. His nose was bleeding and he had a significant amount of echhymosis under both eyes. After the bleeding was stopped the patient continued to have a clear to slightly blood tinged nasal drainage. The ER doctor did a quick bedside test of the fluid for glucose. A positive glucoes test indicates:

Correct Answer: The drainage is central spinal fluid

Question 49

3 out of 3 points

A patient with bacterial pneumonia has rhonchi and thick sputum. What is the nurse's immediate action to promote airway clearance?

Correct Answer: Assist the patient to splint the chest when coughing.

Question 50

0 out of 3 points

A patient in the unit has been suffering from pneumonia for the past 24 hours. They have been recieving antibiotic therapy, but they have continued to suffer from a 103.7F temperature. Which intervention would be most effective in restoring normal body temperature?

Correct Answer: Administer antipyretics on an around the clock schedule.

Exam 4

A 46-year-old female with gastroesophageal reflux disease (GERD) is experiencing increasing discomfort. Which patient statement indicates that additional teaching about GERD is needed?

a. "I take antacids between meals and at bedtime each night."
b. "I sleep with the head of the bed elevated on 4-inch blocks."
c. "I eat small meals during the day and have a bedtime snack."
d. "I quit smoking several years ago, but I still chew a lot of gum."

ANS: C

A 50-year-old man vomiting blood-streaked fluid is admitted to the hospital with acute gastritis. To determine possible risk factors for gastritis, the nurse will ask the patient about

a. the amount of saturated fat in the diet.
b. any family history of gastric or colon cancer.
c. a history of a large recent weight gain or loss.
d. use of nonsteroidal antiinflammatory drugs (NSAIDs).

ANS: D

The nurse determines that teaching regarding cobalamin injections has been effective when the patient with chronic atrophic gastritis states which of the following?

a. "The cobalamin injections will prevent gastric inflammation."
b. "The cobalamin injections will prevent me from becoming anemic."
c. "These injections will increase the hydrochloric acid in my stomach."
d. "These injections will decrease my risk for developing stomach cancer."

ANS: B

The nurse will anticipate preparing a 71-year-old female patient who is vomiting "coffee-ground" emesis for

a. endoscopy.
b. angiography.
c. barium studies.
d. gastric analysis.

ANS: A

A family member of a 28-year-old patient who has suffered massive abdominal trauma in an automobile accident asks the nurse why the patient is receiving famotidine (Pepcid). The nurse will

explain that the medication will

a. decrease nausea and vomiting.
b. inhibit development of stress ulcers.
c. lower the risk for *H. pylori* infection.
d. prevent aspiration of gastric contents.

ANS: B

At his first postoperative checkup appointment after a gastrojejunostomy (Billroth II), a patient reports that dizziness, weakness, and palpitations occur about 20 minutes after each meal. The nurse will teach the patient to

a. increase the amount of fluid with meals.
b. eat foods that are higher in carbohydrates.
c. lie down for about 30 minutes after eating.
d. drink sugared fluids or eat candy after meals.

ANS: C

Which assessment should the nurse perform **first** for a patient who just vomited bright red blood?

a. Measuring the quantity of emesis
b. Palpating the abdomen for distention
c. Auscultating the chest for breath sounds
d. Taking the blood pressure (BP) and pulse

ANS: D

A 22-year-old female patient with an exacerbation of ulcerative colitis is having 15 to 20 stools daily and has excoriated perianal skin. Which patient behavior indicates that teaching regarding maintenance of skin integrity has been effective?

a. The patient uses incontinence briefs to contain loose stools.
b. The patient asks for antidiarrheal medication after each stool.
c. The patient uses witch hazel compresses to decrease irritation.
d. The patient cleans the perianal area with soap after each stool.

ANS: C

After a total proctocolectomy and permanent ileostomy, the patient tells the nurse, "I cannot manage all these changes. I don't want to look at the stoma." What is the **best** action by the nurse?

a. Reassure the patient that ileostomy care will become easier.
b. Ask the patient about the concerns with stoma management.
c. Develop a detailed written list of ostomy care tasks for the patient.
d. Postpone any teaching until the patient adjusts to the ileostomy.

ANS: B

The nurse preparing for the annual physical exam of a 50-year-old man will plan to teach the patient about

a. endoscopy.
b. colonoscopy.
c. computerized tomography screening.
d. carcinoembryonic antigen (CEA) testing.

ANS: B

Four hours after a bowel resection, a 74-year-old male patient with a nasogastric tube to suction complains of nausea and abdominal distention. The **first** action by the nurse should be to

a. auscultate for hypotonic bowel sounds.
b. notify the patient's health care provider.
c. reposition the tube and check for placement.
d. remove the tube and replace it with a new one.

ANS: C

A 46-year-old female patient returns to the clinic with recurrent dysuria after being treated with trimethoprim and sulfamethoxazole (Bactrim) for 3 days. Which action will the nurse plan to take?

a. Teach the patient to take the prescribed Bactrim for 3 more days.
b. Remind the patient about the need to drink 1000 mL of fluids daily.
c. Obtain a midstream urine specimen for culture and sensitivity testing.
d. Suggest that the patient use acetaminophen (Tylenol) to treat the symptoms.

ANS: C

The nurse determines that instruction regarding prevention of future urinary tract infections (UTIs) has been effective for a 22-year-old female patient with cystitis when the patient states which of the following?

a. "I can use vaginal antiseptic sprays to reduce bacteria."
b. "I will drink a quart of water or other fluids every day."
c. "I will wash with soap and water before sexual intercourse."
d. "I will empty my bladder every 3 to 4 hours during the day."

ANS: D

Which information will the nurse include when teaching the patient with a urinary tract infection (UTI) about the use of phenazopyridine (Pyridium)?

a. Pyridium may cause photosensitivity
b. Pyridium may change the urine color.
c. Take the Pyridium for at least 7 days.
d. Take Pyridium before sexual intercourse.

ANS: B

Which finding by the nurse will be **most** helpful in determining whether a 67-year-old patient with benign prostatic hyperplasia has an upper urinary tract infection (UTI)?

a. Bladder distention
b. Foul-smelling urine
c. Suprapubic discomfort
d. Costovertebral tenderness

ANS: D

Which finding by the nurse will be **most** helpful in determining whether a 67-year-old patient with benign prostatic hyperplasia has an upper urinary tract infection (UTI)?

a. Bladder distention
b. Foul-smelling urine
c. Suprapubic discomfort
d. Costovertebral tenderness

ANS: D

To prevent recurrence of uric acid renal calculi, the nurse teaches the patient to avoid eating

a. milk and cheese.
b. sardines and liver.
c. legumes and dried fruit.
d. spinach, chocolate, and tea.

ANS: B

The nurse teaches a 64-year-old woman to prevent the recurrence of renal calculi by

a. using a filter to strain all urine.
b. avoiding dietary sources of calcium.
c. choosing diuretic fluids such as coffee.
d. drinking 2000 to 3000 mL of fluid a day.

ANS: D

A 34-year-old male patient seen at the primary care clinic complains of feeling continued fullness after voiding and a split, spraying urine stream. The nurse will ask about a history of

a. recent kidney trauma.
b. gonococcal urethritis.
c. recurrent bladder infection.
d. benign prostatic hyperplasia.

ANS: B

A 68-year-old female patient admitted to the hospital with dehydration is confused and incontinent of urine. Which nursing action will be best to include in the plan of care?

a. Restrict fluids between meals and after the evening meal.
b. Apply absorbent incontinent pads liberally over the bed linens.
c. Insert an indwelling catheter until the symptoms have resolved.
d. Assist the patient to the bathroom every 2 hours during the day.

ANS: D

Which assessment finding for a patient who has just been admitted with acute pyelonephritis is **most** important for the nurse to report to the health care provider?

a. Complaint of flank pain
b. Blood pressure 90/48 mm Hg
c. Cloudy and foul-smelling urine
d. Temperature 100.1° F (57.8° C)

ANS: B

Which nursing action is of highest **priority** for a 68-year-old patient with renal calculi who is being admitted to the hospital with gross hematuria and severe colicky left flank pain?

a. Administer prescribed analgesics.
b. Monitor temperature every 4 hours.
c. Encourage increased oral fluid intake.
d. Give antiemetics as needed for nausea.

ANS: A

Which nursing action is of highest **priority** for a 68-year-old patient with renal calculi who is being admitted to the hospital with gross hematuria and severe colicky left flank pain?

a. Administer prescribed analgesics.

b. Monitor temperature every 4 hours.
c. Encourage increased oral fluid intake.
d. Give antiemetics as needed for nausea.

ANS: A

A patient is admitted to the emergency department with possible renal trauma after an automobile accident. Which prescribed intervention will the nurse implement **first**?

a. Check blood pressure and heart rate.
b. Administer morphine sulfate 4 mg IV.
c. Transport to radiology for an intravenous pyelogram.
d. Insert a urethral catheter and obtain a urine specimen.

ANS: A

A 32-year-old man who has a profuse, purulent urethral discharge with painful urination is seen at the clinic. Which information will be **most** important for the nurse to obtain?

a. Contraceptive use
b. Sexual orientation
c. Immunization history
d. Recent sexual contacts

ANS: D

A 48-year-old male patient who has been diagnosed with gonococcal urethritis tells the nurse he had recent sexual contact with a woman but says she did not appear to have any disease. In responding to the patient, the nurse explains that

a. women do not develop gonorrhea infections but can serve as carriers to spread the disease to males.
b. women may not be aware they have gonorrhea because they often do not have symptoms of infection.
c. women develop subclinical cases of gonorrhea that do not cause tissue damage or clinical manifestations.
d. when gonorrhea infections occur in women, the disease affects only the ovaries and not the genital organs.

ANS: B

Which infection, reported in the health history of a woman who is having difficulty conceiving, will the nurse identify as a risk factor for infertility?

a. *N. gonorrhoeae*
b. *Treponema pallidum*
c. Condyloma acuminatum
d. Herpes simplex virus type 2

ANS: A

A woman is diagnosed with primary syphilis during her eighth week of pregnancy. The nurse will plan to teach the patient about the

a. likelihood of a stillbirth.
b. plans for cesarean section
c. intramuscular injection of penicillin.
d. antibiotic eye drops for the newborn.

ANS: C

A 68-year-old patient is being admitted with a possible stroke. Which information from the assessment indicates that the nurse should consult with the health care provider before giving the prescribed aspirin?

a. The patient has dysphasia.
b. The patient has atrial fibrillation.
c. The patient reports that symptoms began with a severe headache.
d. The patient has a history of brief episodes of right-sided hemiplegia.

ANS: C

A 73-year-old patient with a stroke experiences facial drooping on the right side and right-sided arm and leg paralysis. When admitting the patient, which clinical manifestation will the nurse expect to find?

a. Impulsive behavior
b. Right-sided neglect
c. Hyperactive left-sided tendon reflexes
d. Difficulty comprehending instructions

ANS: D

A female patient who had a stroke 24 hours ago has expressive aphasia. The nurse identifies the nursing diagnosis of impaired verbal communication. An appropriate nursing intervention to help the patient communicate is to

a. ask questions that the patient can answer with “yes” or “no.”
b. develop a list of words that the patient can read and practice reciting.
c. have the patient practice her facial and tongue exercises with a mirror.
d. prevent embarrassing the patient by answering for her if she does not respond.

ANS: A

For a patient who had a right hemisphere stroke the nurse establishes a nursing diagnosis of

a. risk for injury related to denial of deficits and impulsiveness.
b. impaired physical mobility related to right-sided hemiplegia.
c. impaired verbal communication related to speech-language deficits.
d. ineffective coping related to depression and distress about disability.

ANS: A

When caring for a patient with a new right-sided homonymous hemianopsia resulting from a stroke, which intervention should the nurse include in the plan of care?

a. Apply an eye patch to the right eye.
b. Approach the patient from the right side.
c. Place objects needed on the patient’s left side.
d. Teach the patient that the left visual deficit will resolve.

ANS: C

Several weeks after a stroke, a 50-year-old male patient has impaired awareness of bladder fullness, resulting in urinary incontinence. Which nursing intervention will be **best** to include in the initial plan for an effective bladder training program?

a. Limit fluid intake to 1200 mL daily to reduce urine volume.
b. Assist the patient onto the bedside commode every 2 hours.
c. Perform intermittent catheterization after each voiding to check for residual urine.

d. Use an external "condom" catheter to protect the skin and prevent embarrassment.

ANS: B

A 72-year-old patient who has a history of a transient ischemic attack (TIA) has an order for aspirin 160 mg daily. When the nurse is administering medications, the patient says, "I don't need the aspirin today. I don't have a fever." Which action should the nurse take?

a. Document that the aspirin was refused by the patient.
b. Tell the patient that the aspirin is used to prevent a fever.
c. Explain that the aspirin is ordered to decrease stroke risk.
d. Call the health care provider to clarify the medication order.

ANS: C

A patient in the clinic reports a recent episode of dysphasia and left-sided weakness at home that resolved after 2 hours. The nurse will anticipate teaching the patient about

a. alteplase (tPA).
b. aspirin (Ecotrin).
c. warfarin (Coumadin).
d. nimodipine (Nimotop).

ANS: B

A 58-year-old patient with a left-brain stroke suddenly bursts into tears when family members visit. The nurse should

a. use a calm voice to ask the patient to stop the crying behavior.
b. explain to the family that depression is normal following a stroke.
c. have the family members leave the patient alone for a few minutes.
d. teach the family that emotional outbursts are common after strokes.

ANS: D

A patient in the emergency department with sudden-onset right-sided weakness is diagnosed with an intracerebral hemorrhage. Which information about the patient is **most** important to communicate to the health care provider?

a. The patient's speech is difficult to understand.
b. The patient's blood pressure is 144/90 mm Hg.
c. The patient takes a diuretic because of a history of hypertension.
d. The patient has atrial fibrillation and takes warfarin (Coumadin).

ANS: D

After receiving change-of-shift report on the following four patients, which patient should the nurse see **first**?

a. A 60-year-old patient with right-sided weakness who has an infusion of tPA prescribed
b. A 50-year-old patient who has atrial fibrillation and a new order for warfarin (Coumadin)
c. A 40-year-old patient who experienced a transient ischemic attack yesterday who has a dose of aspirin due
d. A 30-year-old patient with a subarachnoid hemorrhage 2 days ago who has nimodipine (Nimotop) scheduled

ANS: A

Which finding will the nurse expect when assessing a 58-year-old patient who has osteoarthritis (OA) of the knee?

a. Discomfort with joint movement
b. Heberden's and Bouchard's nodes
c. Redness and swelling of the knee joint
d. Stiffness that increases with movement

ANS: A

Which action will the nurse include in the plan of care for a 33-year-old patient with a new diagnosis of rheumatoid arthritis?

a. Instruct the patient to purchase a soft mattress.
b. Suggest that the patient take a nap in the afternoon.
c. Teach the patient to use lukewarm water when bathing.
d. Suggest exercise with light weights several times daily.

ANS: B

A patient with rheumatoid arthritis (RA) complains to the clinic nurse about having chronically dry eyes. Which action by the nurse is **most** appropriate?

a. Teach the patient about adverse effects of the RA medications.
b. Suggest that the patient use over-the-counter (OTC) artificial tears.
c. Reassure the patient that dry eyes are a common problem with RA.
d. Ask the health care provider about discontinuing methotrexate (Rheumatrex) .

ANS: B

Which information will the nurse include when preparing teaching materials for patients with exacerbations of rheumatoid arthritis?

a. Affected joints should not be exercised when pain is present.
b. Application of cold packs before exercise may decrease joint pain.
c. Exercises should be performed passively by someone other than the patient.
d. Walking may substitute for range-of-motion (ROM) exercises on some days.

ANS: B

The nurse suggests that a patient recently diagnosed with rheumatoid arthritis (RA) plan to start each day with

a. a warm bath followed by a short rest.
b. a short routine of isometric exercises.
c. active range-of-motion (ROM) exercises.
d. stretching exercises to relieve joint stiffness.

ANS: A

A 31-year-old woman is taking methotrexate (Rheumatrex) to treat rheumatoid arthritis. Which information from the patient's health history is important for the nurse to report to the health care provider about the methotrexate?

a. The patient had a history of infectious mononucleosis as a teenager.
b. The patient is trying to get pregnant before her disease becomes more severe.
c. The patient has a family history of age-related macular degeneration of the retina.
d. The patient has been using large doses of vitamins and health foods to treat the RA.

ANS: B

Final 1

. The nurse is caring for a client who is 1 day postoperative for an open thoracotomy. This client has a benign neoplasm of the left lung. The client is receiving oxygen mist at 40%. The O2 saturation measured by pulse oximeter was 83. ABG results are: pH 7.32, PO2 93 mmHg, PCO2 50 mmHg, HCO3 25 mEq/L. Which of the following nursing actions would be a priority for this client?
a. Switch to O2 with a rebreathing bag
b. Increase O2 to 70%
c. Position the client in high-Fowler's, and encourage the use of incentive spirometer and coughing
d. Place the client in the prone position and have the respiratory therapists do postural drainage

2. A nurse is caring for a client who has Addison's disease and is at risk for Addisonian crisis. Nursing care for this client should include which of the following nursing actions?
a. Taking daily weights
b. Providing a low-carbohydrate diet
c. Instituting fluid restrictions
d. Administering oral corticosteroids

3. A patient is admitted to the emergency department with a severe exacerbation of asthma. Which finding is of most concern to the nurse?
a. Peak expiratory flow rate of 60% of personal best
b. Unable to speak and sweating profusely
c. PaO2 of 80 mmHg and PaCO2 of 50 mmHg
d. Presence of inspiratory and expiratory wheezing

4. A nurse is preparing teaching for a female client who smokes, is obese, and has hypertension. In
establishing health promotion goals for the client, the nurse should recognize that which of the following is an inappropriate recommendation for the client?
a. Start a weight reduction diet
b. Use nicotine patches to stop smoking
c. Exercise moderately three times a week
d. Eliminate sodium from the diet
5. While admitting a client for a cardiac catheterization, the nurse asks the client about allergies.
The client states, "I always get a rash when I eat shellfish." Which of the following is the priority nursing intervention?
a. Notify the provider of the client's allergy
b. Attach a wrist band indicating the client's allergy
c. Notify the dietary department of the client's allergy
d. Ask the client if any other foods cause such a reaction

6. A patient with acute pharyngitis is seen in the clinic with fever and severe throat pain that affects swallowing. On inspection, the throat is reddened and edematous with patchy yellow exudates. The nurse anticipates that collaborative management will include
a. Treatment with antibiotics
b. Treatment with antifungal agents
c. A throat culture or rapid strep antigen test
d. Treatment with medication only if the pharyngitis does not resolve in 3-4 days

7. A patient with sleep apnea who received a new prescription for a continuous positive airway pressure device (CPAP) a week ago returns to the clinic and says that severe daytime fatigue is still a problem. Which action should the nurse take first?
a. Teach about radiofrequency ablation
b. Discuss the possible surgical approaches used for sleep apnea
c. Ask the patient whether the CPAP is being used every night
d. Plan to schedule a night time PSG study

8. The nurse is caring for an HIV+ patient who was admitted with fever, productive cough, and a reported 10 pound weight loss. A PPD skin test was administered in the left forearms 2 days ago.
Today the nurse observes an area of slight redness and a 6 mm area of induration on the patient's left forearm. The nurse will record the TB skin test as
a. Positive, because the patient is HIV+
b. Positive because the area of induration is greater than 5 mm
c. Negative, the nurse knows induration must be 15 mm or greater to be positive
d. Negative, induration must be 10 mm or greater to be considered positive

9. A nurse is caring for an adolescent client who has a long history of diabetes mellitus and is being
admitted to the emergency department with an acetone odor on the breath. DKA is suspected. The nurse should anticipate using which of the following types of insulin:
a. Regular (Humulin R)
b. Lente (Humulin L)
c. Ultralente (Humulin U)
d. NPH (Humulin NPH)
10. A nurse is caring for a client who has COPD. When developing this client's plan of care, the nurse
should include which of the following interventions?
a. Have the client use the early morning hours for exercise and activity
b. Instruct the client to use pursed lip breathing
c. Encourage the client to use the upper chest for respiration
d. Restrict the client's fluid intake to less than 2 L/day

11. A nurse in an ED is caring for a client who reports vomiting, diarrhea, fever, headache, and

diabetes. The client was recently exposed to the influenza virus. The client's vitals are as follow: BP 198/110 and temperature 38.2 C (100.8 F). The nurse should give immediate consideration to
the client's manifestation of
a. Headache and dizziness
b. Fever
c. Vomiting
d. Diarrhea

12. The patient admitted to the hospital with hyperglycemia and newly diagnosed DM is scheduled
for discharge the second day after admittance. The nurse is implementing patient teaching, which is the best action for the nurse to take
a. Give information about the effects of exercise on glucose control
b. Instruct about the increased risk of cardiovascular disease
c. Provide detailed information about dietary control on glucose
d. Teach glucose self-monitoring and medication administration

13. To assist in delivering whether a patient seen in the ambulatory care setting has chronic insomnia, the nurse will initially
a. Ask the patient to keep a two sleep week diary
b. Arrange the patient to have a sleep study
c. Schedule a polysomnography (PSG) study
d. Teach the patient about the use of an actigraph

14. An ER nurse is caring for a client following an automobile crash. Upon assessment, the nurse observes bleeding from the client's ___. Which of the following interventions is appropriate?
a. Suction the nose gently with a bulb syringe
b. Allow the drainage to drip onto a sterile gauze pad
c. Obtain a culture of the specimen using sterile swabs
d. Insert sterile packing into the nares

15. A nurse working in a dermatologist's office is planning an educational session regarding skin cancer. When discussing risk factors the nurse (stated) the following: (select all that apply)
a. Age under 40 years
b. Chronic skin irritations
c. Overexposure to UV light
d. Being dark-skinned
e. Genetic predisposition

16. The acronym FACES is used to help education patients to identify symptoms of heart failure. What does the acronym mean?
a. Frequent activity lead to cough in the elderly and swelling
b. Fatigue, limitation of activities, chest congestion/cough, edema, shortness of breath

c. Follow of activity plan, continue exercise, and know signs of problems
d. Factors of risk: activity, cough, emotional upset, salt intake

17. A nurse is preparing an in-service training about HIV for a church-based group. Which of the (following should the nurse) include about HIV transmission?
a. It is primarily transmitted through mosquitoes
b. It is primarily transmitted through contact with infected body fluids
c. It is primarily transmitted through casual contact
d. It is primarily transmitted through accidental puncture wounds

18. A nurse is assessing a client who has an acute MI. Which of the following clinical manifestations should the nurse expect (to see). Select all that apply.
a. Tachycardia
b. Diaphoresis
c. Nausea
d. Orthopnea
e. Headache

19. A home health patient with rheumatoid arthritis complains to the nurse about having chronically dry eyes. Which action (should the nurse take)?
a. Teach the patient more about adverse effects to the RA medication
b. Suggest that the patient start using over the counter artificial tears
c. Ask the health provider about lowering the methotrexate dose
d. Reassure the patient that dry eyes are a common problem with RA

20. The patient with a left-sided brain stroke suddenly bursts into tears when family members visit.
The nurse should
a. Have the family members leave the patient alone for a few minutes
b. Use a calm voice to ask the patient to stop crying
c. Explain to the family that depression is normal following a stroke
d. Teach the family that emotional outburst are common after strokes

21. A nurse is caring for a client who has a NG tube. The nurse tests the pH of the secretions to determine if the tube is correctly (placed. The nurse) should expect to aspirate a simple with a pH of
a. 6.0
b. 4.0
c. 8.0
d. 7.0

22. A nurse is providing information on pain control for a client who has acute pain following a subtotal gastric resection. Which (of the following) indicate an understanding of pain control?
a. “I will wait for you to evaluate my pain before asking for more”

b. “I will ask for less medication to avoid addiction”
c. “I will call for pain medication as my pain starts to increase again”
d. “I will call the pain medication before the previous dose wears off”

23. A client with valvular heart disease is at risk for developing left sided heart failure. The nurse
knows to monitor which of the following parameters to determined (that) the client has developed this disorder?
a. Breath sounds
b. Body weight
c. Blood pressure
d. Appetite

24. A nurse is caring for a client who has right-sided acoustic neuroma resulting in impairment of
the seventh cranial nerve. Which of the following is appropriate?
a. Avoid the use of warm water to wash the face
b. Apply an eyepatch to the right eye
c. Place suction equipment at the bedside
d. Instruct the client to perform neck exercises

25. A nurse is preparing for the hospital admission of client who is suspected to have active TB. Which of following precautions should (the nurse try) to implement to safely care for this client?
a. The client may be placed in a room with other clients who require droplet isolation precautions.
b. The protocol of donning and removing personal protective equipment before entering or leaving the room with TB is different (because there) are other types of isolation
c. Staff and visitors are to wear gowns, masks, and gloves while in the client’s room
d. The client should be placed in a private room with a special ventilation system

26. Which of the following patients would be the most at risk for aspiration pneumonia? Select all
that apply
a. Patient with seizures
b. Patient who is receiving NG tube feedings
c. Patient who had thoracic surgery
d. Patient who had a myocardial infarction
e. Patient with a head injury

27. A nurse is assessing a client who has COPD. The nurse should expect the client’s chest to be which of the following shape?
a. Kyphotic
b. Funnel

c. Pigeon
d. Barrel

28. A nurse is assessing a client who has a respiratory disorder. If the client has hypoxia, the nurse
should expect which of the following findings?
a. Bradypnea
b. Cyanosis
c. Bradycardia
d. Pallor

29. A nurse is caring for a client who enters the emergency department of severe chest pain. Which
of the following interventions should the nurse (implement to) determine if the client is experiencing a myocardial infarction?
a. Determine if pain radiates to the left arm
b. Check the client's BP
c. Auscultate heart tones
d. Perform a 12 lead ECG

30. A nurse is caring for an older adult client who has RA and is taking aspirin 650 mg every 4 hours.
(What) should the nurse monitor to evaluate the effectiveness of this medication?
a. Erythrocyte sedimentation rate (ESR)
b. White blood cell (WBC) count
c. Rheumatoid factor (RF)
d. Antinuclear antibody (ANA)

31. A nurse is assessing a client who has DM and is experiencing foot pain. Which of the following are signs and symptoms ___ Select all that apply.
a. Localized edema
b. Increased platelets
c. Bradycardia
d. Increased RBC
e. Increased neutrophils

32. A client who has experienced an acute episode of gastritis receives home instructions by the nurse. Which of the following (should the nurse include in her teaching?)
a. Limit strenuous exercise
b. Avoid drinking alcohol
c. Limit drinking milk
d. Take NSAIDs for pain

33. A nurse is discharge teaching a client who has GERD. Which of the following client statements reveals an understanding (of the teaching)?
a. “I will sleep with the head of my bed elevated”
b. “I can only eat whenever I want”
c. “I will sleep on my left side”
d. “I will lie down following meals”

34. A patient has a stroke affecting the right hemisphere of the brain. Based on the knowledge of
the effects of right brain damage, the (patient has a) diagnosis of
a. Impaired physical mobility related to the right hemaplagia
b. Risk for injury related to denial of deficits and impulsiveness
c. Ineffective coping related to depression and distress about disability
d. Impaired verbal communication related to speech-language deficits

35. When obtaining a health history from a patient suspected of having early TB, what manifestations should the nurse ask the (patient)
a. Fatigue, night sweats, and low grade fevers
b. Cough with purulent mucus and fever with chills
c. Chest pain, hemoptysis, and weight loss
d. Pleuritic pain, nonproductive cough, and temperature elevation at night

36. A nurse is caring for a client admitted with a diagnosis of hyperthyroidism. The client reports aweight loss of 5.4 kg (12 lb) (and loss of appetite). Additional symptoms reported included increased perspiration, fatigue, menstrual irregularity, and restlessness. (What should) the nurse include in the client’s plan of care to prevent a thyroid crisis?
a. Maintain the client’s NPO status
b. Observe the client carefully for signs of hypocalcemia
c. Administer aspirin as prescribed for any sign of hyperthermia
d. Provide a quiet, low-stimulus environment

37. A nurse is caring for a group of clients in an infectious disease unit. The nurse should wear an OSHA-approved N95 respirator mask when (in contact with) which of the following infectious diseases?
a. Pertusis
b. Mycoplasmal pneumonia
c. Respiratory syncytial virus
d. Tuberculosis

38. A nurse at an outpatient surgery center is providing discharge teaching for a client and his wife
following surgical removal of a cataract. Which of the following should the nurse include in the teaching?
a. The client should remain in bed for 3 days

b. Keep the client's eye dressing on for 1 week
c. Feed the client soft foods for several days
d. The client should wear dark glasses while outdoors

39. A 72 year old who has benign prostatic hyperplasia is admitted to the hospital with nausea and
vomiting. Which finding by the nurse will be (monitoring for) determining whether the patient has an upper urinary tract infection?
a. Suprapubic pain
b. Costovertebral tenderness
c. Foul smelling urine
d. Bladder distention

40. Which nursing action would be the highest priority when suctioning a patient with a tracheostomy?
a. Administering pain and/or anti-anxiety medication for 30 minutes prior to suctioning
b. Assessing the patient's oxygenation saturation before, during, and after suctioning
c. Auscultating lung sounds after suctioning is complete
d. Providing a means of communication for the patient during the procedure

41. A nurse is planning care for a client who has a GI bleed. Which of the following actions should the nurse take first?
a. Administer pain medication
b. Explain the procedure for an upper GI series
c. Test the emesis for blood
d. Assess orthostatic blood pressure

42. A nurse is planning care for a client who has a suspected myocardial infarction. Which of the following should the nurse administer first?
a. Morphine sulfate
b. Nitroglycerin (Nitrostat)
c. Oxygen
d. Aspirin (A.S.A.)

43. A nurse is caring for a client who is suspected of having diabetes insipidus and is scheduled for a water deprivation test. During the (day, the nurse will) frequently assess the client for the development of
a. Polyphagia
b. Hyperglycemia
c. Bradycardia
d. Hypotension

44. A nurse in a provider's office is talking with a client about risk factors for osteoarthritis. Which of the following factors should the nurse (assess for? Select all that apply)

a. Aging
b. Obesity
c. Bacteria
d. Smoking
e. Diuretics

45. A nurse is caring for a client who has multiple skin lesions due to being infected with the herpes zoster virus. Which of the following actions by ____ intervention by the nurse's supervisor?
a. The nurse is admitting another client with the same illness to the client's double room
b. The nurse is wearing a special particulate (HEPA) filter mask
c. The nurse is wearing a gown when bathing the client
d. The nurse is wearing gloves when providing direct care to the client

46. A client is prescribed lansoprazole (Prevacid) 15 mg PO administered once a day. Which of the following times should the nurse administer the medication?
a. During the evening meal
b. Thirty minutes after lunch
c. Thirty minutes before breakfast
d. With a bedtime snack

47. A nurse is reviewing lab values for a client who has systemic lupus erythematosus (SLE). Which of the following values should give the nurse the best indications of the client's renal function?
a. Serum creatinine
b. Serum sodium
c. Urine-specific gravity
d. Blood urea nitrogen (BUN)

48. A nurse in the ED is assessing a client. The client's laboratory values are obtained, and she is now requesting an alcoholic (test. When) reviewing the client's admission laboratory results, which of the following medication prescriptions should the nurse question? 3.5 mEq/L Chloride, 106 mEq/LCarbon dioxide, 32 mEq/LBUN, 55 mg/dLGlucose, 468 mg/dLCreatinine
a. Oxazepam (Serax)
b. Regular insulin (Humulin R)
c. Amphotericin B (Fungizone)
d. Glipizide (Glucotrol)

49. A nurse is caring for a client who just had an upper gastrointestinal endoscopic procedure. Which of the following is the assessment priority (for the patient)?
a. Nausea
b. Gag reflex
c. Pain
d. Level of consciousness

50. A nurse is caring for a client who has urinary incontinence following surgery. Findings include
the leakage of small amounts of urine (at) night, along with urinating frequently in small amounts. Her bladder is often distended and palpable upon examination. The nurse (says the patient is) associated with which of the following types of incontinence?
a. Urge incontinence
b. Stress incontinence
c. Overflow incontinence
d. Reflex incontinence

51. A patient with chronic cancer pain is receiving imipramine (Tofranil) in addition to long acting morphine for pain control. Which information (shows the nurse that the) imipramine is effective?
a. The patient states: The pain is manageable and I can accomplish my desired activities
b. The patient states: I feel much less depressed since I've begun taking the imipramine
c. The patient sleeps 8 hours per night
d. The patient has no symptoms of anxiety

52. A nurse must assign a client who has active TB to a bed on a medical surgical unit. Which of the following accommodations (should the nurse set for the patient)
a. A room with air exhaust directly to the outdoor environment
b. A two-bedroom with another nonsurgical client
c. A room with a minimum of four air exchanges per hour
d. A bed in the intensive care unit

53. A nurse is providing education for a client who has glaucoma. Which of the following statements
is appropriate?
a. "Glaucoma results from inadequate production of fluid within the eye"
b. "Without treatment of glaucoma can cause blindness"
c. "Double vision is a common symptom of glaucoma"
d. "You will need to treat glaucoma by instilling eye drops once a week"

54. A client with a severe infection is prescribed IV vancomycin (Vancocin) 1 g in 250 m/L D5W over 2 hours. The nurse should (set the IV pump to) Ml/HR?
a. ___ Ml/HR

55. A nurse is caring for a client who has cellulitis of the leg. Which of the following interventions should be included in the nurse's care plan?
a. Elevate the left leg on two pillows
b. Apply fresh ice packs every 4 hours
c. Enforce strict bedrest for 3 days
d. Apply antibiotic ointment to the wound with dressing changes

56. A patient with poor circulation to the feet requires teaching about foot care. Which of the following should nurse (include in the plan of care)?
a. The patient will list three ways to protect the feet from injury by discharge
b. The patient will understand the rationale for proper foot care after instructions
c. The nurse will instruct the patient on appropriate foot care before discharge
d. The nurse will demonstrate the proper technique for trimming toe nails

57. A nurse is caring for a client who is one day post-operative from an appendectomy and is HIV positive. Which of the following _____ gown as personal protection equipment?
a. Administering an IM injection
b. Completing a dressing change
c. Talking to the client at the bedside
d. Administering an IV piggyback medication

58. A client is admitted to the emergency room with a respiratory rate of seven per min. Arterial blood gases (ABG) reveal the ___. (What is an appropriate analysis of the ABGs? Ph 7.22 PaCO2 68 mmHg Base excess -2 PaO2 78 mmHg saturation 80%
a. Metabolic alkalosis
b. Respiratory alkalosis
c. Respiratory acidosis
d. Metabolic acidosis

59. A nurse if caring for a client who has multiple skin lesions due to being infected with the herpes zoster virus. Which of the following actions by the …intervention by the nurse supervisor?
a. The nurse is admitting another client with the same illness to the client's double room
b. The nurse is wearing a special particulate (HEPA) filter mask
c. The nurse is wearing a gown when bathing the client
d. The nurse is wearing gloves when providing direct care to the client

60. A nurse is planning care for a client who has pernicious anemia. Which of the following should the nurse implement?
a. Vitamin B6 (pyridoxine) supplements
b. Iron Supplements
c. Vitamin B12 (cyanocobalamin) injections
d. Blood transfusions

61. A nurse is caring for a client who has a peptic ulcer. Which of the following findings is a risk factor for this condition?
a. History of bulimia
b. Has occasional glass of wine
c. Drinks green tea
d. History of corticosteroid use

62. A nurse if caring for a client at a rehabilitation center 3 weeks after a cerebrovascular accident
(CVA). Because of the client's CVA affected the left side of the brain which of the following goals should the nurse anticipate including in the client's rehabilitation program?
a. Learn to control compulsive behavior
b. Have a regular, formed stool at least every other day
c. Improve left-side motor function
d. Establish the ability to communicate effectively

63. A nurse is performing teaching with a client who has newly diagnosed type 2 diabetes mellitus.The nurse should recognize that the client understands teaching when he identifies which of the following manifestations of hypoglycemia? (Select all that apply)
a. Acetone Breath
b. Moist clammy skin
c. Vertigo
d. Polydipsia
e. Polyuria
f. Tachycardia

64. A client who has had a significant myocardial infarction receives a referral to the cardiac rehabilitation unit. During his first visit to the unit, he doesn't understand why he needs to be there because there is nothing more to do as the damage is done. Which of the following is an appropriate response?
a. You are probably right and I agree with you, but I still think you should go
b. Your doctor is the expert here, and I'm sure he would only recommend what is best for you
c. It's not unusual to feel that way at first, but once you learn the routine, you'll be fine
d. Cardiac rehabilitation cannot undo the damage to your heart but it can help you get back to your previous level of activity safely

65. A nurse in a clinic is reviewing the laboratory values obtained from a client being seen for suspected hypothyroidism. If the diagnosis is accurate, the nurse should expect to see and elevated
a. Thyroxine
b. Triiodothyronine
c. Thyroid stimulating hormone (TSH)
d. Free thyroxine

66. Which information noted by the nurse when caring for a patient with a bladder infection is most
important to report to the health care provider?
a. Temperature 100.1 F
b. Hematuria

c. Left-sided flank pain
d. Dysuria

67. A nurse is providing dietary teaching for a client who has a history of recurring uric acid stones.
The nurse should instruct the client that it is most important to avoid which of the following foods?
a. Turkey
b. Asparagus
c. Whole grain bread
d. Brown gravy

68. A nurse is caring for a client who is unconscious following a cerebral hemorrhage. Which of the
following nursing interventions is of highest priority?
a. Monitor the client's electrolyte levels
b. Record the client's intake and output
c. Suction saliva from the client's mouth
d. Perform passive range of motion on each extremity

69. A client who has a history of myocardial infarction is prescribed aspirin (Ecotrin) 325 mg. The
nurse correctly understands that the aspirin is order's action as an
a. Anti-inflammatory
b. Antiplatelet aggregate
c. Analgesic
d. Antipyretic

70. A nurse in a clinic is assessing a client who has AIDS, has a significantly decreased CD4 cell count, and is at increased risk for infection. The nurse (tells) that the client is likely have which of the following infectious oral conditions?
a. Gingivitis
b. Xerostomia
c. Haltosis
d. Candidiasis

71. A nurse is providing teaching for a client who has a new diagnosis of fibromyalgia. Which of the following should the nurse include in the (teaching)?
a. Low-impact aerobics can help reduce episodes of pain
b. Antidepressant medications should be avoided during treatment
c. Naps during the day will increase fatigue
d. Regular back massages can help decrease pain

72. A nurse is caring for a client who has an indwelling urinary catheter. The client repeats an urage to urinate. Which of the following actions (should the nurse include in her plan of care)?
a. Check the catheter tubing for kinks and note the amount of urine output in the drainage bag
b. Explain to the client that the urge to urinate is common in clients who have urinary catheters
c. Replace the client's current catheter with a new one
d. Remind the client that a catheter is in place and it is not necessary to go to the bathroom

73. The nurse is caring for a patient with carotid artery narrowing who has just returned from having a left carotid angioplasty and stenting. Which of the following information is of most concern to the nurse?
a. There are fine crackles at the lung bases
b. The BP is 142/88 mmHg
c. The patient has difficulty talking
d. The pulse rate is 104 bpm

74. A nurse is caring for an older adult client who is hospitalized. At bedtime, the client says, "I am
afraid that I may fall while walking to the bathroom during (the night and I) tend to get a bit disoriented to new surroundings." The nurse should
a. Obtain a bedside commode for the client's use
b. Leave a night-light on in the client's room
c. Put the side rails up and tell the client to call the nurse before voiding
d. Limit the client's fluid intake in the morning

75. A nurse is assessing a client who has systemic lupus erythematosus (SLE). Which of the following
findings is the highest priority to report to the provider?
a. Dry, raised rash on the face
b. Client's report of feelings of depression
c. Presence of peripheral edema
d. Joint pain in hands and knees

76. A client is about to start taking celecoxib (Celebrex) to treat osteoarthritis symptoms. The nurse should instruct the client to watch for and report which of the following possible indications of a serious reaction to the drug?
a. Black, tarry stools
b. Polyuria
c. Bone pain
d. Dry mouth

77. A nurse is developing an educational poster regarding risk factors for cardiovascular accdients (CVA) for a group of clients. In a listing of nonmodifiable risk factors, the nurse should include
a. Race
b. Smoking
c. Hypertension
d. Obesity

78. A nurse in the emergency department is caring for a client who reports chest pressure, indigestion, fatigue, and occasional shortness (of breath. Which of the) following laboratory tests will provide the most specific indication of whether or not the client has had a myocardial infarction (MI)?
a. Aspartate aminotransferase (AST)
b. Myoglobin
c. Creatinine kinase
d. Troponin I

79. Which of the following strategies would best assist the nurse in communication with a patient who has a hearing loss?
a. Exaggerate facial expressions
b. Speak louder
c. Write out names and difficult words
d. Speak normally but slowly
e. Over enunciate speech

80. Which instructions are most appropriate for the nurse to provide to a patient who has an hordeolum (stye)?
a. Application of warm and most compresses for at least four times per day
b. Post-op surgical care after the removal of the hordeolum
c. Correct technique for instillation of saline eye drops
d. Use of sunglasses when outdoors or in bright light

81. A nurse is caring for a client who has Cushing's syndrome. The nurse should recognize which of the following as manifestations of Cushing's syndrome? Select all that apply.
a. Obese extremities
b. Alopecia
c. Tremors
d. Purple striations
e. Moon face
f. Buffalo hump

82. A nurse is caring for a client who just had an upper GI endoscopic procedure. Which of the following is the assessment priority (for the nurse)?
a. Nausea

b. Gag reflex
c. Pain
d. Level of consciousness