A nurse is assessing for compartment syndrome in a client who has a short leg cast. Which of the following findings should the nurse identify as a manifestation of this condition?
Pain that increases with passive movement

Rationale: The nurse should identify that a client who has compartment syndrome experiences pain that increases with passive movement. Compartment syndrome results from a decrease in blood flow in the extremity caused by a decrease in the muscle compartment size due to a cast that is too tight.
A nurse is providing teaching to a client who has a severe form of stage II Lyme disease. Which of the following statements made by the client reflects an understanding of the teaching?
My joints ache because I have Lyme disease

Rationale: Lyme disease is a vector-borne illness transmitted by the deer tick. The disease course occurs in three stages beginning with joint and muscle pain in stage I. If left untreated, these symptoms continue throughout stage II and, by stage III, become

A nurse is preparing to administer phenytoin 600 mg PO daily to a client. The amount available is oral solution 125 mg/5 mL. How many mL should the nurse administer? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.)
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A nurse is caring for a client who has an arterial line. Which of the following actions should the nurse take?
place a pressure bag around the flush solution

Rationale: The nurse should place a pressure bag around the flush solution of 0.9% sodium chloride because the pressure from an artery is greater than that of the line. An arterial line is not appropriate access for administering antibiotics. The nurse should use the arterial line to obtain arterial blood gas samples and monitor hemodynamic pressures.
A nurse is updating the plan of care for a client who is receiving chemotherapy. Which of the following findings should the nurse identify as the priority?
Report of sore throat

Rationale: When using the urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is a report of a sore throat, which could be a manifestation of an infection. The client is at risk for neutropenia due to myelosuppression; therefore, an infection could lead to sepsis.
A nurse is reviewing the medical record of a client who has systemic lupus erythematosus (SLE). Which of the following findings should the nurse expect?
Facial butterfly rash

Rationale: A butterfly rash is a manifestation of SLE. It appears as a dry, red rash on the client's cheeks and nose and can disappear during times of remission.

A nurse is planning care for a client who is postoperative following a parathyroidectomy. Which of the following actions should the nurse identify as the priority?
Place tracheostomy tray at the bedside

Rationale: The priority action the nurse should take when using the airway, breathing, circulation approach to client care is to place a tracheostomy tray at the client's bedside in case of airway obstruction.

A nurse is assessing a client who has diabetes insipidus. Which of the following findings should the nurse expect?
Low urine specific gravity

Rationale: An expected finding for a client who has diabetes insipidus is a urine specific gravity between 1.001 and 1.005. Decreased water reabsorption by the renal tubules is caused by an alteration in antidiuretic hormone release or the kidneys' responsiveness to the hormone.

A nurse is providing teaching to a client who has stage II cervical cancer and is scheduled for brachytherapy. Which of the following instructions should the nurse include?
You will need to stay still in the bed during each treatment session."

Rationale: The nurse should instruct the client that they will need to remain on bed rest with very limited movement because excessive movement can cause the radioactive source to become dislodged.

The nurse should instruct the client that there is not excreted radiation between treatments.
The nurse should instruct the client that there will likely be between two and five treatments, once or twice each week.
The nurse should instruct the client that blood in the urine is an adverse effect of brachytherapy and is not an expected finding.
A nurse is planning care for a client who is scheduled for a thoracentesis. Which of the following interventions should the nurse include in the plan?
Encourage the client to take deep breaths after the procedure.

Rationale: After a thoracentesis, the client should deep breathe to re-expand the lung.
A nurse is caring for a client who is receiving a blood transfusion. The client becomes restless, dyspneic, and has crackles noted to the lung bases. Which of the following actions should the nurse anticipate taking?
Slow the infusion rate

Rationale: Dyspnea, restlessness, and the onset of crackles during a blood transfusion are manifestations of circulatory overload. The nurse should slow or stop the infusion to improve the client's ability to breathe, place the client in an upright position, and notify the provider. The provider might prescribe a diuretic to alleviate the fluid overload.

A nurse is providing teaching to a client who has end-stage kidney disease and is waiting for a kidney transplant. Which of the following information should the nurse provide?
Hemodialys is something required following surgery.

Rationale: When a kidney comes from a deceased donor, it might not function immediately, requiring the recipient to continue hemodialysis postoperatively.

A nurse is caring for a client who has hypothyroidism. Which of the following manifestations should the nurse expect?
Constipation

Rationale: A client who has hypothyroidism can experience constipation due to the decrease in the client's metabolism, resulting in slow motility of the gastrointestinal tract. The nurse should instruct the client to increase fiber and fluid intake to reduce the risk for constipation.

A nurse is providing preoperative teaching for a client who is scheduled for a mastectomy. Which of the following statements should the nurse make?
I will refer you to community resources that can provide support.

Rationale: The nurse should provide the client with support resources, including community programs, to assist the client with acceptance of body image changes.

A nurse is caring for a client who had a nephrostomy tube inserted 12 hr ago. Which of the following findings should the nurse report to the provider?
Client reports back pain

Rationale: The nurse should notify the provider if the client reports back pain, which can indicate that the nephrostomy tube is dislodged or clogged.

A nurse is teaching a family about the care of a parent who has a new diagnosis of Alzheimer's disease. Which of the following information should the nurse include in the teaching?
Create complete outfits and allow the client to select one each day

Rationale: The family should place completed outfits on hangers and allow the client to select which one to wear each day.

A nurse is caring for a client who has breast cancer and tells the nurse that they would like to have acupuncture because it provides greater relief than pain medication. Which of the following statements should the nurse make?
"I can speak to the provider about incorporating acupuncture into your treatment plan."

Rationale: The nurse should serve as an advocate for the client by acting on behalf of the client and offering to speak with the provider. The client has the right to make

choices and decisions about their treatment and the nurse should support these decisions and assist the client to carry them out.

A nurse is caring for a client following extubation of an endotracheal tube 10 min ago. Which of the following findings should the nurse report to the provider immediately?
Stridor

Rationale: Using the urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is stridor. Stridor can indicate a narrowing airway or possible obstruction caused by edema or laryngeal spasms. The nurse should report the finding immediately and implement an intervention.

A nurse is reviewing the laboratory findings of a client who developed chest pain 6 hr ago. The nurse should identify which of the following findings as an indication of a myocardial infarction (MI)?
Troponin I 8 ng/mL

Rationale: Troponins are proteins present in skeletal and cardiac muscle that are involved with muscle contraction. The elevation of either troponin T or troponin I is an indication of cardiac injury. The client's laboratory value is above the expected reference range for troponin I, indicating an MI has occurred.

A nurse is preparing to administer a blood transfusion to a client who has anemia. Which of the following actions should the nurse take first?
Check for the type and number of units of blood to administer

Rationale: According to evidence-based practice, the nurse should first confirm that the type and number of units of blood to administer matches what is indicated in the client's medication administration record.

A nurse is reviewing the laboratory results of a client who has aplastic anemia. Which of the following findings indicates a potential complication?
WBC count 2,000

Rationale: A WBC count of 2,000/mm3 is below the expected reference range and indicates a risk for severe immunosuppression.

A nurse is providing discharge teaching to a client who is postoperative following a modified radical mastectomy. Which of the following instructions should the nurse include?
Numbness can occur along the inside of the affected arm.

Rationale: The nurse should instruct the client that numbness can occur near the incision and along the inside of the affected arm due to nerve injury.

A nurse is preparing to present a program about prevention of atherosclerosis at a health fair. Which of the following recommendations should the nurse plan to include? (Select all that apply.)
Follow a smoking cessation program is correct. Smoking cessation is an important lifestyle modification to prevent atherosclerosis.
Maintain an appropriate weight is correct. Preventing obesity through diet and exercise can help to prevent atherosclerosis.
Eat a low-fat diet is correct. Eating a low-fat diet decreases LDL cholesterol and can prevent atherosclerosis.

Increase fluid intake is incorrect. Increasing intake of fruits, vegetables, and grains can prevent atherosclerosis.

Decrease intake of complex carbohydrates is incorrect. Decreasing intake of simple sugars and sweetened foods and increasing complex carbohydrates, such as fiber, can reduce the risk of heart disease.

A nurse is caring for a client who has homonymous hemianopsia as a result of a stroke. To reduce the risk of falls when ambulating, the nurse should provide which of the following instructions to the client?
Scan the environment by turning your head from side to side."

Rationale: Homonymous hemianopsia is the loss of the same visual field in both eyes. Turning their head from side to side helps enlarge a client's visual field. This technique is also useful for the client during mealtimes.

A nurse is caring for a client who has a pneumothorax and a closed-chest drainage system. Which of the following findings is an indication of lung re-expansion?
Bubbling in the water seal chamber has ceased.

Rationale: Bubbling in the water seal chamber ceases when the lung re-expands.
A nurse is providing discharge teaching to a client who is to self-administer heparin subcutaneously. Which of the following statements by the client indicates an understanding of the teaching?
I will use an electric razor to shave.

Rationale: Heparin is an anticoagulant that places the client at the risk for bleeding. Therefore, the nurse should instruct the client to use an electric razor when shaving to reduce the risk of cuts to the skin.

A nurse is providing follow-up care for a client who sustained a compound fracture 3 weeks ago. The nurse should recognize that an unexpected finding for which of the following laboratory values is a manifestation of osteomyelitis and should be reported to the provider?
Sedimentation rate.

Rationale: An increased sedimentation rate occurs when a client has any type of inflammatory process, such as osteomyelitis.

A nurse is performing a preoperative assessment for a client. The nurse should identify that an allergy to which of the following foods can indicate a latex allergy?
Avocados.

Rationale: Clients who have an avocado allergy might have an allergic reaction or a sensitivity to latex. Allergies to certain fruits, such as strawberries and bananas, can also indicate latex allergy or sensitivity.

shellfish allergy = allergic reaction to povidone-iodine.
peanut allergy = allergic reaction to propofol.
egg allergy = allergic reaction to propofol.

A nurse is caring for a client who has DKA. Which of the following findings should indicate to the nurse that the client's condition is improving?
Glucose 272

Rationale: A glucose reading less than 300 mg/dL indicates improvement in the client's status.
A nurse is caring for a client who has diabetic ketoacidosis (DKA). Which of the following should the nurse plan to administer?
Regular insulin 20 units IV.

Rationale: DKA is a complication of diabetes mellitus that results in dehydration, ketosis, metabolic acidosis, and elevated blood glucose levels. Management of DKA involves providing hydration, correcting acid-base imbalances, and decreasing blood glucose levels. Regular insulin is a fast-acting insulin that can be effective within 10 min when administered intravenously.

A nurse is evaluating the plan of care for four clients after 2 days of hospitalization. The nurse should identify the need to revise the plan for which of the following clients?
A client who is postoperative following abdominal surgery and reports feeling that something "popped" when they coughed.

Rationale: A feeling of something popping or loosening with coughing might indicate a wound dehiscence. This client will need to have revisions to the plan of care, which can include management of the dehiscence, prevention of evisceration, or possible surgical repair of an evisceration if one occurs.

A nurse is providing teaching to a client who has a new prescription for psyllium. Which of the following information should the nurse include in the teaching?
Drink 240 mL (8 oz) of water after administration.

SN:

The client should take the medication after meals to prevent appetite suppression.
The client should expect results in 12 to 24 hr and bowel regularity in 2 to 3 days.
Reducing dietary fiber intake does not affect medication absorption. However, the client should increase dietary fiber intake for management of chronic constipation.

A nurse is assessing a client who is at risk for the development of pernicious anemia resulting from peptic ulcer disease. Which of the following images depicts a condition caused by pernicious anemia?
This image depicts glossitis, which can indicate pernicious anemia. Glossitis, a smooth red tongue, is also a manifestation of deficiencies in vitamin B6, zinc, niacin, or folic acid.

A nurse is providing discharge instructions to a client who has laryngeal cancer and is receiving radiation therapy. Which of the following statements by the client indicates an understanding of the teaching?
"I will avoid direct exposure to the sun."

Rationale: The client should avoid exposure of irradiated skin areas to the sun for at least 1 year after completing radiation therapy. Skin in the radiation path is especially sensitive to sun damage.

SN:
Head and neck radiation can damage the salivary glands and cause dry mouth, which predisposes the client to mucositis. The client should rinse the mouth with plain water or 0.9% sodium chloride.
A nurse is admitting a client who has active tuberculosis. Which of the following types of transmission precautions should the nurse initiate?
Airborne.

Rationale: Airborne precautions are required for clients who have infections due to micro-organisms that can remain suspended in air for lengthy periods of time, such as tuberculosis, measles, varicella, and disseminated varicella zoster.

A nurse is reviewing the medical record of a client who has osteomyelitis and a prescription for gentamicin. Which of the following findings from the client's medical record should indicate to the nurse the need to withhold the medication and notify the provider? (Click on the "Exhibit" button for additional information about the client. There are three tabs that contain separate categories of data.)
Serum creatinine.

Rationale: A client who has an elevated serum creatinine level should not receive gentamicin because the medication is nephrotoxic.

A nurse is planning discharge teaching for a client who has an external fixation device for a fracture of the lower extremity. Which of the following instructions should the nurse include in the plan of care?
Use crutches with rubber tips.

Rationale: Using crutches with rubber tips prevents the client from slipping and decreases the risk of falls.

A nurse is providing teaching to a client who is perimenopausal and has a prescription for hormone replacement therapy. For which of the following adverse effects should the nurse instruct the client to notify the provider? (Select all that apply.)

Calf pain is correct. Calf pain is an indication of deep-vein thrombosis. The client should report this finding to the provider immediately.
Numbness in the arms is correct. Numbness in the arms can indicate a cerebrovascular accident, which is an adverse effect of hormone replacement therapy. The client should report this finding to the provider immediately.
Intense headache is correct. An intense headache can indicate a cerebrovascular accident, which is an adverse effect of hormone replacement therapy. The client should report this finding to the provider immediately.

SN:
Vaginal dryness is an expected finding of menopause.
Night sweats are a manifestation of menopause and do not require notification of the provider.

A nurse is teaching a group of newly licensed nurses about pain management for older adult clients. Which of the following statements by a newly licensed nurse indicates an understanding of the teaching?
"Ibuprofen can cause gastrointestinal bleeding in older adult clients."

Rationale: A common adverse effect of ibuprofen is gastrointestinal bleeding, and older adult clients have an increased risk for gastrointestinal toxicity and bleeding.
A nurse is caring for a client who has a cervical spinal cord injury sustained 1 month ago. Which of the following manifestations indicates that the client is experiencing autonomic dysreflexia (AD)?
Heart rate 52/min.

Rationale: A client who is experiencing AD will exhibit multiple manifestations, including bradycardia, severe headache, and flushing.

SN:
Untreated, AD can result in stroke, organ damage, or death. Manifestations of AD include diaphoresis above the site of the spinal cord injury.
A client who has a spinal injury that involves cervical or high thoracic vertebrae can experience AD any time after the shock of the initial spinal injury. A hallmark

manifestation of AD is a sudden, significant rise in systolic and diastolic pressures. Anxiety is a manifestation of AD. Therefore, the nurse should expect the client to exhibit tachypnea.

A nurse is assessing a client who has advanced lung cancer and is receiving palliative care. The client has just undergone thoracentesis. The nurse should expect a reduction in which of the following common manifestations of advanced cancer?
Dyspnea

Rationale: Thoracentesis, the removal of pleural fluid, can temporarily relieve hypoxia and thus ease the client's breathing and improve comfort.

A nurse is providing teaching to a client who takes ginkgo biloba as an herbal supplement. Which of the following statements should the nurse make?
"Ginkgo biloba can cause an increased risk for bleeding."

A nurse on a medical-surgical unit is reviewing the medical record of an older adult client who is receiving IV fluid therapy. Which of the following client information should indicate to the nurse that the client requires re-evaluation of the IV therapy prescription? (Click on the "Exhibit" button for additional information about the client. There are three tabs that contain separate categories of data.)
EXHIBIT
BUN

A nurse is receiving report on a client who is postoperative following an open repair of Zenker's diverticulum. The nurse should anticipate the surgical incision to be in which of the following locations? (You will find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.)
A )Neck

A nurse is obtaining a medication history from a client who is scheduled to undergo cataract surgery. The nurse should recognize that which of the following client medications is a contraindication for the surgery and notify the provider?
Warfarin

A nurse is assessing a client who has peripheral arterial disease. Which of the following findings should the nurse expect?
Hair loss on the lower legs

A home health nurse is providing teaching to a client who has a stage 1 pressure injury on the greater trochanter of his left hip. Which of the following instructions should the nurse include in the teaching?
Change position every hour.

A nurse is assessing a client who has a diagnosis of rheumatoid arthritis. Which of the following nonpharmacological interventions should the nurse suggest to the client to reduce pain?
Alternate application of heat and cold to the affected joints.

A nurse is assessing a client following the completion of hemodialysis. Which of the following findings is the nurse's priority to report to the provider?
Restlessness

A nurse is caring for a client who is 4 hr postoperative following an open reduction internal fixation of the right ankle. Which of the following assessment findings should the nurse report to the provider?
Extremity cool upon palpation

A nurse is assessing a client who is postoperative following a thyroidectomy. Which of the following findings is the nurse's priority?
Temperature 38.9° C (102° F)

A nurse is planning care for a client who is having a modified radical mastectomy of the right breast. Which of the following interventions should the nurse include in the plan of care?
Instruct the client that the drain will be removed when there is 25 mL of output or less over a 24-hr period.

A nurse is teaching a client about the use of transcutaneous electrical nerve stimulation (TENS) for the management of bone cancer pain. The nurse should explain that applying a TENS unit to the painful area has which of the following effects?
A tingling sensation replacing the pain

A nurse is providing teaching to a client who has a recent diagnosis of constipation-predominant irritable bowel syndrome. Which of the following instructions should the nurse include in the teaching?
Consume at least 30 g of fiber daily.

A nurse is providing teaching to a client who has AIDS. Which of the following statements by the client indicates an understanding of the teaching?
"I will take my temperature once a day."

A nurse is reviewing the medical record of a client who is taking warfarin for chronic atrial fibrillation. Which of the following values should the nurse identify as a desired outcome for this therapy?
INR 2.5

A nurse is caring for a newly admitted client who has a gastric hemorrhage and is going into shock. Identify the sequence of actions the nurse should take. (Move the steps into

the box on the right, placing them in the selected order of performance. Use all the steps.)
AdminiSTER o2
Initiate IV therapy
Insert an NG tube
Administer ranitidine

A nurse is assessing heart sounds of a client who reports substernal precordial pain. Identify which of the following sounds the nurse should document in the client's medical record by listening to the audio clip. (Click on the audio button to listen to the clip.)
Pericardial friction rub

A nurse is teaching a client about osteoporosis prevention. The nurse should instruct the client that which of the following medications can increase their risk for developing osteoporosis?
Prednisone

A nurse is providing education to a client who is at risk for osteoporosis. Which of the following instructions should the nurse include?
Walk for 30 min four times per week.

A nurse is teaching a client who has a cardiac dysrhythmia about the purpose of undergoing continuous telemetry monitoring. Which of the following statements by the client reflects an understanding of the teaching?
"This identifies if the pacemaker cells of my heart are working properly."

A nurse is caring for a client who is 8 hr postoperative following a total hip arthroplasty. The client is unable to void on the bedpan. Which of the following actions should the nurse take first?
Scan the bladder with a portable ultrasound.

A nurse is assessing a client while suctioning the client's tracheostomy tube. Which of the following findings should indicate to the nurse the client is experiencing hypoxia?
The client's heart rate increases.

A nurse is providing discharge instructions to a client who has active tuberculosis (TB). Which of the following information should the nurse include in the instructions?
Sputum specimens are necessary every 2 to 4 weeks until there are three negative cultures.

A PACU nurse is assessing a client who is postoperative following a right nephrectomy. The client's initial vital signs were heart rate 80/min, blood pressure 130/70 mm Hg, respiratory rate 16/min, and temperature 36° C (96.8° F). Which of the following vital sign changes should alert the nurse that the client might be hemorrhaging?
Heart rate 110/min

A nurse is caring for a client who has a positive culture for methicillin-resistant Staphylococcus aureus (MRSA). Which of the following actions should the nurse take?
Bathe the client using chlorhexidine solution.

A nurse is assessing a client's hydration status. Which of the following findings indicates fluid volume overload?
Distended neck veins

A nurse is providing postoperative teaching for a client who had a total knee arthroplasty. Which of the following instructions should the nurse include?
Flex the foot every hour when awake.

A nurse at an urgent care clinic is caring for a client who is experiencing an anaphylactic reaction. After ensuring a patent airway, which of the following nursing interventions is the priority?
Applying oxygen via face mask

A nurse in an emergency department is assessing an older adult client who has a fractured wrist following a fall. During the assessment, the client states, "Last week I crashed my car because my vision suddenly became blurry." Which of the following actions is the nurse's priority?
Check the client's neurologic status.

A nurse is caring for an older adult client who has dementia and requires acute care for a respiratory infection. The client is agitated and is attempting to remove their IV catheter. Which of the following actions should nurse take to avoid restraining the client?
Keep the client occupied with a manual activity.

A nurse is caring for a client who has terminal cancer. The client tells the nurse, "I wish I could stop these treatments. I am ready to die." Which of the following statements should the nurse make?
"Discontinuing with the treatments is your choice if it is your wish to do so."

A nurse is planning care for an older adult client who has dementia. Which of the following interventions should the nurse include in the plan of care?
Place personal items, such as pictures, at the client's bedside.

A nurse is providing teaching to a client who has asthma about the use of a metered-dose inhaler. The nurse should identify that which of the following client actions indicates an understanding of the teaching?
Holding breath for 10 seconds after inhaling

A nurse is administering packed RBCs to a client. Which of the following assessment findings indicates a hemolytic transfusion reaction?

Low back pain and apprehension

A nurse is caring for a client who is having a tonic-clonic seizure while in bed and has become cyanotic. Which of the following actions should the nurse take? (Select all that apply.)
Loosen restrictive clothing on the client.
Prepare to suction the client's airway.

A nurse is caring for a client who has increased intracranial pressure (ICP) and is receiving mannitol via continuous IV infusion. Which of the following findings should the nurse report to the provider as an adverse effect of this medication?
Crackles heard on auscultation

A nurse is providing teaching to a client who has anemia and a new prescription for an oral iron supplement. Which of the following statements by the client indicates an understanding of the teaching?
"I will eat more high-fiber foods."

A nurse is providing discharge teaching about infection prevention to a client who has AIDS. Which of the following statements by the client indicates understanding of the teaching?
"I will no longer floss my teeth after brushing my teeth."
A nurse is assessing a client who is postoperative following a transurethral resection of the prostate (TURP) and notes clots in the client's indwelling urinary catheter and a decrease in urinary output. Which of the following actions should the nurse take?
Irrigate the indwelling urinary catheter.

A nurse is providing teaching to a client who has hypertension and a new prescription for verapamil. Which of the following information should the nurse include in the teaching?
"Increase fiber intake to avoid constipation."

A nurse is checking the ECG rhythm strip for a client who has a temporary pacemaker. The nurse notes a pacemaker artifact followed by a QRS complex. Which of the following actions should the nurse take?
Document that depolarization has occurred.

A nurse is caring for a client who is receiving total parenteral nutrition (TPN) and is NPO. When reviewing the chart, the nurse notes the following prescription: capillary blood glucose AC and HS. Which of the following actions should the nurse take?
Contact the provider to clarify the prescription.

A nurse is caring for a client who is receiving mechanical ventilation via a tracheostomy tube. The nurse should recognize that which of the following complications is associated with long-term mechanical ventilation?
Stress ulcers

A nurse is reviewing the ABG results of a client who has advanced COPD. Which of the following results should the nurse expect?
PaCO2 56 mm Hg

A nurse is providing education to a client who has tuberculosis (TB) and their family. Which of the following information should the nurse include in the teaching?
Family members in the household should undergo TB testing.

A nurse is planning care for a client who is postoperative following a laparotomy and has a closed-suction drain. Which of the following actions should the nurse take to manage the drain?
Compress the drain reservoir after emptying.

A nurse is planning care for a client who has a sealed radiation implant for cervical cancer. Which of the following interventions should the nurse include in the plan of care?
Keep a lead-lined container in the client's room.

A nurse is reviewing the laboratory results of a client who has AIDS and is taking amphotericin B for a fungal infection. The nurse should identify that which of the following values is an indication of an adverse effect of the medication?
BUN 34 mg/dL

A nurse is planning a health promotional presentation for a group of African American clients at a community center. Which of the following disorders presents the greatest risk to this group of clients?
Hypertension