Pretest

Question 1

A c. What document should be in guiding the care of this client?

A) Client Self Determination Act

B) Physician's treatment orders

C) Advance Directives.

D) Clinical Pathway protocols

Review Information: The correct answer is: C) Advance Directives. This document specifies the client's wishes

Question 2

You are the of a health care team that consists of one licensed practical/vocational nurse, one nursing assistant , a nursing student and yourself. To whom is it appropriate to assign complete care for

A) Yourself

B) The nursing student

C) The licensed vocational nurse

D) The nursing assistant

Review Information: The correct answer is:A) Yourself.

While the nurse may delegate a bed bath for a stable client, this care should be performed by an RN for a new admission. Only tasks that do not require independent judgment should be delegated.

3Question 3

A mother brings her the clinic, complaining that the child seems to be The nurse expects to find which of the following on the initial history and physical assessment?

A) Increased temperature and lethargy

B) Rash and restlessness

C) Increased sleeping and listlessness

D) Diarrhea and poor skin turgor

Review Information: The correct answer is:B) Rash and restlessness.

Question 4

As the nurse takes a history of a 3 year-old with neuroblastoma, what comments by the parents require follow-up and are consistent with the diagnosis?

A) "The child has been listless and has lost weight."

B) "Her urine is dark yellow and small in amounts."

C) "Clothes are becoming tighter across her abdomen."

D+) "We notice muscle weakness and some unsteadiness."

Review Information: The correct answer is:C) "Clothes are becoming tighter across her abdomen.".

One of the most common signs of neuroblastoma is increasing abdominal girth. The parents'' report that clothing is tight is significant, and should be followed by additional assessments.

Question 5

A 16 year-old presents to the emergency department. The triage nurse finds that this teenager is legally married and signed the consent form for treatment. What would be the appropriate INITIAL action by the nurse?

A) Refuse to see the client until a parent or legal guardian can be contacted

B) Withhold treatment until telephone consent can be obtained from the spouse

C) Refer the client to a community pediatric hospital emergency room

D) Assess and treat in the same manner as any adult client

Review Information: The correct answer is:D) Assess and treat in the same manner as any adult client.

Minors may become known as an "emancipated minor" through marriage, pregnancy, high school graduation, independent living or service in the military. Therefore, this client, who is married, has the legal capacity of an adult.

Question 6

A newly admitted elderly client is severely dehydrated. When planning care for this client, which one of the following is an appropriate task for an Unlicensed Assistive Personnel (UAP)?

A) Obtain a history of fluid loss

B) Report output of less than 30 ml/hr

C) Monitor response to IV fluids

D) Check skin turgor every four hours

Review Information: The correct answer is:B) Report output of less than 30 ml/hr.

When directing a UAP, the nurse must communicate clearly about each delegated task with specific instructions on what must be reported. Because the RN is responsible for all care-related decisions,only implementation tasks should be assigned because they do not require independent judgment.

Question 7

The nurse is assessing a 4 year-old for possible rheumatic fever. Which of the following would the nurse suspect is related to this diagnosis?

A) Diagnosis of chickenpox six months ago

B) Exposure to strep throat in daycare last month

C) Treatment for ear infection two months ago

D) Episode of fungal skin infection last week

Review Information: The correct answer is:B) Exposure to strep throat in daycare last month.

Evidence supports a strong relationship between infection with Group A streptococci and subsequent rheumatic fever (usually within 2-6 weeks). Therefore, the history of playmates recovering from strep throat would indicate that the child diagnosed with rheumatic fever most likely also had strep throat. Sometimes, such an infection has no clinical symptoms.

Question 8

When the nurse becomes aware of feeling reluctant to interact with a manipulative client, the BEST action by the nurse is to

A) Discuss the feeling of reluctance with an objective peer or supervisor

B) Limit contacts with the client to avoid reinforcing the manipulative behavior

C) Confront the client regarding the negative effects of his/her behavior on others

D) Develop a behavior modification plan that will promote more functional behavior

Review Information: The correct answer is:A) Discuss the feeling of reluctance with an objective peer or supervisor.

The nurse who is experiencing stress in the therapeutic relationship can gain objectivity through supervision. The nurse must attempt to discover attitudes and feelings in the self that influence the nurse-client relationship.

Question 9

A client is being treated for paranoid schizophrenia. When the client became loud and boisterous, the nurse immediately placed him in seclusion as a precautionary measure. The client willingly complied. The nurse's action

A) May result in charges of unlawful seclusion and restraint

B) Leaves the nurse vulnerable for charges of assault and battery

C) Was appropriate in view of the client's history of violence

D) Was necessary to maintain the therapeutic milieu of the unit

Review Information: The correct answer is:A) May result in charges of unlawful seclusion and restraint.

Seclusion should only be used when there is an immediate threat of violence or threatening behavior.

Question 10

A client has been admitted to the Coronary Care Unit with a Myocardial Infarction. Which of the following nursing diagnosis should have PRIORITY?

A) Pain related to ischemia

B) Risk for altered elimination: constipation

C) Risk for complication: dysrhythmias

D) Anxiety

Review Information: The correct answer is:A) Pain related to ischemia.

Pain is related to ischemia, and relief of pain will decrease myocardial oxygen demands, reduce blood pressure and heart rate and relieve anxiety. Pain also stimulates the sympathetic nervous system and increased preload, further increasing myocardial demands.

Question 11

The nurse manager who is responsible for hiring professional nursing staff is required to comply with the Americans with Disabilities Act. The provisions of the law require the nurse manager to

A) Maintain an environment free from hazards

B) Provide reasonable accommodations for disabled individuals

C) Make all necessary accommodations for disabled individuals

D) Consider only physical disabilities in making employment decisions

Review Information: The correct answer is:B) Provide reasonable accommodations for disabled individuals.

The law is designed to permit persons with disabilities access to job opportunities. Employers must evaluate an applicant's ability to perform the job and not discriminate on the basis of a disability. Employers also must make "reasonable accommodations.

Question 12

The mother of a school-aged child in a long leg cast asks the nurse how to relieve itching inside the cast. Which of the following is appropriate for the nurse to suggest as a remedy?

A) Scratching the outside of the cast vigorously, applying pressure over the area

B) Blowing a hair dryer or heat lamp on the cast over the area that is itching

C) Using a long, smooth piece of wood to gently scratch the affected area

D) Applying an ice pack over the area of the cast that is affected

Review Information: The correct answer is:D) Applying an ice pack over the area of the cast that is affected.

Applying ice is a safe method of relieving the itching.

Question 13

Which of the following BEST describes the application of time management strategies in the role of the nurse manager?

A) Scheduling staff efficiently to cover client needs

B) Assuming a fair share of the client care as a role model

C) Setting daily goals to prioritize work

D) Delegating tasks to reduce work load

Review Information: The correct answer is:C) Setting daily goals to prioritize work.

Time management strategies must include setting priorities and meeting goals.

Question 14

The clinic nurse assesses a toddler with a tentative diagnosis of neuroblastoma. Symptoms the nurse observes that suggest this problem include

A) Lymphedema and nerve palsy

B) Hearing loss and ataxia

C) Headaches and vomiting

D) Abdominal mass and weakness

Review Information: The correct answer is:D) Abdominal mass and weakness.

Clinical manifestations of neuroblastoma include an irregular abdominal mass that crosses the midline, weakness, pallor, anorexia, weight loss and irritability.

Question 15

A fifteen year-old client has been placed in a Milwaukee Brace. Which one of the following statements from the client indicates the need for additional teaching?

A) "I will only have to wear this for six months."

B) "I should inspect my skin daily."

C) "The brace will be worn day and night."

D) "I can take it off when I shower."

Review Information: The correct answer is:A) "I will only have to wear this for six months.".

The brace must be worn long-term, usually for 1-2 years.

Question 16

The nurse manager has been using a decentralized block scheduling plan to staff the nursing unit. However, staff have asked for many changes and exceptions to the schedule over the past few months. The manager considers self-scheduling knowing that

A) Quality of care will improve

B) Staff turnover should decrease

C) Flexible scheduling will occur

D) Team morale will improve

Review Information: The correct answer is:D) Team morale will improve.

Nurses are more satisfied with autonomy and control. The nurse manager becomes the facilitator of scheduling rather than the decision-maker of the schedule.

Question 17

A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

A) Diffuse expiratory wheezing

B) Loose, productive cough

C) No relief from inhalant

D) Fever and chills

Review Information: The correct answer is:A) Diffuse expiratory wheezing.

In asthma, the airways are narrowed - creating difficulty getting air in and a wheezing sound.

Question 18

The nurse manager hears a physician loudly criticizing one of the staff nurses in the hearing of others. The employee does not respond to the physician's complaints. The nurse manager's FIRST action should be

A) Walk up to the physician and quietly ask that this unacceptable behavior stop

B) Allow the staff nurse to handle this situation without interference

C) Notify the Nursing Director and Medical Staff Chief of a breech of professional conduct

D) Request an immediate private meeting with the physician and staff nurse

Review Information: The correct answer is:D) Request an immediate private meeting with the physician and staff nurse.

Assertive communication respects the needs of all parties to express themselves, but not at the expense of others. The nurse manager needs first to protect clients and other staff from this display and come to the assistance of the nurse employee.

Question 19

A client voluntarily admits herself to the hospital due to suicidal ideation. The client has been on the unit for two days and is now demanding to be released. The MOST appropriate action is for the nurse to

A) Tell the client that she cannot be released because she is still suicidal

B) Inform the client that she can be released only if she signs a no suicide contract

C) Discuss with the client the decision to leave and prepare for her discharge

D) Instruct her regarding her right to sign out upon receipt of the physician's discharge order

Review Information: The correct answer is:C) Discuss with the client the decision to leave and prepare for her discharge.

Clients voluntarily admitted to the hospital have a right to demand and obtain release. Discussing the decision allows opportunity for other interventions.

Question 20

A client is admitted with infective endocarditis (IE). Which symptom would alert the nurse to a complication of this condition?

A) Dyspnea

B) Heart murmur

C) Macular rash

D) Hemorrhage

Review Information: The correct answer is:B) Heart murmur.

Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leaving ulcerations on the valve leaflets. These emboli produce symptoms of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs and obstruct blood flow.

Question 21

A nurseadmits a premature infant who has respiratory distress syndrome. In planning care, nursing actions are based on the fact that the MOST likely cause of this problem stems from the infant's inability to

A) Stabilize thermoregulation

B) Maintain alveolar surface tension

C) Begin normal pulmonary blood flow

D) Regulate intracardiac pressure

Review Information: The correct answer is:B) Maintain alveolar surface tension.

Respiratory distress syndrome is primarily a disease related to developmental delay in lung maturation. Although many factors lead to the development of the problem, the central factor relates to the lack of a normally functioning surfactant system due to immaturity in lung development.

Question 22

An 18 year-old client is admitted to intensive care from the emergency room following a diving accident. The injury is suspected to be at the level of the 2nd cervical vertebrae. The nurse's PRIORITY assessment should be

A) Response to stimuli

B) Bladder control

C) Respiratory function

D) Muscle weakness

Review Information: The correct answer is:

C) Respiratory function.

Spinal injury at the C-2 level results in quadriplegia. While the client will experience all of the problems identified, respiratory assessment is a priority.

Question 23

The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is CRITICAL for the nurse to include in the plan of care?

A) Hourly urine output

B) White blood count

C) Blood glucose every four hours

D) Temperature every two hours

Review Information: The correct answer is:A) Hourly urine output.

Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

Question 24

The nurse admitting a 5 month-old who vomited nine times in the past six hours should observe for signs of

A) Metabolic acidosis

B) Metabolic alkalosis

C) Respiratory acidosis

D) Respiratory alkalosis

Review Information: The correct answer is:B) Metabolic alkalosis.

Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss and lead to metabolic alkalosis.

Question 25

A child is injured on the school playground and appears to have a fractured leg. The FIRST action the school nurse should take is

A) Call for emergency transport to the hospital

B) Immobilize the limb and joints above and below the injury

C) Assess the child and the extent of the injury

D) Apply cold compresses to the injured area

Review Information: The correct answer is:C) Assess the child and the extent of the injury.

When applying the nursing process, assessment is the first step in providing care. The 5 "Ps" of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

Question 26

As the nurse interviews the parents of a child with asthma, it is a PRIORITY to ask about

A) Household pets

B) New furniture

C) Lead based paint

D) Plants such as cactus

Review Information: The correct answer is:A) Household pets.

Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

Question 27

An 80 year-old client was admitted with a diagnosis of possible cerebral vascular accident. Blood pressure has ranged from 180/110 to 160/100. Over the past several hours, the nurse noted increasing lethargy. Which of the following assessments should the nurse report IMMEDIATELY to the physician?

A) Slurred speech

B) Incontinence

C) Muscle weakness

D) Rapid pulse

Review Information: The correct answer is:A) Slurred speech.

Changes in speech patterns and level of conscious can be indicators of continued intercranial bleeding. Treatment options may change based on further diagnostic tests.

Question 28

A 3 year-old child is brought to the clinic by his grandmother to be seen for "scratching his bottom and wetting the bed at night." Based on these complaints, the nurse would INITIALLY assess for

A) Allergies

B) Hyperactivity

C) Regression

D) Pinworms

Review Information: The correct answer is:D) Pinworms.

Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span.

Question 29

A 72 year-old client with osteomyelitis requires a six week course of intravenous antibiotics. In planning for home care, the MOST important action by the nurse is

A) Investigating the client's insurance coverage for home IV antibiotic therapy

B) Determining if there are adequate hand washing facilities in the home

C) Assessing the client's ability to participate in self care and/or the reliability of a caregiver

D) Selecting the appropriate venous access device

Review Information: The correct answer is:C) Assessing the client''s ability to participate in self care and/or the reliability of a caregiver.

The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

Question 30

The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. The BEST response by the nurse is

A) "Folic acid should be taken before and after conception."

B) "Multivitamin supplements are recommended during pregnancy."

C) "A well balanced diet promotes normal fetal development."

D) "Increased dietary iron improves the health of mother and fetus."

Review Information: The correct answer is:A) "Folic acid should be taken before and after conception.".

The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

Question 31

The nurse is caring for a newborn with a neural tube defect. The BEST covering for the lesion is

A) Telfa dressing with antibiotic ointment

B) Moist sterile nonadherent dressing

C) Dry sterile dressing

D) Sterile occlusive pressure dressing

Review Information: The correct answer is:B) Moist sterile nonadherent dressing.

Before surgical closure the sac is prevented from drying by the application of a sterile, moist, nonadherent dressing over the defect. Dressings are changed frequently to keep them moist.

Question 32

A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is most important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula

B) Boil the tap water for 10 minutes prior to preparing the formula

C) Let tap water run for 2 minutes before adding to concentrate

D) Buy bottled water labeled "lead free" to mix the formula

Review Information: The correct answer is:C) Let tap water run for 2 minutes before adding to concentrate.

Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used insealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

Question 33

A client is admitted to the rehabilitation unit following a CVA and mild dysphagia. The MOST appropriate intervention for this client is

A) Position client in upright position while eating

B) Place client on a clear liquid diet

C) Tilt head back to facilitate swallowing reflex

D) Offer finger foods such as crackers or pretzels

Review Information: The correct answer is:A) Position client in upright position while eating.

An upright position facilitates proper chewing and swallowing.

Question 34

The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, "I will receive tissue from

A) a tissue bank."

B) a pig."

C) my thigh."

D) synthetic skin."

Review Information: The correct answer is:C) my thigh.".

Autografts are done with tissue transplanted from the client''s own skin.

Question 35

The nurse is caring for a newborn with tracheoesophageal fistula. Which of the following nursing diagnoses is a PRIORITY?

A) Risk for dehydration

B) Ineffective airway clearance

C) Altered nutrition

D) Risk for injury

Review Information: The correct answer is:B) Ineffective airway clearance.

The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

Question 36

A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The MOST important reason for the nurse to elevate the casted leg is to

A) Promote the client's comfort

B) Reduce the drying time

C) Decrease irritation to the skin

D) Improve venous return

Review Information: The correct answer is:D) Improve venous return.

Elevating the leg both improves venous return and reduces swelling.

Question 37

A nurse is working with family members of a newly diagnosed client with Alzheimer's disease. Which of the following interventions is MOST helpful?

A) Teaching relaxation techniques

B) Implementing a daily exercise routine

C) Improving daily nutritional intake

D) Suggesting communication strategies

Review Information: The correct answer is:D) Suggesting communication strategies.

Since Alzheimer''s disease is a progressive chronic illness that greatly challenges caregivers, the nurse can be of greatest assistance in helping family to identify language changes, and select verbal and nonverbal communication strategies to minimize aberrant behavior.

Question 38

The nurse is teaching a client with non-insulin dependent diabetes mellitus about the prescribed diet. The nurse should teach the client to

A) Maintain previous calorie intake

B) Keep a candy bar available at all times

C) Reduce carbohydrates intake to 25% of total calories

D) Keep a regular schedule of meals and snacks

Review Information: The correct answer is:D) Keep a regular schedule of meals and snacks.

Currently, calorie-controlled diets with strict mealplans are rarely suggested for clients who have diabetes. Try to incorporate schedule or food changes into clients'' existing dietary patterns. Help clients learn to read labels and identify specific canned foods, frozen entrees, or other foods which are acceptable and those which should be avoided.

Question 39

The mother of a two month-old baby calls the nurse at a well-baby clinic two days after the first DTaP immunization. She reports that the baby feels very warm, has cried inconsolably for as long as three hours, and has had several shaking spells. The response of the nurse should be to

A) instruct the mother to call 911 for an ambulance to transport the infant

B) suggest that these are expected reactions and to begin every 4 hour antipyretics

C) tell the mother to take the infant immediately to the nearest emergency room

D) give instructions to bring the infant to the clinic now

Review Information: The correct answer is:A)instruct the mother to call 911 for an ambulance to transport the infant

The exhibited findings of the infant indicate a severe reaction to the immunizations. Immediate attention is needed & an ambulance with trained staff needs to transport because of the risk of grand mal seizures from potential encephalopathy which is a critical reaction. The mother would need to be instructed after this acute reaction to inform the provider of this reaction to the first dose of DTaP. Based on the need and risk involved to the infant, the health care provider may decide that further DTaP immunizations are contraindicated for life. The clinic nurse would need to document in the notes for this infant: the instructions given, findings reported by the mother and specific follow-up needs for the next clinic visit in relation to teaching and evaluation of the outcome of this event.

Question 40

The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

A) Donating blood

B) Using public bathrooms

C) Unprotected sex

D) Touching a person with AIDS

Review Information: The correct answer is:C) Unprotected sex.

Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the highest risk for infection.

Question 41

A 6 year-old child is seen for the first time in the clinic. Upon assessment, the nurse finds that the child has short palpebral fissures, thinned upper lip, and hypoplastic philtrum of the upper lip. The mother states that the child seems to have problems in learning to count and recognizing basic colors. Based on this data, the nurse suspects that the child is MOST likely showing the effects of

A) Congenital abnormalities

B) Chronic toxoplasmosis

C) Fetal alcohol syndrome

D) Lead poisoning

Review Information: The correct answer is:C) Fetal alcohol syndrome.

Major features of fetal alcohol syndrome consist of facial and associated physical features, such as short palpebral fissure, hypoplastic philtrum, thinned upper lip, short, upturned nose. Behavioral problems, cognitive impairment and psychosocial deficits are also associated with this syndrome.

Question 42

The nurse is performing the admission assessment of a client with an acute episode of asthma. Which of the following assessments would the nurse anticipate finding?

A) Prolonged inspiration

B) Expiratory wheezes

C) Expectorating large amounts of purulent mucous

D) Lethargy

Review Information: The correct answer is:B) Expiratory wheezes.

Asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest.

Question 43

The nurse is planning a meal plan that would provide the most iron for a child with anemia. Which of the following dinner menus would be BEST?

A) Fish sticks, french fries, banana, cookies, milk

B) Ground beef patty, lima beans, wheat roll, raisins, milk

C) Chicken nuggets, macaroni, peas, cantaloupe, milk

D) Peanut butter and jelly sandwich, apple slices, milk

Review Information: The correct answer is:B) Ground beef patty, lima beans, wheat roll, raisins, milk.

Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, dried fruits such as raisins. This dinner is the best choice, high in iron and is appropriate for a toddler.

Question 44

A ten year-old client is recovering from a splenectomy following a traumatic injury. The clients laboratory results show a hemoglobin of 9 g/dL and a hematocrit of 28 percent. The BEST approach for the nurse to use is to

A) Limit milk and milk products

B) Encourage bed activities and games

C) Plan nursing care around lengthy rest periods

D) Promote a diet rich in iron

Review Information: The correct answer is:C) Plan nursing care around lengthy rest periods.

The initial priority for this client is rest due to the inability of red blood cells to carry oxygen.

Question 45

The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a PRIORITY?

A) Limit fluids

B) Client controlled analgesia

C) Cold compresses to elbow

D) Passive range of motion exercise

Review Information: The correct answer is:B) Client controlled analgesia.

Management of a crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

Question 46

As the nurse provides discharge teaching to the parents of a 15 month-old child with Kawasaki Disease who has received immunoglobulin therapy, which one of the following instructions would be MOST appropriate?

A) High doses of aspirin will be continued for some time

B) Complete recovery is expected within several days

C) Active range of motion exercises should be done frequently

D) The measles, mumps and rubella vaccine should be delayed

Review Information: The correct answer is:D) The measles, mumps and rubella vaccine should be delayed.

Discharge instructions for a child with Kawasaki Disease should include immunoglobulin therapy may interfere with the body''s ability to form appropriate amounts of antibodies and live immunizations should be delayed.

Question 47

The nurse is giving instructions to the parents of a child with Cystic Fibrosis. The nurse would emphasize that pancreatic enzymes should be taken

A) Once each day

B) Three times daily after meals

C) With each meal or snack

D) Each time carbohydrates are eaten

Review Information: The correct answer is:C) With each meal or snack.

Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

Question 48

The nurse is assessing an eight month-old infant with a malfunctioning ventriculoperitoneal shunt. Which one of the following manifestations would the infant be MOST likely to exhibit?

A) Lethargy

B) Irritability

C) Negative Moro

D) Depressed fontanel

Review Information: The correct answer is:B) Irritability. Signs of IICP (increased intracranial pressure) in infants include bulging fontanel, instability, high-pitched cry, and cries when held. Vital sign changes include pulse that is variable, i.e., rapid, slow and bounding, or feeble. Respirations are more often slow, deep, and irregular.

Question 49

The nurse is performing a physical assessment on a toddler. Which of the following should be the FIRST action?

A) Perform traumatic procedures

B) Use minimal physical contact

C) Proceed from head to toe

D) Explain the exam in detail

Review Information: The correct answer is:B) Use minimal physical contact.

The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler''s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

Question 50

A client has been tentatively diagnosed with Graves' disease (hyperthyroidism). Which of the following symptoms noted on the initial nursing assessment is expected?

A) Recent weight gain

B) Physical growth delay

C) Protruding eyeballs

D) Sudden onset of irritability

Review Information: The correct answer is:C) Protruding eyeballs.

Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves'' Disease.

Question 51

When assessing a client admitted to the hospital for diabetic acidosis, which of the following clinical manifestations would the nurse expect?

A) A blood pH level above 7.5

B) Arterial blood PCO2 above 40

C) Blood pH level below 7.3

D) Arterial blood PCO2 below 10

Review Information: The correct answer is:C) Blood pH level below 7.3.

In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis (pH < 7.3).

Question 52

The nurse is explaining the proper use of syrup of ipecac to a group of parents. For which of the following accidental poisonings is the treatment appropriate?

A) Oven cleaner

B) Drain cleaner

C) Kerosene

D) Chewable vitamins

Review Information: The correct answer is:D) Chewable vitamins.

Of the above choices, poisoning with vitamins is the only case in which it is safe to induce vomiting with syrup of ipecac.

Question 53

A two year-old child is brought to the pediatrician's office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which one of the following statements?

A) Place the child on clear liquids and gelatin for 24 hours

B) Continue with the regular diet and include oral rehydration fluids

C) Give bananas, apples, rice and toast as tolerated

D) Place NPO for 24 hours, then rehydrate with milk and water

Review Information: The correct answer is:B) Continue with the regular diet and include oral rehydration fluids.

Current recommendations for mild to moderate diarrhea are to maintain a normal diet with rehydration fluids.

Question 54

The nurse is teaching an elderly client how to use MDI's (multi-dose inhalers). The nurse is concerned that the client is unable to coordinate the release of the medication with the inhalation phase. The nurse's BEST recommendation for the client is

A) Nebulized treatments for home care

B) Adding a spacer device to the MDI canister

C) Asking a family member to assist the client with the MDI

D) Request a visiting nurse to follow the client at home

Review Information: The correct answer is:B) Adding a spacer device to the MDI canister.

The majority of pulmonary medications for COPD are delivered by inhalation.This is often preferred over oral administration because a lower drug dose is needed and systemic side effects are reduced. In addition, the onset of action of bronchodilator medication given via inhalation is faster.

Question 55

Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual

B) Flakes evident on a student's shoulders

C) Oval pattern occipital hair loss

D) Whitish oval specks sticking to the hair

Review Information: The correct answer is:D) Whitish oval specks sticking to the hair.

Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment includes shampoo application, such as lindane for children over 2 years of age, and meticulous combing and removal of all nits.

Question 56

When parents call the emergency room to report that a toddler has swallowed drain cleaner, the nurse instructs them to call for emergency transport to the hospital. While waiting for an ambulance, the BEST action the nurse would suggest to the parents is

A) Administer syrup of ipecac

B) Offer small amounts of water

C) Have the child drink milk

D) Give ginger ale or cola

Review Information: The correct answer is:B) Offer small amounts of water.

Small amounts of water will dilute the corrosive substance prior to gastric lavage.

Question 57

A client is scheduled for an IVP (Intravenous Pyelogram). Which of the following data from the client's history indicate a potential hazard for this test?

A) Reflex incontinence

B) Allergic to shellfish

C) Claustrophobia

D) Hypertension

Review Information: The correct answer is:B) Allergic to shellfish. It is important to know if the client has an allergy to iodine or shellfish. If the client does, they may have an allergic reaction to the IVP contrast dye injected during the procedure.

Question 58

A high school nurse is advising a class of unwed pregnant students that the MOST important action they can perform to deliver a healthy child is

A) Maintaining good nutrition

B) Staying in school

C) Keeping in contact with the child's father

D) Getting adequate sleep

Review Information: The correct answer is:A) Maintaining good nutrition. Nurses can serve a pivotal role in providing nutritional education and case management interventions. Weight gain during pregnancy is one of the strongest predictors of infant birth weight. Specifically, teens need to increase their intake of protein, vitamins, and minerals including iron. Pregnant teens who gain between 26 and 35 pounds have the lowest incidence of low-birth-weight babies.

Question 59

The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which of the following should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal

B) Finely ground meat should be started early to provide iron

C) Egg white is added early to increase protein intake

D) Solid foods should be mixed with formula in a bottle

Review Information: The correct answer is:A) Solid foods are introduced one at a time beginning with cereal.

Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

Question 60

The nurse is caring for a client with sickle cell disease who is scheduled to receive a unit of packed red blood cells. Which of the following is an appropriate action for the nurse when administering the infusion?

A) Storing the packed red cells in the medicine refrigerator while starting IV

B) Slow the rate of infusion if the client develops fever or chills

C) Limit the infusion time of each of the unit to a maximum of four hours

D) Assess vital signs every 15 minutes throughout the entire infusion

Review Information: The correct answer is:C) Limit the infusion time of each of the unit to a maximum of four hours.

Infuse the specified amount of blood within 4 hours. If the infusion will exceed this time, the blood should be divided into appropriately sized quantities.

Question 61

A client with a documented pulmonary embolism has the following arterial blood gases: PO2 - 70 mm hg, PCO2 - 32 mm hg, pH - 7.45, SaO2 - 87%, HCO3 - 22. Based on thisdata, what is the FIRST nursing action?

A) Review other lab data

B) Notify the physician

C) Administer oxygen

D) Calm the client

Review Information: The correct answer is:C) Administer oxygen.

The client has a low PCO2 due to increased respiratory rate from the hypoxemia and signs of respiratory alkalosis. Immediate intervention is indicated.

Question 62

A client diagnosed with hepatitis C discusses his health history with the admitting nurse. The nurse should recognize which of the following as the MOST important data?

A) Recent travel to Central America

B) Ingestion of raw shellfish last week

C) Multiple sex partners

D) Blood transfusion 15 years ago

Review Information: The correct answer is:D) Blood transfusion 15 years ago.

The client who was transfused prior to blood screening for hepatitis C may show symptoms many years later.

Question 63

A client is recovering from a thyroidectomy. While monitoring the client's initial post operative condition, which of the following should the nurse report immediately?

A) Tetany and paresthesia

B) Mild stridor and hoarseness

C) Irritability and insomnia

D) Headache and nausea

Review Information: The correct answer is:

A) Tetany and paresthesia.

Because the parathyroid gland may be damaged in this surgery, secondary hypocalcemia may occur. Symptoms of hypoparathyroidism include tetany, paresthesia, muscle cramps and seizures.

Question 64

A client is admitted with a right upper lobe infiltrate, and also to rule out tuberculosis. The isolation precautions the nurse would institute include

A) Positive pressure ventilation

B) Gown and gloves

C) Particulate respirator mask

D) Barrier precautions

Review Information: The correct answer is:C) Particulate respirator mask.

Tight fitting, high-efficiency masks are required when caring for clients who have suspected communicable disease of the airborne variety.

Question 65

A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to include at the change of shift report?

A) The client lost 2 pounds

B) The client's potassium level is 4 mEq/liter.

C) The client's urine output was 1500 cc in five hours

D) The client is to receive another dose of Lasix at 10 PM

Review Information: The correct answer is:C) The client's urine output was 1500 cc in five hours.

Although all of these may be correct information to include in report, the essential piece would be the urine output.

Question 66

The nurse is caring for a client with a colostomy. During a teaching session, the nurse recommends that the pouch be emptied

A) When it is one third to one half full

B) Prior to meals

C) After each fecal elimination

D) At the same time each day

Review Information: The correct answer is:A) When it is one third to one half full.

If the pouch becomes more than half full it may separate from the flange.

Question 67

A couple asks the nurse about risks of several birth control methods. The MOST appropriate response by the nurse would be

A) Norplant is safe and may be removed easily

B) Oral contraceptives should not be used by smokers

C) Depo-Provera is convenient with few side effects

D) The IUD gives protection from pregnancy and infection

Review Information: The correct answer is:B) Oral contraceptives should not be used by smokers.

The use of oral contraceptives in a pregnant woman who smokes increases her risk of cardiovascular problems.

Question 68

Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

A) An increase in appetite

B) A decrease in fluid retention

C) A decrease in lethargy

D) A reduction in jaundice

Review Information: The correct answer is:C) A decrease in lethargy. Lactulose produces and acid environment in the bowel and trapsammonia in the gut; the laxative effect then aids in removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

Question 69

The mother of a 3 month-old infant tells the nurse that she wants to change from formula towhole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

A) Solid foods should be introduced at 3-4 months

B) Whole milk is difficult for a young infant to digest

C) Fluoridated tap water should be used to dilute milk

D) Supplemental apple juice can be used between feedings

Review Information: The correct answer is:B) Whole milk is difficult for a young infant to digest.

Cow''s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. Also it contains little iron and creates a high renal solute load.

Question 70

The nurse is assessing a 55 year-old female client who is scheduled for abdominal surgery. Which of the following information would indicate that the client is at risk for thrombusformation in the post-operative period?

A) Estrogen replacement therapy

B) 10% less than ideal body weight

C) Hypersensitivity to heparin

D) History of hepatitis

Review Information: The correct answer is:A) Estrogen replacement therapy.

Estrogen increases the hypercoagualability of the blood and increased the risk for development of thrombophlebitis.

Question 71

The nurse is planning discharge for a 90 year-old client with musculo-skeletal weakness. Which of the following interventions would be MOST effective in preventing falls?

A) Place nightlights in bedroom

B) Wear eyeglasses at all times

C) Install grab bars in the bathroom

D) Teach muscle strengthening exercises

Review Information: The correct answer is:A) Place nightlights in bedroom.

Because more falls occur in the bedroom than any other location, begin there. However, work in partnership with the client and family so they are willing to move furniture, lamp cords, and storage areas; add lighting; remove throw rugs; and decrease other environmental hazards.

Question 72

While obtaining the history of a two week-old infant during the well-baby exam, the nurse finds that the neonatal screening for phenylketonuria (PKU) was done when the infant was less than 24 hours-old. It is a PRIORITY for the nurse to

A) Schedule the infant for a repeat test in two weeks

B) Obtain a repeat blood test at this point

C) Contact the hospital of birth for the results

D) Document that the test results are pending

Review Information: The correct answer is:B) Obtain a repeat blood test at this point.

Testing for PKU is most reliable when protein has been ingested. A repeat blood specimen must be obtained by the third week of life if the initial specimen was taken from an infant less than 24 hours-old.

Question 73

Two hours after the normal spontaneous vaginal delivery of a woman who is gravida 4 para 4, the nurse notes that the fundus is boggy and displaced slightly above and to the left of the umbilicus. The appropriate INITIAL nursing action is to

A) Assess lochia for color and amount

B) Monitor pulse and blood pressure

C) Call the physician immediately

D) Ask the woman to empty her bladder

Review Information: The correct answer is:D) Ask the woman to empty her bladder.

A full bladder can displace the uterus and prevent contraction. After the woman empties the bladder, the fundus should be assessed again.

Question 74

An 8 year-old client is admitted to the hospital for surgery. The child's parent reports several allergies. Which of the following should all health care personnel be aware of?

A) Shellfish

B) Molds

C) Balloons

D) Perfumed soap

Review Information: The correct answer is:C) Balloons.

Allergy to balloons indicates a latex allergy. All personnel in contact with the child will need to be aware of this condition and use non-latex gloves.

Question 75

The nurse is caring for a client who is post-op following a thoracotomy. The client has two chest tubes in place,connected to one chest drain. The nursing assessment reveals bubbling in the water seal chamber when the client coughs. What is the MOST appropriate nursing action?

A) Clamp the chest tube

B) Call the surgeon immediately

C) Continue to monitor the client to see if the bubbling increases

D) Instruct the client to try to avoid coughing

Review Information: The correct answer is:C) Continue to monitor the client to see if the bubbling increases.

Bubbling associated with coughing after lung surgery is to be expected as small amounts of air escape the pleural space when pressures inside the chest increase with coughing. Monitoring is the only nursing action required.

Question 76

The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. The nurse should instruct the client to

A) Complete the entire course of the medication for an effective cure

B) Begin treatment with acyclovir at the onset of symptoms of recurrence

C) Stop treatment if she thinks she may be pregnant to prevent birth defects

D) Continue to take prophylactic doses for at least five years after the diagnosis

Review Information: The correct answer is:B) Begin treatment with acyclovir at the onset of symptoms of recurrence.

When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective.

Question 77

An eight year-old child is hospitalized during the edema phase of minimal change nephrotic syndrome. The nurse is assisting in choosing the lunch menu. Which one of the following is the BEST choice?

A) Bologna sandwich, pudding, milk

B) Frankfurter, baked potato, milk

C) Chicken strips, corn on the cob, milk

D) Grilled cheese sandwich, apple, milk

Review Information: The correct answer is:C) Chicken strips, corn on the cob, milk.

This menu is lowest in sodium. Ideally, low fat milk would be available.

Question 78

The nurse is teaching parents about accidental poisoning in children. Which of the following should be emphasized?

A) Start treatment before calling the Poison Control Center

B) Empty the child's mouth in any case of possible poisoning

C) Do not move the child if a toxic substance was inhaled

D) Induce vomiting if the poison is a hydrocarbon

Review Information: The correct answer is:B) Empty the child''s mouth in any case of possible poisoning.

Emptying the mouth of poison interferes with further ingestion and should be done first to limit contact with the substance.

Question 79

Which of the following symptoms contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?

A) Drowsiness, lethargy, and inactivity

B) Dry mouth, nasal congestion, and blurred vision

C) Rash, blood dyscrasias, severe depression

D) Hyperglycemia, weight gain, and edema

Review Information: The correct answer is:C) Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

Question 80

The nurse is planning care for a 14 year-old client returning from scoliosis corrective surgery. Which of the following actions should receive PRIORITY in the plan?

A) Antibiotic therapy for 10 days

B) Teach client isometric exercises for legs

C) Assess movement and sensation of extremities

D) Assist to stand up at bedside within the first 24 hours

Review Information: The correct answer is:C) Assess movement and sensation of extremities.

Following corrective surgery for scoliosis, neurological status requires special attention and assessment, especially that of the extremities.

Question 81

A three year-old child diagnosed as having celiac disease attends a day care center. Which of the following would be an appropriate snack?

A) Cheese crackers

B) Peanut butter sandwich

C) Potato chips

D) Vanilla cookies

Review Information: The correct answer is:C) Potato chips.

Children with celiac disease should eat a gluten free diet. Gluten is found mainly in grains of wheat and rye and in smaller quantities in barley and oats. Corn, rice, soybeans and potatoes are digestible in persons with celiac disease.

Question 82

The nurse is caring for a 14 month-old just diagnosed with Cystic Fibrosis. The parents state this is the first child in either family with this disease, and ask about the risk to future children. The BEST response by the nurse is based on the knowledge that there is a

A) 1 in 4 chance for each child to carry that trait

B) 1 in 4 risk for each child to have the disease

C) 1 in 2 chance of avoiding the trait and disease

D) 1 in 2 chance that each child will have the disease

Review Information: The correct answer is:B) 1 in 4 risk for each child to have the disease.

Cystic Fibrosis is an autosomal recessive transmission pattern. In this situation, both parents must be carriers of the trait for the disease since neither one of them has the disease. Therefore, for each pregnancy, there is a 25% chance of the child having the disease, 50% chance of carrying the trait and a 25% chance of having neither the trait or the disease.

Question 83

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do FIRST?

A) Notify the physician

B) Administer the prn dose of Albuterol

C) Apply oxygen at 2 liters per nasal cannula

D) Repeat the peak flow reading in 30 minutes

Review Information: The correct answer is:

B) Administer the prn dose of Albuterol.

Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client''s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

Question 84

What nursing observation signifies that a client has attained the stage of concrete operations (Piaget)?

A) Explores his environment using sight and movement

B) Can think in mental images or word pictures

C) Makes the moral judgment that "stealing is wrong"

D) Reasons that homework is time-consuming but necessary

Review Information: The correct answer is:C) Makes the moral judgment that "stealing is wrong".

The stage of concrete operations is depicted by logical thinking and moral judgments.

Question 85

The nurse is caring for a 17 month-old with acetaminophen poisoning. Which of the following lab reports should the nurse review FIRST?

A) Protime (PT) and partial thromboplastin time (PTT)

B) Red blood cell and white blood cell counts

C) Blood urea nitrogen and creatinine clearance

D) Liver enzymes (AST and ALT)

Review Information: The correct answer is:D) Liver enzymes (AST and ALT).

Because acetaminophen is toxic to the liver and causes hepatic cellular necrosis, liver enzymes are released into the blood stream and serum levels of those enzymes rise. Other lab values are reviewed as well.

Question 86

The nurse is teaching parents about diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

A) Formula or breast milk

B) Broth and tea

C) Rice cereal and apple juice

D) Gelatin and ginger ale

Review Information: The correct answer is:A) Formula or breast milk.

The usual diet for a young infant should be followed.

Question 87

The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk because this medication

A) Retards pepsin production

B) Stimulates hydrochloric acid production

C) Slows stomach emptying time

D) Decreases production of hydrochloric acid

Review Information: The correct answer is:B) Stimulates hydrochloric acid production.

Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

Question 88

The nurse is planning care for a 3 month-old infant immediately postoperative following placement of a ventriculoperitoneal shunt for hydrocephalus. The nurse needs to

A) Assess for abdominal distention

B) Maintain infant in an upright position

C) Begin formula feedings when infant is alert

D) Pump the shunt to assess for proper function

Review Information: The correct answer is:A) Assess for abdominal distention.

The child is observed for abdominal distention because cerebrospinal fluid may cause peritonitis or a postoperative ileus as a complication of distal catheter placement.

Question 89

The mother of a two year-old hospitalized child asksthe nurse's advice about the child's screaming every time the mother gets ready to leave the hospital room. The BEST response of the nurse would be to

A) Request the mother to remain with the child at all times

B) Explain that this behavior will stop with in a few days

C) Help the mother understand this is a normal response to hospitalization

D) Suggest that the mother "sneak out" of the child's room when he sleep

Review Information: The correct answer is:C) Help the mother understand this is a normal response to hospitalization.

The protest phase of separation anxiety is a normal response for a child this age.

Question 90

When caring for a client receiving warfarin sodium (Coumadin), the nurse would monitor the results of the client's

A) Bleeding time

B) Coagulation time

C) Prothrombin time

D) Partial thromboplastin time

Review Information: The correct answer is:C) Prothrombin time.

Coumadin is ordered daily, based on the client''s prothrombin time (PT). This test evaluates the adequacy of the extrinsicsystem and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

Question 91

The nurse is caring for a four year-old two hours after tonsillectomy and adenoidectomy. Which of the following assessments must be reported IMMEDIATELY?

A) Vomiting of dark emesis

B) Complaints of throat pain

C) Apical heart rate of 110

D) Increased restlessness

Review Information: The correct answer is:D) Increased restlessness.

Restlessness and increased respiratory and heart rates are often early signs of hemorrhage.

care of infants and children.

Question 92

The nurse admits a 7 year-old to the emergency room following a leg injury. X-rays show that there is a femur fracture near the epiphysis. The nurse should be aware that at this age, the injury MOST likely will

A) Heal quickly because of thin periosteum

B) Result in retarded bone growth

C) Stimulate bone growth in the affected leg

D) Show more rapid union than that of a younger child

Review Information: The correct answer is:

B) Result in retarded bone growth.

An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. Limbs will be different in length.

Question 93

A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse assesses this as

A) Dystonia

B) Akathesia

C) Brady dysknesia

D) Tardive dyskinesia

Review Information: The correct answer is:D) Tardive dyskinesia.

Signs of tardive dyskinesia include smacking lips, grinding of teeth and "fly catching" tongue movements.

Question 94

While the nurse assesses a 2 month-old infant, the mother expresses concern because a flat pink birthmark on the baby's forehead and eyelid has not gone away. The nurse should tell the parents that

A) Mongolian spots are a normal finding in dark-skinned children

B) Port wine stains are often associated with other malformations

C) Telangiectatic nevi are normal and will disappear as the baby grows

D) The child is too young for surgical removal at this time

Review Information: The correct answer is:C) Telangiectatic nevi are normal and will disappear as the baby grows.

Telangiectatic nevi, salmon patch or stork bite birthmarks are a normal variation and the facial nevi will generally disappear by ages 1-2 years.

Question 95

A client has returned to the unit following a renal biopsy. Which of the following nursing interventions is appropriate?

A) Ambulate the client 4 hours after procedure

B) Maintain client on NPO status for 24 hours

C) Monitor vital signs

D) Change dressing every eight hours

Review Information: The correct answer is:C) Monitor vital signs.

The potential complication of this procedure is internal hemorrhage. Monitoring vital signs is critical to detect early indications of bleeding.

Question 96

The nurse assessing a newborn notices that the breasts are enlarged bilaterally with a white, thin discharge. The INITIAL action of the nurse should be to

A) Notify the attending practitioner

B) Ask about medications taken in pregnancy

C) Record the findings as "normal"

D) Obtain fluid to send for culture

Review Information: The correct answer is:C) Record the findings as "normal".

Newborn infants of both sexes may have engorged breasts and may secrete milk during the first few days and weeks following birth.

Question 97

A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive PRIORITY?

A) Maintaining proper body alignment

B) Frequent neurovascular assessments of the affected leg

C) Inspection of pin sites for evidence of drainage or inflammation

D) Applying an over-bed trapeze to assist the client with movement in bed

Review Information: The correct answer is:B) Frequent neurovascular assessments of the affected leg.

The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

Question 98

The nurse is teaching a client newly diagnosed with asthma how to use the metered-dose inhaler (MDI). The client asks when they will know the canister is empty. The BEST response is

A) Drop the canister in water to observe floating

B) Estimate how many doses are usually in the canister

C) Count the number of doses as the inhaler is used

D) Shake the canister to detect any fluid movement

Review Information: The correct answer is:A) Drop the canister in water to observe floating.

Dropping the canister into a bowl of water assesses the amount of medications remaining in a metered-dose inhaler. The client should obtain a refill when the inhaler rises to the surface and begins to tip over.

Question 99

While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is MOST important for the nurse to teach them to

A) Maintain good oral hygiene and dental care

B) Omit medication if the child is seizure free

C) Administer acetaminophen to promote sleep

D) Serve a diet that is high in iron

Review Information: The correct answer is:A) Maintain good oral hygiene and dental care.

Swollen and tender gums occur often with use of phenytoin. Oral hygiene and regular visits to the dentist should be emphasized.

Question 100

A two year-old child has just been diagnosed with Cystic Fibrosis. The child's father asks the nurse "What are the chances that another child of ours will have Cystic Fibrosis?" Which of the following is the BEST response?

A) "The probability of recurrence is unknown."

B) "Cystic Fibrosis is more common in Asians."

C) "Each of your children have a 25% chance of having Cystic Fibrosis."

D) "The incidence of Cystic Fibrosis is approximately 1: 14,000 live births."

Review Information: The correct answer is:C) "Each of your children have a 25% chance of having Cystic Fibrosis.".

Cystic Fibrosis is an autosomal recessive disease. There is a 25% chance of each pregnancy of these parents resulting in a child with Cystic Fibrosis.

Question 101

A 7 month pregnant woman is admitted with complaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test

B) Abdominal ultrasound

C) Pelvic exam

D) X-ray of abdomen

Review Information: The correct answer is:B) Abdominal ultrasound.

The standard for diagnosis of placenta previa, which is suggested in the client''s history, is abdominal ultrasound.

Question 102

The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose

B) Decreased albumin

C) Decreased potassium

D) Increased sodium retention

Review Information: The correct answer is:C) Decreased potassium.

In bulimia, loss of electrolytes can occur in addition to signs and symptoms of starvation and dehydration.

Question 103

An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze FIRST?

A) Potassium levels

B) Blood pH

C) Magnesium levels

D) Blood urea nitrogen

Review Information: The correct answer is:A) Potassium levels.

The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake while taking diuretics.

Question 104

A mother telephones the clinic and tells the nurse she is concerned because her breastfed 1 month-old has soft, yellow stoolsafter each feeding. The nurse's BEST response would be based on the knowledge that

A) This type of stool is normal for breast fed infants

B) The stool should have turned to light brown by now

C) Formula supplements will add bulk to the stools

D) Water should be offered several times each day

Review Information: The correct answer is:A) This type of stool is normal for breast fed infants.

In breast-fed infants, stools are frequent and yellow to golden and vary from soft to thick liquid in consistency. No change in feedings is indicated.

Question 105

The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which of the following nursing diagnoses is a PRIORITY at this time?

A) Risk for fluid volume deficit related to morphine overdose

B) Decreased gastrointestinal mobility related to mucosal irritation

C) Ineffective breathing patterns related to central nervous system depression

D) Altered nutrition related to inability to control nausea and vomiting

Review Information: The correct answer is:C) Ineffective breathing patterns related to central nervous system depression.

Respiratory depression is a life-threatening risk in this overdose.

Question 106

A pregnant client asks the nurse about the scheduled blood test for alpha-fetoprotein (AFP). The nurse's BEST explanation i

A) "It tells us how far along your pregnancy is."

B) "The results help determine if the baby is growing normally."

C) "Placental exchange of oxygen is measured."

D) "Possible neurological defects may be identified."

Review Information: The correct answer is:D) "Possible neurological defects may be identified.".

A fetus with neural tube defects loses alfa-fetoprotein (AFP) to the amniotic fluid and hence the maternal blood. High levels indicate the possibility of defects such as spina bifida and meningocele. Further assessments are indicated if a test is positive.

Question 107

The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees F at 8:00 AM. At 10:00 AMthe child's mother reports that the child "feels very warm" to touch. The FIRST action by the nurse should be to

A) Reassure the mother that this is normal

B) Offer the child cold oral fluids

C) Reassess the child's temperature

D) Administer the prescribed acetaminophen

Review Information: The correct answer is:C) Reassess the child''s temperature.

A child''s temperature may have rapid fluctuations. The nurse should listen to and show respect for what

parents say.

Question 108

The nurse is assessing an eight month-old child. The nurse would anticipate that the child would be able to

A) Say two words

B) Pull up to stand

C) Sit without support

D) Use a spoon

Review Information: The correct answer is:C) Sit without support.

The age at which the normal child develops the ability to sit steadily without support is 8 months.

Question 109

The nurse is teaching a newly diagnosed asthma client on how to use a peak flow meter. The nurse explains that this should be used to

A) Determine oxygen saturation

B) Measure forced expiratory volume

C) Monitor atmosphere for presence of allergens

D) Provide metered doses for inhaled bronchodilator

Review Information: The correct answer is:B) Measure forced expiratory volume.

The peak flow meter is used to measure peak expiratory flow volume. It provides useful information about the presence and/or severity of airway obstruction.

Question 110

The nurse is performing a pre-kindergarten physical on a five year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) Vastus intermedius

B) Gluteus rainlinus

C) Vastus lateralis

D) Dorsogluteal

Review Information: The correct answer is:C) Vastus lateralis.

Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

Question 111

A client experienced the loss of a seven month fetus. The nurse planning for discharge should emphasize

A) Discussing feelings with support persons

B) Focusing on the other healthy children

C) Seeking causes for the fetal death

D) Planning another pregnancy very soon

Review Information: The correct answer is:A) Discussing feelings with support persons.

In communicating therapeutically, the nurse helps the couple begin the grief process by suggesting they seek family, friends and support groups to listen to their feelings.

Question 112

The parents of a 4 year-old hospitalized child tell the nurse they will leave for a time and return at 6 PM. When the child asks when the parents will come again, the nurse can BEST respond by saying

A) "They will be back right after supper."

B) "In about 2 hours, you will see them."

C) "After you play awhile, they will be here."

D) "When the clock hands are on 6 and 12."

Review Information: The correct answer is:A) "They will be back right after supper."

Time is not completely understood by a 4 year-old. The child interprets time with his own frame of reference. Thus it is best to explain time in relationship to an event.

Question 113

The nurse is providing instructions for a client with asthma. Which of the following should the client monitor on a daily basis?

A) Respiratory rate

B) Peak air flow volumes

C) Pulse oximetry

D) Skin color

Review Information: The correct answer is:B) Peak air flow volumes.

The peak airflow volume decreases about 24 hours before clinical manifestations.

Question 114

Therapeutic nurse-client interaction occurs when the nurse

A) Assists the client to clarify the meaning of what the client is communicating

B) Interprets the client's covert communication

C) Praises the client for appropriate behavior

D) Advises the client on ways to resolve problems

Review Information: The correct answer is:A) Assists the client to clarify the meaning of what the client is communicating.

Clarification is a facilitating/therapeutic communication strategy. Approval, changing the focus/subject, and advising are non-therapeutic/barriers to communication.

Question 115

A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

A) Hypothermia

B) Edema

C) Dyspnea

D) Epistaxis

Review Information: The correct answer is:D) Epistaxis.

A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

Question 116

The nurse is caring for a client with a distal tibia fracture. The client has had a closed reduction and application of a toe to groin cast. Thirty-six hours after surgery, the client suddenly becomes confused, short of breath and spikes a temperature of 103 degrees F. The FIRST assessment the nurse should perform is

A) Orientation to time, place and person

B) Pulse oximetry

C) Circulation to casted extremity

D) Blood pressure

Review Information: The correct answer is:B) Pulse oximetry.

Restlessness, confusion, irritability and disorientation may be the first signs of fat embolism syndrome followed by a very high temperature. The nurse needs to confirm hypoxia first.

Question 117

Which nursing intervention will be MOST effective in helping a withdrawn client to develop relationship skills?

A) Offer the client frequent opportunities to interact with you

B) Remind the client frequently to interact with other clients

C) Assist the client to analyze the meaning of her behavior

D) Identify for her other clients who have similar problems

Review Information: The correct answer is:A) Offer the client frequent opportunities to interact with you.

The withdrawn client is uncomfortable in social interaction. The nurse client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

Question 118

The nurse is assessing a client with a stage 2 skin ulcer. Which of the following treatments is most effective to promote healing?

A) Covering the wound with a dry dressing

B) Using hydrogen peroxide soaks

C) Leaving the area open to dry

D) Applying a transparent film cover

Review Information: The correct answer is:D) Applying a transparent film cover.

For this type of ulcer, the most effective treatment is a transparent cover.

Question 119

A female client is admitted for a breast biopsy. She says, tearfully to the nurse, "If this turns out to be cancer and I have to have my breast removed, my husband will never come near me." The nurse's BEST response would be

A) "You are underestimating your husband's ability to love you."

B) "Are you concerned that your husband will reject you?"

C) "Are you wondering about the effect on your sexual relations?"

D) "Are you worried that the surgery will change you?"

Review Information: The correct answer is:D) "Are you worried that the surgery will change you?"

This is a response that encourages further discussion without focusing on an area that the nurse, but possibly not the client, feels is a problem.

Question 120

When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue

A) Angry outbursts at significant others

B) Fears of being left alone

C) Giving away valued personal items

D) Experiencing the loss of a boyfriend

Review Information: The correct answer is:C) Giving away valued personal items.

80% of all potential suicide victims give some type of clue. These clues might lead one to suspect that a client is holding suicidal thoughts or is developing a plan.

Question 121

The nurse is caring for a 4 year-old admitted after receiving burns to more than 50% of his body. Which laboratory data should be reviewed by the nurse as a PRIORITY in the first 24 hours?

A) Blood urea nitrogen

B) Hematocrit

C) Blood glucose

D) White blood count

Review Information: The correct answer is:A) Blood urea nitrogen.

Glomerular filtration is decreased in the initial response to severe burns, with fluid shift. Kidney function must be monitored closely, or renal failure may follow in a few days.

Question 122

The nurse is caring for a client in a Coronary Care Unit two days following a Myocardial Infarction. The client has many questions about his condition. The nurse should focus teaching about

A) Immediate needs and concerns

B) Post discharge rehabilitation

C) Medication therapy at home

D) Activity and rest schedule

Review Information: The correct answer is:A) Immediate needs and concerns.

Client education of the post MI client should be limited to immediate needs and concerns.

Question 123

The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?

A) Client should be NPO after midnight

B) Client should receive a sedative medication prior to the test

C) Discontinue anti-coagulant therapy prior to the test

D) No special preparation is necessary

Review Information: The correct answer is:D) No special preparation is necessary.

This is a non-invasive procedure and does not require preparation.

Question 124

While interviewing a client, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to

A) Ask the client what she is feeling

B) Assess the client for auditory hallucinations

C) Recognize the behavior as a side effect of medication

D) Re-focus the discussion on a less anxiety provoking topic

Review Information: The correct answer is:A) Ask the client what she is feeling.

The initial step in anxiety intervention is observing, identifying, and assessing anxiety.

Question 125

Parents of a 4 year-old boy have just been informed that their son has a congenital neurologic demyelinating disorder that is terminal. The nurse evaluates their reaction as which phase of the crisis process?

A) Pre-crisis phase

B) Impact phase

C) Crisis phase

D) Resolution phase

Review Information: The correct answer is:B) Impact phase.

The impact of crisis is indicative of high levels of stress, sense of helplessness, confusion, disorganization, and the inability to apply problem solving behavior.

Question 126

A postpartum mother is unwilling to allow the father to participate in the newborn's care, although he is interested in doing so. She states, "I am afraid the baby will be confused about who the mother is. Baby raising is for mothers, not fathers." The nurse's BEST initial intervention is to

A) Discuss with the mother sharing parenting responsibilities

B) Help the mother to express her feelings and concerns

C) Arrange for the parents to attend infant care classes

D) Talk with the father and help him accept the wife's decision

Review Information: The correct answer is:B) Help the mother to express her feelings and concerns.

Non-judgmental support for expressed feelings may lead to resolution of competitive feelings in a new family. Cultural influences may also be revealed.

Question 127

Which of the following statements made by a female client indicate to the nurse that she may have a thought disorder?

A) "I'm so angry about this. Wait until my husband hears about this."

B) "I'm a little confused. What time is it?"

C) "I can't find my 'mesmer' shoes. Have you seen them?"

D) "I'm fine. It's my daughter who has the problem."

Review Information: The correct answer is:C) "I can''t find my ''mesmer'' shoes. Have you seen them?".

A Neologism is a new word self invented by a person and not readily understood by another that is often associated with a thought disorder.

Question 128

The nurse is aware that which of the following psychosocial needs are BEST described in the adolescent when hospitalized?

A) Independence, confidence, narcissism

B) Group sports, competition, being right

C) Privacy, autonomy, peer interactions

D) School performance, reading, journal writing

Review Information: The correct answer is:C) Privacy, autonomy, peer interactions.

Adolescents display the need for privacy, autonomy and peer interaction concurrent with an evolving sense of identity.

Question 129

The nurse is observing a client with an obsessive-compulsive disorder in an in-patient setting. Which of the following behaviors is consistent with this diagnosis?

A) Repeatedly checking that the door is locked

B) Verbalized suspicions about thefts

C) Preference for consistent care givers

D) Repetitive, involuntary movements

Review Information: The correct answer is:A) Repeatedly checking that the door is locked.

Behaviors that are repeated are symptomatic of obsessive-compulsive disorders. These behaviors often interfere with normal function and employment.

Question 130

A young adult seeks treatment in an out-patient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the MOST therapeutic approach by the nurse?

A) Listen quietly without comment

B) Ask for further information on the spies

C) Confront the client on a delusion

D) Contact the government agency

Review Information: The correct answer is:A) Listen quietly without comment.

The client''s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid incorporation into the delusion.

Question 131

The client's self-esteem is MOST damaged by the nurse's

A) Anger

B) Indifference

C) Disapproval

D) Fear

Review Information: The correct answer is:B) Indifference.

Positive connectedness/caring objectivity characterizes therapeutic relationships and is incongruent with indifference.

Question 132

An 8 year-old client is admitted to the child mental health unit for evaluation. Following his mother's departure, the client cries and refuses his dinner. The BEST approach by the nurse is to

A) Offer to play with him

B) Remind him that he is expected to eat his meals

C) Tell him that he will be denied privileges for uncooperative behavior

D) Tell him that his mother will be upset with him if he does not cooperate

Review Information: The correct answer is:A) Offer to play with him.

Play is both distracting and an avenue for a child's communication. Play facilitates mastery of feelings.

Question 133

A client is admitted to a psychiatric unit with delusions. The nurse can expect which of the following signs and symptoms?

A) Flight of ideas and hyperactivity

B) Suspiciousness and resistance to therapy

C) Anorexia and hopelessness

D) Panic and multiple physical complaints

Review Information: The correct answer is:B) Suspiciousness and resistance to therapy.

Clinical features of delusional disorder include extreme suspiciousness, jealousy, distrust, belief that others intend to harm.

Question 134

A client states, "People think I'm no good, you know what I mean?" Which of the following nursing responses would be MOST therapeutic for this client?

A) "Well people often take their own feelings of inadequacy out on others."

B) "I think you're good. So you see, there's one person who likes you."

C) "I'm not sure what you mean. Tell me a bit more about that."

D) "Have you done something to create this impression on people?"

Review Information: The correct answer is:C) "I'm not sure what you mean. Tell me a bit more about that."

Therapeutic communication technique that elicits more information is delivered in an open non-judgmental fashion.

Question 135

A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which of the following is the BEST nursing action in response to the client's attire?

A) Gently remind her that she is no longer on stage

B) Directly assist client to her room for appropriate apparel

C) Quietly point out to her the dress of other clients on the unit

D) Tactfully explain to her the clothing appropriate for the hospital

Review Information: The correct answer is:B) Directly assist client to her room for appropriate apparel.

Allows the client to maintain self-esteem while modifying behavior.

Question 136

An appropriate goal for a client with anxiety would be to

A) Ventilate her feelings to the nurse

B) Establish contact with reality

C) Learn self-help techniques for reducing anxiety

D) Become desensitized to past trauma

Review Information: The correct answer is:C) Learn self-help techniques for reducing anxiety.

Exploring alternative coping mechanisms will decrease present anxiety to a manageable level. Assisting the client to learn self-help techniques will assist in learning to cope with anxiety.

Question 137

Handshaking is the preferred form of touch or contact used with clients in a psychiatric setting. The rationale behind this limited touch practice is that

A) Some clients misconstrue hugs as an invitation to sexual advances

B) Handshaking keeps the gesture on a professional level

C) Refusal to touch a client denotes lack of concern

D) Inappropriate touch often results in charges of assault and battery

Review Information: The correct answer is:

A) Some clients misconstrue hugs as an invitation to sexual advances.

Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as a sexual advance.

Question 138

A client with paranoid delusions stares at the nurse for several days. The client suddenly walks up to the nurse and shouts "You think you're so perfect and pure and good." An appropriate response for the nurse is

A) "Is that why you've been starring at me?"

B) "You seem to be in a really bad mood."

C) "Perfect? I don't quite understand."

D) "You are angry right now."

Review Information: The correct answer is:

D) "You are angry right now.".

The nurse recognizes the underlying emotion with matter of fact attitude.

Question 139

A client being treated for hypertension returns to the clinic for follow up.He says, "I know these pills are important, but I just can't take these water pills anymore. I drive a truck for a living, and I can't be stopping every 20 minutes to go to the bathroom." The MOST appropriate nursing diagnosis would be

A) Noncompliance related to medication side effects

B) Knowledge deficit related to misunderstanding of disease state

C) Defensive coping related to chronic illness

D) Altered health maintenance related to occupation

Review Information: The correct answer is:

A) Noncompliance related to medication side effects.

The client kept his appointment, and stated he knew the pills were important. He is unable to comply with the regimen due to side effects, not a lack of knowledge about his disease.

Question 140

A spouse is concerned because the client frequently daydreams about moving to Arizona to get away from the pollution and crowding in southern California. The nurse explains that

A) Such fantasies can gratify unconscious wishes or prepare for anticipated future events

B) Detaching or dissociating in this way postpones painful feelings

C) This conversion or transferring of a mental conflict to a physical symptom can lead to marital conflict

D) Isolating her feelings in this way reduces conflict

Review Information: The correct answer is:

A) Such fantasies can gratify unconscious wishes or prepare for anticipated future events.

Fantasy is imagined events (daydreaming) to express unconscious conflicts or gratifying unconscious wishes.

Question 141

An important goal in the development of a therapeutic in-patient milieu is

A) Providing a businesslike atmosphere where clients can work on individual goals

B) Providing a group forum in which clients decide on unit rules, regulations, and policies

C) Providing a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions

D) Discouraging expressions of anger because they can be disruptive to other clients

Review Information: The correct answer is:

C) Providing a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions.

A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

Question 142

The nurse's PRIMARY intervention for a client who is experiencing a panic attack is to

A) Develop a trusting relationship

B) Assist the client to describe his experience in detail

C) Maintain safety for the client

D) Teach the client to control his or her own behavior

Review Information: The correct answer is:

C) Maintain safety for the client.

Clients who display signs of severe anxiety need to be supervised closely until the anxiety is decreased because they may harm themselves or others.

Question 143

A 64 year-old client scheduled for surgery with a general anesthetic refuses to remove her dentures prior to leaving the unit for the operating room. The MOST appropriate intervention by the nurse is

A) Explain to the client that the dentures must come out as they may get lost or broken in the operating room

B) Ask the client if she is having second thoughts about the procedure

C) Notify the surgeon of the client's refusal

D) Ask the client if she would prefer removing the dentures in the operating room receiving area

Review Information: The correct answer is:

D) Ask the client if she would prefer removing the dentures in the operating room receiving area.

Clients anticipating surgery may experience a variety of fears. This choice allows the client control over the situation and fosters the client''s sense of self-esteem and self-concept.

Question 144

Which of the following interventions BEST demonstrates the nurse's sensitivity to a 16 year-old's appropriate need for autonomy?

A) Alertness for feelings regarding body image

B) Allows young siblings to visit

C) Provides opportunity to discuss concerns without presence of parents

D) Explores his feelings of resentment to identify causes

Review Information: The correct answer is:

C) Provides opportunity to discuss concerns without presence of parents.

This intervention provides the teen with the opportunity to have control and encourages decision making.

Question 145

A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are

A) Brittle hair, lanugo, amenorrhea

B) Diarrhea, nausea, vomiting, dental erosion

C) Hyperthermia, tachycardia, increased metabolic rate

D) Excessive anxiety about symptoms

Review Information: The correct answer is:

A) Brittle hair, lanugo, amenorrhea.

Physical findings associated with anorexia are brittle hair, lanugo, and dehydration, lowered metabolic rate and vital signs.

Question 146

A depressed client in an assisted living facility tells the nurse that "life isn't worth living anymore." What is the BEST response to this statement?

A) "Come on, it is not that bad."

B) "Have you thought about hurting yourself?"

C) "Did you tell that to your family?"

D) "Think of the many positive things in life."

Review Information: The correct answer is:

B) "Have you thought about hurting yourself?".

It is appropriate and necessary to determine if someone who has voiced suicidal ideation is considering a suicidal act. This response is most therapeutic in the circumstances.

Question 147

A client, recovering from alcoholism, asks the nurse, "What can I do when I start recognizing relapse triggers within myself?" How might the nurse BEST respond?

A) "When you have the impulse to stop in a bar, contact a sober friend and talk with him."

B) "Go to an AA meeting when you feel the urge to drink."

C) "It is important to exercise daily and get involved in activities that will cause you not to think about drug use."

D) "Identify your relapse triggers as part of getting better."

Review Information: The correct answer is:

D) "Identify your relapse triggers as part of getting better.".

This option encourages the process of self evaluation and problem solving.

Question 148

A client was admitted to the eating disorder unit with bulimia nervosa. When the nurse assesses for a history of complications of this disorder, the following are expected

A) Respiratory distress, dyspnea

B) Bacterial gastrointestinal infections, overhydration

C) Metabolic acidosis, constricted colon

D) Dental erosion, parotid gland enlargement

Review Information: The correct answer is:

D) Dental erosion, parotid gland enlargement.

Dental erosion related to purging and parotid gland enlargement due to purging are common complications.

Question 149

A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states," This is not my baby, and I do not want it." The nurse's BEST response is

A) "This is a common occurrence after birth, but you will come to accept the baby."

B) "Many women have postpartum blues and need some time to love the baby."

C) "What a beautiful baby! Her eyes are just like yours."

D) "You seem upset; tell me what the pregnancy and birth were like for you."

Review Information: The correct answer is:

D) "You seem upset; tell me what the pregnancy and birth were like for you.".

A non-judgmental, open ended response facilitates dialogue between the client and nurse.

Question 150

Which of the following times is a depressed client at highest risk for attempting suicide?

A) Immediately after admission, during one-to-one observation

B) 7 to 14 days after initiation of antidepressant medication and psychotherapy when energy increases

C) Following an angry outburst with family

D) When the client is removed from the security room

Review Information: The correct answer is:

B) 7 to 14 days after initiation of antidepressant medication and psychotherapy when energy increases.

As the depression lessens, the depressed client acquires energy to follow the plan.

Question 1

The nurse manager informs the nursing staff at morning report that the clinical nurse specialist will be conducting a research study on staff attitudes toward client care. All staff are invited to participate in the study if they wish. This affirms the ethical principle of

A) Anonymity

B) Beneficence

C) Justice

D) Autonomy

Review Information: The correct answer is:

D) Autonomy.

Individuals must be free to make independent decisions about participation in research without coercion from others.

Question 2

The nurse is preparing to take a toddler's blood pressure for the first time. Which of the following actions should the nurse do FIRST?

A) Explain that the procedure will help him to get well

B) Show a cartoon character with a blood pressure cuff

C) Explain that the blood pressure checks the heart pump

D) Permit handling the equipment before putting the cuff in place

Review Information: The correct answer is:

D) Permit handling the equipment before putting the cuff in place.

The best way to gain the toddler's cooperation is to encourage handling the equipment. Detailed explanations are not helpful.

Question 3

The nurse must know that the MOST accurate oxygen delivery system available is

A) The venturi mask

B) Nasal cannula

C) Partial non-rebreather mask

D) Simple face mask

Review Information: The correct answer is:

A) The venturi mask.

The most accurate way to deliver oxygen to the client is through a venturi system such as the Venti Mask. The Venti Mask is a high flow device that entrains room air into a reservoir device on the mask and mixes the room air with 100% oxygen. The size of the opening to the reservoir determines the concentration of oxygen. The client's respiratory rate and respiratory

pattern do not affect the concentration of oxygen delivered. The maximum amount of oxygen that can be delivered by this system is 55%.

Question 4

The nurse is assessing a comatose client receiving gastric tube feedings. Which of the following assessments requires an IMMEDIATE response from the nurse?

A) Decreased breath sounds in right lower lobe

B) Aspiration of a residual of 100cc of formula

C) Decrease in bowel sounds

D) Urine output of 250 cc in past eight hours

Review Information: The correct answer is:

A) Decreased breath sounds in right lower lobe.

The most common problem associated with enteral feedings is atelectasis. Maintain client at 30 degrees during feedings and monitor for signs of aspiration. Check for tube placement prior to each feeding or every four to eight hours if continuous feeding.

Question 5

A pregnant client who is at 34 weeks gestation is diagnosed with a pulmonary embolism (PE). The nurse would anticipate the physician ordering

A) Oral Coumadin therapy

B) Heparin 5000 units subcutaneously b.i.d.

C) Heparin infusion to maintain the PTT at 1.5-2.5 times the control value

D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value

Review Information: The correct answer is:

D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value.

Several studies have been conducted in pregnant women where oral anticoagulation agents are contraindicated. Warfarin (Coumadin) is known to cross the placenta and is therefore reported to be teratogenic.

Question 6

Which of the following BEST describes the goal of total quality management or continuous quality improvement in a health care setting?

A) Observing reactive service and product problem solving

B) Improving processes in a proactive, preventive mode

C) Conducting chart audits to find common errors

D) Creating a flow chart to organize daily tasks

Review Information: The correct answer is:

B) Improving processes in a proactive, preventive mode.

Total Quality Management and Continuous Quality Improvement have a major goal of identifying ways to do the right thing at the right time in the right way by proactive problem-solving.

Question 7

A new nurse manager is responsible for interviewing applicants for a staff nurse position. Which of the following interview strategies is the BEST?

A) Vary the interview style for each candidate to learn different techniques

B) Use simple questions requiring "yes" and "no" answers to gain definitive information

C) Develop an interview guide for consistency in interviewing each candidate

D) Ask personal information of each applicant to assure meeting of job demands

Review Information: The correct answer is:

C) Develop an interview guide for consistency in interviewing each candidate.

An interview guide used for each candidate enables the nurse manager to be more objective in the decision making.

Question 8

The nurse is caring for a client who has altered cerebral tissue perfusion related to a subarachnoid hemorrhage. To reduce the risk of rebleeding, the nurse should plan to

A) Restrict visitors to immediate family

B) Arouse the client frequently

C) Keep client's hips flexed at 120 degrees

D) Apply warming blankets

Review Information: The correct answer is:

A) Restrict visitors to immediate family.

Maintaining a quiet environment will assist in decreasing cerebral swelling and rebleeding.

Question 9

The nurse is caring for a client with renal calculi. Which physician order would be a PRIORITY?

A) Morphine sulfate as client controlled analgesia

B) Push oral fluids and keep vein open

C) Continuous warm compresses to the flank area

D) Intravenous antibiotics

Review Information: The correct answer is:

A) Morphine sulfate as client controlled analgesia.

Administering narcotic analgesics provide prompt relief of the severe pain caused by kidney stones.

Question 10

The nurse is teaching parents of a 7 month-old about adding table foods. Which of the following is an APPROPRIATE finger food?

A) Hot dog pieces

B) Sliced bananas

C) Whole grapes

D) Popcorn

Review Information: The correct answer is:

B) Sliced bananas.

Finger foods should be bite-size pieces of soft food such as bananas.

Question 11

While assessing the vital signs in children, the nurse should know that the apical heart rate is preferred until the radial pulse can be accurately assessed at about

A) One year of age

B) Two years of age

C) Three years of age

D) Four years of age

Review Information: The correct answer is:

B) Two years of age.

A child should be at least 2 years of age to use the radial pulse to assess heart rate.

Question 12

A newborn weighed 7 pounds 2 ounces at birth. The nurse assesses her at home two days later and finds the weight to be 6 pounds 7 ounces. When the parents question this loss, the nurse explains that

A) The newborn needs additional assessments

B) The mother should breast feed more often

C) A change to formula is indicated

D) The loss is within normal limits

Review Information: The correct answer is:

D) The loss is within normal limits.

A newborn is expected to lose 5-10% of the birth weight in the first few days because of changes in elimination and feeding.

Question 13

A five year-old has been rushed to the emergency room several hours after acetaminophen poisoning. Which of the following laboratory results should receive PRIORITY attention by the nurse?

A) Sedimentation rate

B) Profile 2

C) Bilirubin

D) Neutrophils

Review Information: The correct answer is:

C) Bilirubin.

Bilirubin, along with liver enzymes ALT and AST, may rise in the second stage (1-3 days) after a significant overdose, indicating cellular necrosis and liver dysfunction. A prolonged prothrombin may also occur.

Question 14

An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When the nurse obtains the child's health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The PRIORITY nursing action is based on the understanding that

A) Live vaccines are withheld in children with renal chronic illness

B) The MMR vaccine should be given now, prior to the transplant

C) An inactivated form of the vaccine can be given at any time

D) The risk of vaccine side effects precludes giving the vaccine

Review Information: The correct answer is:

B) The MMR vaccine should be given now, prior to the transplant.

MMR is a live virus vaccine, and should be given at this time. Post-transplant, immunosuppressive drugs will be given and the administration of the live vaccine at that time would be contraindicated because of the compromised immune system.

Question 15

The nurse working with clients from many different cultures recognizes that it is a PRIORITY to

A) Speak another language

B) Learn about all the cultures

C) Refer to experts from those countries

D) Recognize personal attitudes and biases

Review Information: The correct answer is:

D) Recognize personal attitudes and biases.

The nurse must discover personal attitudes, prejudices and biases. Sensitivity to these will affect interactions with clients and families across cultures.

Question 16

When teaching a client about the use of sublingual nitroglycerin, the nurse should emphasize that the MOST common side effect is

A) Headache

B) Dry mouth

C) Depression

D) Anorexia

Review Information: The correct answer is:

A) Headache.

The most common side effect is headache, related to the generalized vasodilatation.

Question 17

The nurse is planning care for an 8 year-old child. Which of the following should be included in the plan of care?

A) Encourage child to engage in activities in the playroom

B) Promote independence in activities of daily living

C) Talk with the child and allow him to express his opinions

D) Provide frequent reassurance and cuddling

Review Information: The correct answer is:

A) Encourage child to engage in activities in the playroom.

According to Erikson, the school age child is in the stage of industry versus inferiority. To help them achieve industry, the nurse should encourage them to carry out tasks and activities in their room or in the playroom.

Question 18

The nurse is preparing to administer a tube feeding to a post-operative client. To accurately assess for a gastostomy tube placement, the PRIORITY is to

A) Auscultate the abdomen while instilling 10 cc of air into the tube

B) Place the end of the tube in water to check for air bubbles

C) Retract the tube several inches to check for resistance

D) Measure the length of tubing from nose to epigastrium

Review Information: The correct answer is:

A) Auscultate the abdomen while instilling 10 cc of air into the tube.

If a swoosh of air is heard over the abdominal cavity while instilling air into the gastric tube, this indicates that it is accurately placed in the stomach. The feeding can begin after assessing the client for bowel sounds.

Question 19

You are caring for a client with Parkinson's disease who has developed hallucinations. Which of the following medications that the client is receiving may have been a contributing factor?

A) L-Dopa

B) Cogentin

C) Baclofen

D) Benadryl

Review Information: The correct answer is:

A) L-Dopa.

While it is unclear whether some 1/3 of clients with Parkinson's disease have a dementia, the nurse should ask about hallucinations because the Parkinson's disease medications will cause hallucinations when they are at too high a dose. This should be asked at each client visit in home care or clinic visits.

Question 20

A nurse admits a client transferred from the emergency room. The client, diagnosed with a myocardial infarction, is complaining of substernal chest pain, diaphoresis and nausea. The FIRST action by the nurse should be

A) Order an EKG

B) Administer pain medication as ordered

C) Start an IV

D) Measure vital signs

Review Information: The correct answer is:

B) Administer pain medication as ordered.

Decreasing the clients pain is the most important priority at this time. As long as pain is present there is danger in extending the infarcted area.

Question 21

Decentralized scheduling is used on a nursing unit. A CHIEF advantage of this management strategy is that it

A) Considers client and staff needs

B) Conserves time for planning

C) Frees the nurse manager from this task

D) Allows for requests for special privileges

Review Information: The correct answer is:

A) Considers client and staff needs.

Decentralized staffing takes into consideration specific client needs and staff interests and abilities.

Question 22

A client with angina has been instructed about the use of sublingual nitroglycerin. Which of the following statements made to the nurse indicates a need for FURTHER teaching?

A) "I will rest briefly right after taking one tablet."

B) "I can take 2-3 tablets at once if I have severe pain."

C) "I'll call the doctor if pain continues after 3 tablets 5 minutes apart."

D) "I understand that the medication should be kept in the dark bottle."

Review Information: The correct answer is:

B) "I can take 2-3 tablets at once if I have severe pain."

Clients must understand that just one sublingual tablet should be taken at a time. After rest and a five minute interval, a second and then a third tablet may be necessary.

Question 23

The nurse is talking with the family of an 18 month-old newly diagnosed with retinoblastoma. A PRIORITY in communicating with the parents is

A) Discussing the need for genetic counseling

B) Informing them that combined therapy is seldom effective

C) Preparing for the child's permanent disfigurement

D) Suggesting that total blindness may follow surgery

Review Information: The correct answer is:

A) Discussing the need for genetic counseling.

The hereditary aspects of this disease are well documented. While the parents focus on the needs of this child, they should be aware that the risk is high for future offspring.

Question 24

The nurse is teaching a client about precautions with Coumadin. The nurse should instruct the client to avoid foods with excessive amounts of

A) Calcium

B) Vitamin K

C) Iron

D) Vitamin E

Review Information: The correct answer is:B) Vitamin K.

Eating foods with excessive amounts of Vitamin K contained in green leafy vegetables may alter anticoagulant effects.

Question 25

The clinic nurse is counseling a substance-abusing post partum client on the risks of continued cocaine use. In order to provide continuity of care, which of the following is a PRIORITY nursing diagnosis?

A) Social isolation

B) Ineffective coping

C) Altered parenting

D) Sexual dysfunction

Review Information: The correct answer is:

C) Altered parenting.

The cocaine abusing mother puts her newborn and other children at risk for neglect and abuse. Continuing to use drugs has the potential to impact parenting behaviors. Social service referrals are indicated.

Question 26

As a part of a 9 pound newborn's assessment, the nurse performs a dextro-stick at one hour. The blood glucose level is 45 mg/dl. What FIRST action by the nurse is appropriate?

A) Give oral glucose

B) Notify the pediatrician

C) Repeat the test in 2 hours

D) Check other laboratory findings

Review Information: The correct answer is:

C) Repeat the test in 2 hours.

This blood sugar is within the normal range for a full term newborn. Because of the birth weight, repeated blood sugars will be drawn.

Question 27

A client with atrial fibrillation is receiving digoxin (Lanoxin). It is MOST important for the nurse to

A) Monitor blood pressure every 4 hours

B) Measure apical pulse prior to administration

C) Maintain accurate intake and output records

D) Record an EKG strip after administration

Review Information: The correct answer is:

B) Measure apical pulse prior to administration.

Digitoxin decreases conduction velocity through the AV node and prolongs the refractory period. If the apical heart rate is less than 60 beats/minute, withhold the drug. The apical pulse should be taken with a stethoscope so that there will be no mistake about what the heart rate actually is.

Question 28

A client is brought to the emergency room following a motor vehicle accident. When assessing the client one-half hour after admission, the nurse notes several physical changes. Which of the following changes would require the nurse's IMMEDIATE attention?

A) Increased restlessness

B) Tachycardia

C) Tracheal deviation

D) Tachypnea

Review Information: The correct answer is:

C) Tracheal deviation.

The deviated trachea is a sign that a mediastinal shift has occurred. This is a medical emergency.

Question 29

A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which of the following client statements from the assessment data is likely to explain his noncompliance?

A) "I have problems with diarrhea."

B) "I have difficulty falling asleep."

C) "I have diminished sexual function."

D) "I often feel jittery."

Review Information: The correct answer is:

C) "I have diminished sexual function."

Inderal beta-blocks cells prohibiting the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

Question 30

The nurse is instructing a client with moderate persistent asthma on the proper method for using MDI's (multi-dose inhalers). Which medication should be administered FIRST?

A) Steroid

B) Anticholinergic

C) Mast cell stabilizer

D) Beta agonist

Review Information: The correct answer is:

D) Beta agonist.

The beta-agonist is taken first to open the airway.

Dettenrneier, .A. (1992).

Pulmonary Nursing Care.

St. Louis: Mosby.

Lewis, S., Collier, I., & Heitkemper, M.M. (1996).

Medical-Surgical Nursing. (4th ed.).

St. Louis: Mosby.

Question 31

A nurse assessing the newborn of a diabetic mother understands that hypoglycemia is related to

A) Disruption of fetal glucose supply

B) Pancreatic insufficiency

C) Maternal insulin dependency

D) Reduced glycogen reserves

Review Information: The correct answer is:

A) Disruption of fetal glucose supply.

After delivery, the high glucose levels which crossed the placenta to the fetus are suddenly stopped. The newborn continues to secrete insulin in anticipation of glucose. When oral feedings begin, the newborn will adjust insulin production within a day or two.

Lowdermilk, D., Perry, S., Bobak, I. (1997).

Maternal and Women's Health Care. (6th ed.).

St. Louis, Mosby.

Wong, D. (1999).

Whaley and Wong's Nursing Care of Infants and Children. (5th ed.).

St. Louis: Mosby.

Question 32

The nurse is administering an intravenous piggyback infusion of penicillin. Which of the following client statements would require the nurse's IMMEDIATE attention?

A) "I have a burning sensation when I urinate."

B) "I have soreness and aching in my muscles."

C) "I am itching all over."

D) "I have cramping in my stomach."

Review Information: The correct answer is:

C) "I am itching all over."

Complaints of itching, feeling hot all over and/or the appearance of raised, red welts on the skin are symptoms of an allergic reaction to the penicillin infusion. Therefore, the drug administration should be stopped immediately.

Carroll, P. (1994).

Speed: The Essential Response to Anaphylaxis.

RN 57(6), 26-31.

Ignatavicius, D.D., Workman, M.L., Mishler, M.A. (1995).

Medical-Surgical Nursing.

Philadelphia: WB Saunders.

Question 33

A 16 year-old boy is admitted for Ewing's sarcoma of the tibia. In discussing his care with the parents, the nurse understands that the initial treatment MOST often includes

A) Amputation just above the tumor

B) Surgical excision of the mass

C) Bone marrow graft in the affected leg

D) Radiation and chemotherapy

Review Information: The correct answer is:

D) Radiation and chemotherapy.

The initial treatment of choice for Ewing's sarcoma is a combination of radiation and chemotherapy.

Wong, D. (1999).

Whaley & Wong's Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 34

A client is receiving dexamethasone (Decadron) therapy. The nurse plans to monitor the client's

A) Urine output every four hours

B) Blood glucose levels every twelve hours

C) Neurological signs every two hours

D) Oxygen saturation every eight hours

Review Information: The correct answer is:

B) Blood glucose levels every twelve hours.

The drug Decadron increases glycogenesis. This may lead to hyperglycemia. Therefore the blood sugar level and acetone production must be monitored.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Skidmore-Roth, Linda. (2001).

Mosby's Nursing Drug Reference 2002.

St. Louis: Mosby-Year Book, Inc.

Question 35

When managing a client's pain, which of the following statements BEST describes the ethical considerations of the nurse?

A) The client's self-report is the most important consideration

B) Cultural sensitivity is fundamental to pain management

C) Clients have the right to have their pain relieved

D) Nurses should not prejudge a client's pain using their own values

Review Information: The correct answer is:

A) The client's self-report is the most important consideration.

Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B. Saunders Company.

Springhouse. (1997).

Diseases. (2nd ed.).

Springhouse, PA: Springhouse Corporation.

Question 36

The nurse is performing an assessment of the motor function in a client with a head injury. The BEST technique is

A) A firm touch to the trapezius muscle or arm

B) Pinching any body part

C) Sternal rub

D) Gentle pressure on eye orbit

Review Information: The correct answer is:

D) Gentle pressure on eye orbit.

This is an acceptable stimuli.

Urden, L., Davie, J. & Thelan, L. (1997).

Essentials of Critical Care. (2nd ed.).

St. Louis: Mosby-Yearbook.

Barker, E. (1994).

Neuro-Science Nursing.

St. Louis: Mosby.

Question 37

A 3 year-old child has tympanostomy tubes in place. The child's mother asks the nurse if he can swim in the family pool. The BEST response from the nurse is

A) "Your child should not swim at all while the tubes are in place."

B) "Your child may swim in your own pool but not in a lake or ocean."

C) "Your child may swim if he wears ear plugs."

D) "Your child may swim anywhere."

Review Information: The correct answer is:

C) "Your child may swim if he wears ear plugs.".

Water should not enter the ears. Children should use ear plugs when bathing or swimming and should not put their head under the water.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 38

The nurse is caring for a 2 year-old who is being treated with chelation therapy, calcium disodium edetate, for lead poisoning. The nurse should be alert for which of the following side effects?

A) Neurotoxicity

B) Hepatomegaly

C) Nephrotoxicity

D) Ototoxicity

Review Information: The correct answer is:

C) Nephrotoxicity.

Nephrotoxicity is a common side effect of calcium disodium edetate, in addition to lead poisoning in general.

McHenry & Salerno. (2000).

Mosby Pharmacology in Nursing.

St. Louis: Mosby-Yearbook.

Wong, D. (1999).

Whaley & Wong's Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 39

The nurse admits a two year-old child who has had a seizure. Which of the following statement by the child's parent would be important in determining the etiology of the seizure?

A) "He has been taking long naps for a week."

B) "He has had an ear infection for the past two days."

C) "He has been eating more red meat lately."

D) "He seems to be going to the bathroom more frequently."

Review Information: The correct answer is:

B) "He has had an ear infection for the past two days.".

Contributing factors to seizures in children include those such as age (more common in first 2 years), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention.

Wong, D. (1999).

Whaley & Wong's Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 40

The nurse is caring for a client with Hodgkin's disease who will be receiving radiation therapy. The nurse recognizes that, as a result of the radiation therapy, the client is MOST likely to experience

A) High fever

B) Nausea

C) Face and neck edema

D) Night sweats

Review Information: The correct answer is:

B) Nausea.

Because the client with Hodgkin's disease is usually healthy when therapy begins, the nausea is especially troubling.

Springhouse. (1998).

Illustrated Handbook of Nursing Care.

Springhouse PA: Springhouse Corporation.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 1

The nurse is performing an assessment on a client with pneumococcal pneumonia. Which of the following assessments would the nurse anticipate finding?

A) Bronchial breath sounds in outer lung fields

B) Decreased tactile fremitus

C) Hacking, nonproductive cough

D) Hyperresonance of areas of consolidation

Review Information: The correct answer is:

A) Bronchial breath sounds in outer lung fields.

Pneumonia causes a marked increase in interstitial and alveolar fluid. Consolidated lung tissue transmits bronchial breath sounds to outer lung fields.

Black, J. & Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing, Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical Nursing; Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby.

Question 2

In providing care to a 14 year-old adolescent with scoliosis, which of the following will be MOST difficult for this client?

A) Compliance with treatment regimens

B) Looking different from their peers

C) Lacking independence in activities

D) Reliance on family for their social support

Review Information: The correct answer is:

B) Looking different from their peers.

Conformity to peer influences peaks at around age 14. Since many persons view any disability as deviant, the client will need help in learning how to deal with reactions of others. Treatment of scoliosis is long-term and involves bracing and/or surgery.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 3

When counseling parents of a child who has recently been diagnosed with hemophilia, the nurse must know that in the offspring of a normal father and a carrier mother

A) It is likely that all sons are affected

B) There is a 50% probability that sons will have the disease

C) Every daughter is likely to be a carrier

D) There is a 25% chance a daughter will be a carrier

Review Information: The correct answer is:

D) There is a 25% chance a daughter will be a carrier.

Hemophilia A is a sex-linked recessive traitseen almost exclusively in males. With a normal father and carrier mother, affected individuals are male. There is a 25% chance of having an affected male, 25% chance of having a carrier female, 25% chance of having a normal female and 25% chance of having a normal male.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 4

A three year-old child is treated in the emergency room after ingesting an ounce of a liquid narcotic. What FIRST action should the nurse take?

A) Provide humidified oxygen

B) Suction mouth and nose

C) Assess airway and circulation

D) Start intravenous fluids

Review Information: The correct answer is:

C) Assess airway and circulation.

The first step in treatment of a toxic exposure or ingestion is to assess the airway, breathing and circulation; then stabilize the client. Other nursing actions will follow.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 5

The nurse is caring for a client who is receiving total parenteral nutrition (hyperalimentation and lipids). What is the PRIORITY nursing action on every eight hour shift?

A) Monitor blood pressure, temperature and weight

B) Change the tubing under sterile conditions

C) Check urine glucose, acetone and specific gravity

D) Adjust the infusion rate to provide for total volume

Review Information: The correct answer is:

C) Check urine glucose, acetone and specific gravity.

Because of the high dextrose and protein content in parenteral nutrition, the nurse should assess the urine at least every 8 hours.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 6

The nurse walks into a client's room and finds the client lying still and silent on the floor. The nurse should FIRST

A) Assess the client's airway

B) Call for help

C) Establish that the client is unresponsive

D) See if anyone saw the client fall

Review Information: The correct answer is:

C) Establish that the client is unresponsive.

The first step in CPR is to establish unresponsiveness. Second is to call for help. Third is opening the airway.

Albarrab-Sotelo, R., et al. (1990).

Healthcare Provider''s Manual for Basic Life Support.

American Heart Association.

Cummins, RO. (1994).

Textbook of Advanced Cardiac Life Support.

American Heart Association.

Question 7

The nurse is teaching a client with asthma about the correct use of the Azmacort (triamcinolone) inhaler. Which of the following statements, if made by the client, would indicate that the teaching was effective?

A) "The inhaler can be used whenever I feel short of breath."

B) "I should rinse my mouth after using the inhaler."

C) "If I forget a dose, I can double up on the next dose."

D) "I should never take a dose of Azmacort at the same time I take a dose from another inhaler."

Review Information: The correct answer is:

B) "I should rinse my mouth after using the inhaler."

Azmacort (triamcinolone) is an inhaled corticosteroid, used to prevent asthma attacks. It is often used in conjunction with a bronchodilator. The client should be instructed torinse his mouth after using the inhaler to wash away any steroid residue so as to reduce the risk of oral fungal infections.

National Institute of Health. (1997).

National Asthma Education and Prevention Program: Expert Panel Report II: Guidelines for the Diagnosis and Management of Asthma.

National Institutes of Health.

Springhouse. (1998).

Nursing 98 Drug Handbook

Question 8

The nurse measures the head and chest circumferences of a 20 month-old infant. After comparing the measurements, the nurse finds that they are approximately the same. The appropriate action for the nurse to take would be to

A) Notify the physician

B) Palpate the anterior fontanel

C) Feel the posterior fontanel

D) Record these normal findings

Review Information: The correct answer is:

D) Record these normal findings.

The rate of increase in head circumference slows by the end of infancy, and the head circumference is usually equal to chest circumference at 1 to 2 years of age.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 9

A 7 year-old child is hospitalized following a major burn to the lower extremities. A diet high in protein and carbohydrates is recommended. The nurse informs the child and family that the MOST important reason for this diet is to

A) Promote healing and strengthen the immune system

B) Provide a well balanced nutritional intake

C) Stimulate increased peristalsis absorption

D) Spare protein catabolism to meet metabolic needs

Review Information: The correct answer is:

D) Spare protein catabolism to meet metabolic needs.

Because of the burn injury, the child has increased metabolism and catabolism. By providing a high carbohydrate diet, the breakdown of protein for energy is avoided. Proteins are then used to restore tissue.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 10

The nurse prepares to give a one year-old child an intramuscular injection. The BEST site for this injection would be in the

A) Deltoid muscle

B) Ventrogluteal muscle

C) Dorsogluteal muscle

D) Vastus lateralis muscle

Review Information: The correct answer is:

D) Vastus lateralis muscle.

The preferred site for an injection for an infant is the vastus lateralis muscle which lies along the lateral aspect of the thigh. This site is able to tolerate larger volumes, and it is not located near any nerves or blood vessels.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 11

A client is unconscious following a tonic-clonic seizure. What should the nurse do FIRST?

A) Check the pulse

B) Administer Valium

C) Place the client in a side-lying position

D) Place a tongue blade in the mouth

Review Information: The correct answer is:

C) Place the client in a side-lying position.

Place the client in a side-lying position to maintain an open airway, drain secretions, and prevent aspiration if vomiting occurs.

JAMA. (1992).

Textbook of ACLS. (4th ed.).

JAMA.

Black, J. & Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing, Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Question 12

The nurse caring for a 14 year-old boy with severe Hemophilia A, who was admitted after a fall while playing basketball. In understanding his behavior and in planning care for this client, the nurse must recognize that adolescents with hemophilia

A) Must have structured activities

B) Often take part in active sports

C) Explain limitations to peer groups

D) Avoid risks after bleeding episodes

Review Information: The correct answer is:

B) Often take part in active sports.

Establish an age-appropriate safe environment. Adolescent hemophiliacs should be aware that contact sports may trigger bleeding. However, developmental characteristics of this age group such as impulsivity, inexperience and peer pressure, place adolescents in unsafe environments.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 13

The nurse is caring for two children who have had surgical repair of congenital heart defects. For which one of the defects is it a PRIORITY to assess for signs of heart conduction disturbance?

A) Artrial septal defect

B) Patent ductus arteriosus

C) Aortic stenosis

D) Ventricular septal defect

Review Information: The correct answer is:

D) Ventricular septal defect.

While assessments for conduction disturbance should be included following repair of any defect, it is a priority for this condition. A ventricular septal defect is an abnormal opening between the right and left ventricles. The atrioventricular bundle (bundle of His), a part of the electrical conduction system of the heart, extends from the atrioventricular node along each side of the interventricular septum and then divides into right and left bundle branches. Surgical repair of a ventricular septal defect consists of a purse-string approach or a patch sewn over the opening. Either method involves manipulation of the ventricular septum, thereby increasing risk of interrupting the conduction pathway. Consequently, postoperative complications include conduction disturbances.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 14

In teaching parents about the lifestyle of their child with sickle cell disease, the nurse should emphasize that their child should

A) Avoid overheating

B) Maintain normal activity

C) Be cautious of addiction

D) Delay routine immunizations

Review Information: The correct answer is:

A) Avoid overheating.

Fluid loss caused by overheating can trigger a crisis.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 15

The nurse is caring for a newborn who has just been diagnosed with hypospadias. After discussing the defect with the parents, the nurse should expect that

A) Circumcision can be performed at any time

B) Initial repair is delayed until ages 6-8

C) Post-operative appearance will be normal

D) Surgery will be performed in stages

Review Information: The correct answer is:

D) Surgery will be performed in stages.

Hypospadias, a condition in which the urethral opening is located on the ventral surface or below the penis, is corrected in stages as soon as the infant can tolerate surgery.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 16

One reason that domestic violence remains extensively undetected is

A) Few battered victims seek medical care

B) As few as one in twenty battered victims are accurately identified

C) Expenses due to police and court costs

D) Very little knowledge is currently known about batterers and battering relationships

Review Information: The correct answer is:

B) As few as one in twenty battered victims are accurately identified.

Signs of abuse may not be clearly manifested and a series a minor complaints such as headache, abdominal pain, insomnia, back pain, and dizziness may be covert indications of abuse undetected. Complaints may be vague.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 17

The nurse is caring for a client with COPD who suddenly complains of sharp pains in the right side of his chest, is cyanotic and has a tracheal deviation toward the right side. The nurse recognizes that these symptoms are probably due to

A) Atelectasis

B) Respiratory acidosis

C) Tension pneumothorax

D) Bronchospasm

Review Information: The correct answer is:

C) Tension pneumothorax.

Tracheal deviation is away from the affected side in tension pneumothorax. This situation also produces air hunger, agitation, hypotension, and cyanosis.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 18

An anxious parent of a 4 year-old consults the nurse for guidance in how to answer the child's question, "Where do babies come from?" What is the BEST response to the parent?

A) "When a child asks a question, give a simple answer."

B) "Children ask many questions, but are not looking for answers."

C) "This question indicates interest in sex beyond this age."

D) "Full and detailed answers should be given to all questions."

Review Information: The correct answer is:

A) "When a child asks a question, give a simple answer.".

During discussions related to sexuality, honesty is very important. However, honesty does not mean imparting every fact of life associated with the question. When children ask one question, they are looking for one answer. When they are ready, they will ask about the other pieces.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Bowden, V., Dickey, S. & Greenberg, C. (1998).

Children and Their Families: The Continuum of Care.

Philadelphia: Saunders.

Question 19

When an autistic client begins to eat with her hands, the nurse can BEST handle the problem by

A) Placing the spoon in the client's hand and stating "Use the spoon to eat your food."

B) Commenting "I believe you know better than to eat with your hand."

C) Jokingly stating "Well I guess fingers sometimes work better than spoons."

D) Removing the food and stating "You can't have anymore food until you use the spoon."

Review Information: The correct answer is:

A) Placing the spoon in the client's hand and stating "Use the spoon to eat your food.".

This response identifies adaptive behavior with instruction and verbal expectation.

Antai-Otong, B. (1995).

Psychiatric Nursing: Biological & Behavioral Concepts.

Philadelphia: W.B. Saunders.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Question 20

The parents of a 7 year-old tell the nurse their child has started to "tattle" on siblings. In interpreting this new behavior to the mother, the nurse should explain the child acts this way because

A) The ethical sense and feelings of justice are developing

B) Attempts to control the family use new coping styles

C) Insecurity and attention getting are common motives

D) Complex thought processes help to resolve conflicts

Review Information: The correct answer is:

A) The ethical sense and feelings of justice are developing.

The child is developing a sense of justice and a desire to do what is right. At seven, the child is increasingly aware of family roles and responsibilities. They also do what is right because of parental direction or to avoid punishment.

Pillitteri, A. (1995).

Maternal Child Health Nursing.

Philadelphia: Lippincott-Raven Publishers.

Boynton, R. et al. (1994).

Manual of Ambulatory Pediatrics.

Philadelphia: Lippincott-Raven Publishers.

Question 21

In assessing the healing of a client's wound during a home visit, which of the following is the BEST indicator of good healing?

A) White patches

B) Green drainage

C) Reddened tissue

D) Eschar development

Review Information: The correct answer is:

C) Reddened tissue.

As the wound granulates, redness indicates healing.

Beuscher, T. (1997).

Wound Care. In Martin, K., Larson, B., Gorski, L. & Hayko, D. Mosby''s Home Health Client Teaching Guides: Rx for Teaching, IV F 2, 1-6.

St. Louis: Mosby.

Troia, C. & Black, J. (1997).

Preventing Pressure Ulcers.

In Martin, K., Larson, B., Gorski, L., & Hayko, D. Mosby''s Home Health Client Teaching Guides: Rx for Teaching, IV F 1, 1-6.

St. Louis: Mosby.

Question 22

Clients taking which of the following drugs are at risk for depression?

A) Steroids

B) Diuretics

C) Folic acid

D) Aspirin

Review Information: The correct answer is:

A) Steroids.

Adverse medication effects can cause a syndrome that may or may not remit when the medication is discontinued. Examples include: phenothiazines, steroids, and reserpine.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 23

The nurse is assessing a 4 year-old for possible developmental dysplasia of the right hip. Which of the following would the nurse expect to find?

A) Pelvic tip downward

B) Right leg lengthening

C) Ortolani sign

D) Characteristic limp

Review Information: The correct answer is:

D) Characteristic limp.

Developmental dysplasia produces a characteristic limp in children who are walking.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 24

A client was admitted to the psychiatric unit after refusing to get out of bed. In the hospital the client talks to unseen people and voids on the floor. The nurse could BEST handle the problem of voiding on the floor by

A) Requiring the client to mop the floor

B) Restricting the client's fluids throughout the day

C) Withholding privileges each time the voiding occurs

D) Toileting the client more frequently with supervision

Review Information: The correct answer is:

D) Toileting the client more frequently with supervision.

With altered thought processes the most appropriate nursing approach to alter the behavior is by attending to the physical need.

Gorman, L., Sulton D. & Rainer, M. (1996).

Davis's Manual of Psychosocial Nursing for General client Care.

Philadelphia: F.A. Davis.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Question 25

At a routine clinic visit, parents express concern that their four year-old is wetting the bed several times a month. What is the nurse's BEST response?

A) "This is normal at this time."

B) "How long has this been occurring?"

C) "Do you offer fluids at night?"

D) "Have you tried waking her to urinate?"

Review Information: The correct answer is:

B) "How long has this been occurring?".

Nighttime control should be present by this age, but may not occur until age 5. Involuntary voiding may occur due to infectious, anatomical and/or physiological reasons.

Berman & Kleigman. (1998).

Nelson Essentials of Pediatrics.

Philadelphia: Saunders.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 26

The nurse is caring for a seven year-old child who is being discharged following a tonsillectomy. Which of the following instructions is appropriate for the nurse to teach the parents?

A) Report a persistent cough to the physician

B) The child can return to school in four days

C) Administer chewable aspirin for pain

D) The child may gargle with saline as necessary for discomfort

Review Information: The correct answer is:

A) Report a persistent cough to the physician.

Persistent coughing should be reported to the physician as this may indicate bleeding.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 27

A schizophrenic client talks animatedly but the staff are unable to understand what the client is communicating. The client is observed mumbling to herself and speaking to the radio. A desirable outcome for this client's care will be

A) Expresses feelings appropriately through verbal interactions

B) Accurately interprets events and behaviors of others

C) Demonstrates improved social relationships

D) Engages in meaningful and understandable verbal communication

Review Information: The correct answer is:

D) Engages in meaningful and understandable verbal communication.

Data support impaired verbal communication deficit. The outcome must be related to the diagnosis and supporting data. No data is presented related to feelings or to thinking processes.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Carson, V.B. & Arnold, E.N. (1996).

Mental Health Nursing: The

Question 28

A new nurse on the unit notes that the nurse manager seems to be highly respected by the nursing staff. The new nurse is surprised to find that the manager makes all decisions and rarely asks for staff input. The BEST description of the nurse manager's management style is

A) Participative or democratic

B) Ultraliberal or communicative

C) Autocratic or authoritarian

D) Laissez faire or permissive

Review Information: The correct answer is:

C) Autocratic or authoritarian.

Autocratic leadership style is suggested in this situation. It is appropriate for groups with little education and experience and who need strong direction, while participative or democratic style is usually more successful on nursing units.

Huber, D. (2000).

Leadership and Nursing Care Management.

Philadelphia: Saunders.

Douglass, L. (1996).

The Effective Nurse Leader and Manager. (5th ed.).

St. Louis: Mosby.

Question 29

The nurse is assessing a client with delayed wound healing. Which of the following risk factors is MOST important in this situation?

A) Glucose level of 120

B) History of myocardial infarction

C) Long term steroid usage

D) Diet high in carbohydrates

Review Information: The correct answer is:

C) Long term steroid usage.

Steroid dependency tends to delay wound healing. If the client also smokes, the risk is increased.

Black, J. & Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing, Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Troia, C. & Black, J. (1997).

Preventing Pressure Ulcers.

In Martin, K., Larson, B., Gorski, L., & Hayko, D. Mosby''s Home Health Client Teaching Guides: Rx for Teaching, IV F 1, 1-6.

St. Louis: Mosby.

Question 30

The nurse is caring for a client who is experiencing a seizure. Which of the following is a PRIORITY nursing action?

A) Protect the client from injury

B) Restrain the client during the seizure

C) Insert a tongue blade between the teeth

D) Suction the mouth during the convulsion

Review Information: The correct answer is:

A) Protect the client from injury.

It is a priority to note, and then record, what movements are seen during a seizure because the diagnosis and subsequent treatment often rests solely on the seizure description.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 31

The nurse is caring for a client with HIV infection who has a secondary Herpes Simplex 1 (HSV 1) infection. The nurse knows that the most likely cause of the HSV 1 infection is

A) Immunosuppression caused by the HIV infection

B) Emotional stress caused by the HIV infection

C) Reaction to the HIV medications

D) Poor oral hygiene often associated with HIV

Review Information: The correct answer is:

A) Immunosuppression caused by the HIV infection.

The decreased immunity leads to frequent secondary infections. Herpes simplex virus 1 is an opportunistic infection.

Black, J. & Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing, Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis

Question 32

Which of the following therapeutic communication skills is MOST likely to encourage a depressed client to vent feelings?

A) Direct confrontation

B) Reality orientation

C) Projective identification

D) Silence, active listening

Review Information: The correct answer is:

D) Silence, active listening.

Use of therapeutic communication skills such as silence and active listening encourages verbalization of feelings.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 33

The nurse is teaching parents of an infant about introduction of solid food to their baby. What is the FIRST food they can add to the diet?

A) Vegetables

B) Cereal

C) Fruit

D) Meats

Review Information: The correct answer is:

B) Cereal.

Cereal is usually introduced first because it is well tolerated, easy to digest, and contains iron.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 34

The nurses on a unit are planning for stoma care for clients who have a stoma for fecal diversion. Which stomal diversion poses the highest risk for skin breakdown

A) Ileostomy

B) Transverse colostomy

C) Ileal conduit

D) Sigmoid colostomy

Review Information: The correct answer is:

A) Ileostomy.

Ileostomy output contains gastric and enzymatic agents that when present on skin can denuded skin in several hours. Because of the caustic nature of this stoma output adequate peristomal skin protection must be delivered to prevent skin breakdown.

Colwell, I. (1995).

"Enterostomal Care In Inflammatory Bowel Disease"

In Shorter, R., & Kirsner, J., (eds.). Inflammatory Bowel Disease.

Baltimore, MD: Williams & Wilkins.

Erwin-Toth P., Doughty, D., (1992).

"Principles and Procedure of Stomal Management" In Hampton B., & Bryant R., (eds.). Ostomies and Continent Diversions: Nursing Management.

St. Louis: Mosby Year-Book.

Question 35

A two year-old child has recently been diagnosed with Cystic Fibrosis. The nurse is teaching the parents about home care for the child. Which of the following information is appropriate for the nurse to include?

A) Allow the child to continue with their normal activities

B) Schedule frequent rest periods

C) Limit exposure to other children

D) Restrict activities to inside the house

Review Information: The correct answer is:

A) Allow the child to continue with their normal activities.

Physical Activity is important in a two year-old who is developing autonomy. Physical activity is a valuable adjunct to chest physical therapy. Exercise tends to stimulate mucous secretion and help develop normal breathing patterns.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 36

Which of the following statements describes what the nurse must know in order to provide anticipatory guidance to parents of a toddler about readiness for toilet training?

A) The child learns voluntary sphincter control through repetition

B) Myelination of the spinal cord is completed by this age

C) Neuronal impulses are interrupted at the base of the ganglia

D) The toddler can understand cause and effect

Review Information: The correct answer is:

B) Myelination of the spinal cord is completed by this age.

Voluntary control of the sphincter muscles can be gradually achieved due to the complete myelination of the spinal cord, sometime between the ages of 18 to 24 months of age.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 37

A client complaining of severe shortness of breath is diagnosed with congestive heart failure. The nurse observes a falling pulse oximetry. The client's color changes to gray and she expectorates large amounts of pink frothy sputum. The FIRST action of the nurse would be which of the following?

A) Call the physician

B) Check vital signs

C) Position in high Fowler's

D) Administer oxygen

Review Information: The correct answer is:

D) Administer oxygen.

When dealing with a medical emergency, the rule is airway first, then breathing, and then circulation. Starting oxygen is a priority.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 38

The nurse is caring for a 15 month-old child with a first episode of otitis media. Which of the following interventions should the nurse include in instructions to the child's parents?

A) Explain that the child should complete the full five days of antibiotics

B) Provide them with handout describing care of myringotomy tubes

C) Describe the tympanocentesis to detect persistent infections

D) Emphasize the importance of a return visit after completion of antibiotics

Review Information: The correct answer is:

D) Emphasize the importance of a return visit after completion of antibiotics.

The usual treatment for otitis media is oral antibiotics for 10-14 days. The child should be examined again after completion of the full course of antibiotics to assess for persistent infection or middle ear effusion.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 39

In performing a nutritional assessment on a 2 year-old, the nurse must know that, in general

A) An accurate measurement of intake is not reliable

B) The food pyramid is not used in this age group

C) A serving size at this age is about 2 tablespoons

D) Total intake varies greatly each day

Review Information: The correct answer is:

C) A serving size at this age is about 2 tablespoons.

In children, a general guide to serving sizes is one tablespoon of solid food per year of age. Understanding this, the nurse can assess adequacy of intake.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Whitney, E., Cataldo, C. & Rolfes, S. (1994).

Understanding Normal & Clinical Nutrition. (4th ed.).

Minneapolis/St. Paul: West.

Question 40

During the "tension building" phase of a violent relationship, the battered victim may experience what feelings at the unreasonable demand of the batterer?

A) Anger

B) Helplessness

C) Calm

D) Explosive

Review Information: The correct answer is:

B) Helplessness.

The battered individual internalizes appropriate anger at the batterer's unfairness and instead feels depressed with a sense of helplessness, when the partner explodes in spite of best efforts to please the batterer.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 1

While planning care for a preschool aged child, the nurse understands developmental needs. Which of the following would be of the MOST concern to the nurse?

A) Playing imaginatively

B) Expressing shame

C) Identifying with family

D) Exploring the playroom

Review Information: The correct answer is:

B) Expressing shame.

Erikson describes the stage of the preschool child as being the time when there is normally an increase in initiative. The child should have resolved the sense of shame and doubt at an earlier time.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 2

In order to enhance a client's response to medication for chest pain from acute angina, the nurse should emphasize

A) Learning relaxation techniques

B) Limiting alcohol use

C) Eating smaller meals

D) Avoiding passive smoke

Review Information: The correct answer is:

A) Learning relaxation techniques.

The only factor that can enhance the client''s response to pain medication for angina is reducing anxiety through relaxation methods. Anxiety can be great enough to make the pain medication totally ineffective.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 3

After talking with her spouse, a client voluntarily admitted herself to the substance abuse unit. After the second day on the unit the client states to the nurse "My husband told me to get treatment or he would divorce me. I don't believe I really need treatment but I don't want my husband to leave me." Which of the following responses by the nurse would assist the client?

A) "Unmotivated people can't get well."

B) "In early recovery, it's quite common to have mixed feelings, but I didn't know you had been pressured to come."

C) "In early recovery it's quite common to have mixed feelings, perhaps it would be best to seek treatment on an outclient bases."

D) "In early recovery, it's quite common to have mixed feelings. Let's discuss the benefits of sobriety for you."

Review Information: The correct answer is:

D) "In early recovery, it's quite common to have mixed feelings. Let's discuss the benefits of sobriety for you.".

This response gives the client the opportunity to decrease ambivalent feelings by focusing on the benefits of sobriety. Dependence issues are great for the client fostering ambivalence.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 4

The nurse is teaching a smoking cessation class and notices there are two pregnant women in the group. Which information is a PRIORITY for these women?

A) Low tar cigarettes are less harmful during pregnancy

B) There is a relationship between smoking and low birth weight

C) The placenta serves as a barrier to nicotine

D) Moderate smoking is effective in weight control

Review Information: The correct answer is:

B) There is a relationship between smoking and low birth weight.

Nicotine reduces placental blood flow, and may contribute to fetal hypoxia or placenta previa, decreasing the growth potential of the fetus.

Weiner, S. (1992).

Perinatal Impact of Substance Abuse. March of Dimes Continuing Education Module # 3.

White Plains: March of Dimes.

Bell, G. & Lau, K. (1995).

Perinatal and Neonatal Issues of Substance Abuse.

Pediatric Clinics of North America, 42 (2)

Question 5

The nurse is caring for a 12 year-old with an acute illness. Which of the following indicates the nurse understands common sibling reactions to hospitalization?

A) Younger siblings adapt very well

B) Visitation is helpful for both

C) The siblings may enjoy privacy

D) Those cared for at home cope better

Review Information: The correct answer is:

B) Visitation is helpful for both.

Contact with the ill child helps siblings understand the reasons for hospitalization and maintains the relationship.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 6

The nurse is caring for a 10 year-old child who has just been diagnosed with diabetes insipidus. The parents ask about the treatment prescribed, vasopressin. A PRIORITY in teaching the child and family is

A) The child should carry a nasal spray for emergency use

B) The family must observe the child for dehydration

C) Parents should administer the daily intramuscular injections

D) The client needs to take daily injections in the short-term

Review Information: The correct answer is:

A) The child should carry a nasal spray for emergency use.

Diabetes insipidus results from reduced secretion of the antidiuretic hormone, vasopressin. The child will need to administer daily injections of vasopressin, and should have the nasal spray form of the medication readily available. A medical alert tag should be worn.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 7

The nurse is planning care for a newborn who was infected with HIV in utero. The nurse should be aware that

A) The disease will incubate longer and progress more slowly in this infant

B) The infant is very susceptible to infections

C) Growth and development patterns will proceed at a normal rate

D) Careful monitoring of renal function is indicated

Review Information: The correct answer is:

B) The infant is very susceptible to infections.

HIV infected children are susceptible to opportunistic infections.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 8

The nurse is caring for a post myocardial infarction client in an intensive care unit. It is noted that urinary output has dropped from 60 -70 ml per hour to 30 ml per hour. This change is MOST likely due to

A) Dehydration

B) Diminished blood volume

C) Decreased cardiac output

D) Renal failure

Review Information: The correct answer is:

C) Decreased cardiac output.

Cardiac output and urinary output are directly correlated. The nurse should suspect a drop in cardiac output if the urinary output drops.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 9

The nurse is performing a developmental assessment on an 8 month-old. Which of the following should be reported to the physician?

A) Lifts head from the prone position

B) Rolls from abdomen to back

C) Responds to parents' voices

D) Falls forward when sitting

Review Information: The correct answer is:

D) Falls forward when sitting.

Sitting without support is expected at this age.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 10

When a client is having a general tonic clonic seizure, the nurse should

A) Hold the client's arms at their side

B) Place the client on their side

C) Insert a padded tongue blade in client's mouth

D) Elevate the head of the bed

Review Information: The correct answer is:

B) Place the client on their side.

This position keeps the airway patent and prevents aspiration.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Smeltzer, S.G., Bare, B.G. (1999).

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing. (8th ed.).

New York: Lipppincott.

Question 11

The nurse is teaching a school-aged child and family about the use of inhalers prescribed for asthma. What is the BEST way to evaluate effectiveness of the treatments?

A) Rely on child's self-report

B) Use a peak-flow meter

C) Note skin color changes

D) Monitor pulse rate

Review Information: The correct answer is:

B) Use a peak-flow meter.

The peak flowmeter, if used correctly, shows effectiveness of inhalants.

Combs, J. (1995, January).

Helping children breathe easier at home.

Home health FOCUS, 1(8),

Cronin, S. (1997).

Nursing Care of Clients with Disorders of the Lower Airways and Pulmonary Vessels. In J. Black & E. Matassarin-Jacobs, Medical-Surgical Nursing: Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Question 12

The nurse asks a client with a history of alcoholism about the client's drinking behavior. The client states "I didn't hurt anyone. I just like to have a good time, and drinking helps me to relax." The client is using which defense mechanism?

A) Denial

B) Projection

C) Intellectualization

D) Rationalization

Review Information: The correct answer is:

D) Rationalization.

Rationalization is justifying illogical or unreasonable ideas, actions, or feelings by developing acceptable explanations that satisfies the teller as well as the listener.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Haber, J., Krainovich-Miller,B., McMahon, A. & Price-Hoskins, P. (1997).

Comprehensive Psychiatric Nursing.

St. Louis: Mosby.

Question 13

A client has been receiving lithium (Lithane) for the past two weeks for the treatment of bipolar illness. When planning client teaching, the nurse understands that it is important to emphasize that the client must

A) Maintain a low sodium diet

B) Take a diuretic with lithium

C) Come in for evaluation of serum lithium levels every 1-3 months

D) Have blood lithium levels drawn during the summer months

Review Information: The correct answer is:

D) Have blood lithium levels drawn during the summer months.

Clients taking lithium therapy need to be aware that hot weather may cause excessive perspiration, a loss of sodium and consequently an increase in serum lithium concentration.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 14

The nurse is preparing a client for discharge following in-patient treatment for pulmonary tuberculosis. The nurse should instruct the client to

A) Continue medication use as prescribed until symptoms are relieved

B) Continue medication use as prescribed

C) Avoid contact with children, pregnant women or immuno depressed persons

D) Take medication with Amphogel if epigastric distress occurs

Review Information: The correct answer is:

B) Continue medication use as prescribed.

Early cessation of treatment may lead to development of drug resistant bacteria.

Springhouse. (1998).

Nursing 98 Drug Handbook.

Springhouse PA: Springhouse Corporation.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Question 15

The nurse is administering an intravenous vesicant chemotherapeutic agent to a client. Which assessment would require the nurse's IMMEDIATE action?

A) Stomatitis lesion in the mouth

B) Severe nausea and vomiting

C) Complaints of pain at site of infusion

D) A rash on the client's extremities

Review Information: The correct answer is:

C) Complaints of pain at site of infusion.

A vesicant is a chemotherapeutic agent capable of causing blistering of tissues and possible tissue necrosis if there is extravasation. These agents are irritants which cause pain along the vein wall, with or without inflammation.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 16

The nurse is assessing a client on admission to a community mental health center. The client discloses that she has been thinking about ending her life. The nurse's BEST response would be

A) "Do you want to discuss this with your pastor?"

B) "We will help you deal with those thoughts."

C) "Is your life so terrible that you want to end it?"

D) "Have you thought about how you would do it?"

Review Information: The correct answer is:

D) "Have you thought about how you would do it?".

This response provides an opening to discuss intent and means of committing suicide.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 17

Following a cocaine high, the user commonly experiences an extremely unpleasant feeling called

A) Craving

B) Crashing

C) Outward bound

D) Nodding out

Review Information: The correct answer is:

B) Crashing.

Following cocaine use, the intense pleasure is replaced by an equally unpleasant feeling referred to as crashing.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 18

A pregnant woman is hospitalized for treatment of pregnancy induced hypertension in the 3rd trimester. She is receiving magnesium sulfate intravenously. The nurse understands that this medication is used MAINLY to

A) Maintain normal blood pressure

B) Prevent convulsive seizures

C) Decrease the respiratory rate

D) Increase uterine blood flow

Review Information: The correct answer is:

B) Prevent convulsive seizures.

Magnesium sulfate is a central nervous system depressant. While it has many systemic effects, it is used in the client with pregnancy induced hypertension (PIH) to prevent seizures.

Babcock, I., Lowdermilk, D., and Jensen, M. (1995).

Maternity nursing.

St. Louis: Mosby.

Wong, D. and Perry, S. (1998).

Maternal child nursing care.

St. Louis: Mosby.

Question 19

The nurse is caring for a client two hours after a right lower lobectomy. In evaluating the water-seal chest drainage system, it is noted that the fluid level bubbles constantly. On inspecting the chest and tubing, the nurse does not find any air leaks in the system. The NEXT action for the nurse is to

A) Call the physician immediately

B) Irrigate the tube

C) Clamp the tube

D) Measure the thoracic drainage

Review Information: The correct answer is:

A) Call the physician immediately.

Continuous bubbling is not a normal finding. The physician must act quickly to prevent lung collapse or mediastinal shift.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 20

A 2 year-old child is being treated with Amoxicillin suspension, 200 milligrams per dose, for acute otitis media. The child weighs 30 lb. (15 kg) and the daily dose range is 20-40 mg/kg of body weight, in three divided doses every 8 hours. The nurse should

A) Give the medication as ordered

B) Call the practitioner to clarify the dose

C) Recognize that antibiotics are over-prescribed

D) Hold the medication as the dosage is too low

Review Information: The correct answer is:

A) Give the medication as ordered.

Amoxicillin continues to be the drug of choice in the treatment of acute otitis media. The dose range is 20-40 mg/kg/day divided every 8 hours. 15kg x 40mg = 600mg, divided by 3 = 200 mg per dose. The prescribed dose is correct and should be given as ordered.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Wilson, B., Shannon, M. & Stang, C. (1997).

Nurses Drug Guide 1997.

Stamford: Appleton & Lange.

Question 21

A client was admitted to the psychiatric unit with major depression after a suicide attempt. In addition to feeling sad and hopeless, the nurse would assess for

A) Anxiety, unconscious anger, and hostility

B) Guilt, indecisiveness, poor self-concept

C) Psychomotor retardation or agitation

D) Meticulous attention to grooming and hygiene

Review Information: The correct answer is:

C) Psychomotor retardation or agitation.

Somatic or physiologic symptoms of depression include: fatigue, psychomotor retardation or psychomotor agitation, chronic generalized or local pain, sleep disturbances, disturbances in appetite, gastrointestinal complaints and impaired libido.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 22

The nurse is teaching a client who has a new prescription for sublingual nitroglycerin. Which of the following MUST be emphasized?

A) Rest in bed for an hour after taking medication

B) Take the medication at the same time each day

C) Keep the medication bottle in the refrigerator

D) Carry the nitroglycerine with you at all times

Review Information: The correct answer is:

D) Carry the nitroglycerine with you at all times.

Nitroglycerin should be carried with the client in and out of the home, so it can be used when angina pain occurs.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 23

A client develops volume overload from an IV that has infused too rapidly. What assessments would the nurse expect to find?

A) Auscultation of an S3 heart sound

B) Thready pulse

C) Flattened neck veins

D) Hypoventilation

Review Information: The correct answer is:

A) Auscultation of an S3 heart sound.

Auscultation of an S3 heart sound. This is an early sign of volume overload (or CHF) because during the first phase of diastole, when blood enters the ventricles, an extra sound is produced due to the presence of fluid left in the ventricles.

Long, B., Phipps, W. & Cassmeyer, V. (1993).

Medical-Surgical Nursing: A Nursing Process Approach. (3rd ed.).

St. Louis: Mosby Year-Book.

Daily, E.K. & Schroeder, J.S. (1994).

Techniques in Bedside Hemodynamic Monitoring. (5th ed.).

St. Lou

Question 24

A diabetic client's blood sugar is 306 this morning. After the nurse reports this lab result and the client's symptoms of excessive hunger and thirst, the nurse would expect the physician to order

A) Orange juice

B) Regular insulin

C) NPH Insulin

D) Repeat blood sugar level

Review Information: The correct answer is:

B) Regular insulin.

Regular Insulin is a short-acting insulin which will help reduce the client''s glucose quickly.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 25

A depressed client who has recently been acting suicidal is now more social and energetic than usual. Smilingly he tells the nurse "I've made some decisions about my life." What should be the nurse's INITIAL response?

A) Reflect "You've made some decisions."

B) Ask "Are you thinking about killing yourself?"

C) Say "I'm so glad to hear that you've made some decisions."

D) Suggest "You need to discuss your decisions with your therapist."

Review Information: The correct answer is:

B) Ask "Are you thinking about killing yourself?".

Sudden mood elevation and energy may signal increased risk of suicide. The nurse must validate suicide ideation as a beginning step in evaluating seriousness of risk.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Question 26

Parents of a 7 year-old child call the clinic nurse because their daughter was sent home from school because of a rash. The child had been seen the day before by the practitioner and diagnosed with Fifth Disease (erythema infectiosum) and is otherwise in good health. The MOST appropriate action by the nurse would be to

A) Tell the parents to bring the child to the clinic for further evaluation

B) Refer the school officials to printed materials about this viral illness

C) Inform the teacher that the child is receiving antibiotics for the rash

D) Explain that this rash is not contagious and does not require isolation

Review Information: The correct answer is:

D) Explain that this rash is not contagious and does not require isolation.

Fifth Disease is a viral illness with an uncertain period of communicability (perhaps 1 week prior to and 1 week after onset). Isolation of the child with Fifth Disease is not necessary except in cases of hospitalized children who are immunosuppressed or having aplastic crises. The parents may need written confirmation of this from the physician.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 27

The nurse is participating in a community health fair. As part of the assessments, the nurse should conduct a mental status examination when

A) An individual displays restlessness

B) There are obvious signs of depression

C) Conducting any health assessment

D) The resident reports memory lapses

Review Information: The correct answer is:

C) Conducting any health assessment.

A mental status assessment is a critical part of baseline information, and should be a part of every examination.

Eliopoulos, C. (2000).

Gerontological Nursing. (4th ed.).

Philadelphia: Lippincott.

Voss-Morris, S. (1996).

Geriatric Nursing. (4th ed.).

Philadelphia: Lippincott.

Question 28

In a child with suspected coarctation of the aorta, the nurse would expect to find

A) Strong pedal pulses

B) Diminishing cartoid pulses

C) Normal femoral pulses

D) Bounding pulses in the arms

Review Information: The correct answer is:

D) Bounding pulses in the arms.

Coarctation of the aorta, a narrowing or constriction of the descending aorta, causes increased flow to the upper extremities (increased pressure and pulses).

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 29

The nurse is teaching a parent how to administer oral iron supplements to a 2 year-old child. Which of the following interventions should be included in the teaching?

A) Stop the medication if the stools become tarry green

B) Give the medicine with orange juice and through a straw

C) Add the medicine to a bottle of formula

D) Administer the iron with your child's meals

Review Information: The correct answer is:

B) Give the medicine with orange juice and through a straw.

Absorption of iron is facilitated in an environment rich in Vitamin C. Since liquid iron preparation will stain teeth, a straw is preferred.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Whitney, E., Cataldo, C. & Rolfes, S. (1994).

Understanding Normal & Clinical Nutrition. (4th ed.).

Minneapolis/St. Paul:

Question 30

The nurse is taking a health history on a 14 year-old client. The BEST way to accomplish this is to

A) Have the mother present to verify information

B) Allow an opportunity for the teen to express feelings

C) Use the same type of language as the adolescent

D) Focus the discussion of risk factors in the peer group

Review Information: The correct answer is:

B) Allow an opportunity for the teen to express feelings.

Adolescents need to express their feelings. Generally, they talk freely when given an opportunity and some privacy to do so.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 31

A 38 year-old female client is admitted to the hospital with an acute exacerbation of asthma. This is her third admission for asthma in 7 months. She describes how she doesn't really like having to use her medications all the time. The nurse explains the long-term consequence of uncontrolled airway inflammation which is:

A) Degeneration of the alveoli

B) Chronic bronchoconstriction of the large airways

C) Lung remodeling and permanent changes in lung function

D) Frequent pneumonia

Review Information: The correct answer is:

C) Lung remodeling and permanent changes in lung function.

While an asthma attack is an acute event from which lung function essentially returns to normal, chronic under-treated asthma can lead to lung remodeling and permanent changes in lung function. Increased bronchial vascular permeability leads to chronic airway edema which leads to mucosal thickening and swelling of the airway. Increased mucous secretion and viscosity may plug airways, leading to airway obstruction. Changes in the extracellular matrix in the airway wall may also lead to airway obstruction. These long-term consequences should help you to reinforce the need for daily management of the disease whether or not the patient "feels better".

Evans, R.M., Brown, E.F., Chamberlain, J., & Morain, C. (1997).

Managing Asthma Today : Integrating New Concepts.

Chicago:American Medical Association.

Guidelines for the diagnosis and management of asthma, Expert panel report 2. (1997).

Clinical Practice Guidelines, NIH Publication No. 97-4051. Bethesda, MD.

Question 32

A polydruguser has been in recovery for 8 months. The client has began skipping breakfast and not eating regular dinners. The client has also started frequenting bars to "see old buddies." The nurse understands that the client's behavior is a warning sign to indicate that

A) The client may be headed for relapse

B) The client may be feeling hopeless

C) The client may be inclement with recovery

D) The client may need to increase socialization with friends

Review Information: The correct answer is:

A) The client may be headed for relapse.

It takes 9-15 months to adjust to a lifestyle free of chemical use, thus it is important for clients to acknowledge that relapse is a possibility and to identify early signs of relapse.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 33

A Chinese woman, is admitted with generalized anxietydisorder and inability to care for herself. According to Chinese folk medicine, her health is regulated by the opposing forces of yin and yang. Based on this cultural belief, the nurse would expect her family to attribute her illness to

A) Yang, the positive force that represents light, warmth, and fullness

B) Yin, the negative force that represents darkness, cold, and emptiness

C) Too many hot foods and herbs

D) Her failure to keep her life in balance

Review Information: The correct answer is:

B) Yin, the negative force that represents darkness, cold, and emptiness.

Chinese folk medicine proposes that yin is the negative female force characterized by darkness, cold and emptiness. Excessive yin predisposes one to nervousness.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

Philadelphia: J.B. Lippincott Co.

Varcarolis, E.(1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 34

A client was admitted to the psychiatricunit with a diagnosis of bipolar disorder. He constantly bothers other clients, tries to help the housekeeping staff, demonstrates pressured speech and demands constant attention from the staff. Which of the following activities would be BEST for the client?

A) Reading

B) Checkers

C) Cards

D) Ping-pong

Review Information: The correct answer is:

D) Ping-pong.

This provides an outlet for physical energy and requires limited attention.

Gorman, L., Sulton D. & Rainer, M. (1996).

Davis's Manual of Psychosocial Nursing for General client Care.

Philadelphia: F.A. Davis.

Haber, J., Krainovich-Miller,B., McMahon, A. & Price-Hoskins, P. (1997).

Comprehensive Psychiatric Nursing.

Question 35

The PRIMARY nursing diagnosis for a client with congestive heart failure with pulmonary edema is

A) Pain

B) Impaired gas exchange

C) Cardiac output altered: decreased

D) Fluid volume excess

Review Information: The correct answer is:

C) Cardiac output altered: decreased.

All nursing interventions should be focused on improving cardiac output. Increasing cardiac output is the primary goal of therapy. Comfort will improve as the client improves and the respiratory status will improve as cardiac output increases.

Mosby Year-Book. (1997).

Mosby's Clinical Nursing. (4th ed.).

St. Louis: Mosby Year-Book.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia: Lippincott-Raven Publishers.

Question 36

A neonate born 12 hours ago to a methadone maintained woman isexhibiting a hyperactive MORO reflex and slight tremors. The newborn passed one loose, watery stool. Which of the following is a nursing PRIORITY?

A) Hold the infant at frequent intervals.

B) Assess for neonatal abstinence syndrome

C) Offer fluids to prevent dehydration

D) Administer paregoric to stop diarrhea

Review Information: The correct answer is:

B) Assess for neonatal abstinence syndrome.

Neonatal Abstinence Syndrome is a cluster of signs and symptoms that signal the withdrawal of the infant from the opiates. The symptoms seen in methadone withdrawal are often more severe than for other substances. Initial signs are central nervous system hyper irritability and gastro-intestinal symptoms. If withdrawal signs are severe, there is an increased mortality risk. Scoring the infant ensures proper treatment during the period of withdrawal.

Weiner, S. (1992).

Perinatal Impact of Substance Abuse. March of Dimes Continuing Education Module # 3.

White Plains: March of Dimes.

Weiner, S. & Finnegan, L.P. (1998).

Drug Withdrawal in the Neonate.

In Merenstein, G. & Gardner, S. (Eds).

Question 37

When teaching adolescents about sexually transmitted diseases, the nurse should emphasize that the MOST common infection is

A) Gonorrhea

B) Chlamydia

C) Herpes

D) HIV

Review Information: The correct answer is:

B) Chlamydia.

Chlamydia has the highest incidence of any sexually transmitted disease in this country. Prevention is similar to safe sex practices taught to prevent any STD: use of a condom and spermicide for protection during intercourse.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 38

The use of atropine for treatment of symptomatic bradycardia is contraindicated for a client with which of the following conditions

A) Urinary incontinence

B) Glaucoma

C) Increased intracranial pressure

D) Right sided heart failure

Review Information: The correct answer is:

B) Glaucoma.

Atropine is contraindicated in clients with angle-closure glaucoma.

Skidmore-Roth, Linda. (2001).

Mosby''s Nursing Drug Reference 2002.

St. Louis: Mosby-Year Book, Inc.

Deglin, J. H. and Vallerand, A. H. (2000).

Davis''s Drug Guide for Nurses. (5th ed.).

Philadelphia: F. A. Davis.

Question 39

While teaching a client about their medications, the client asks how long it will take before the effects of lithium take place. The nurse states it will be

A) Immediately

B) Several days

C) Two weeks

D) One month

Review Information: The correct answer is:

C) Two weeks.

Lithium is started immediately to treat bipolar disorder because it is quite effective in controlling mania. Lithium takes approximately two weeks to effect change in a client's symptoms.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 40

The nursing intervention that BEST describes treatment to deal with the behaviors of clients with personality disorders include

A) Pointing out inconsistencies in speech patterns to correct thought disorders

B) Accepting client and the client's behavior unconditionally

C) Encouraging dependency in order to develop ego controls

D) Consistent limit-setting enforced 24 hours per day

Review Information: The correct answer is:

D) Consistent limit-setting enforced 24 hours per day.

Treatment approaches that include restructuring the personality, assisting the person with developmental level and setting limits for maladaptive behavior such as acting out.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 1

A client is admitted with a pressure ulcer in the sacral area. The partial thickness wound is 4cm by 7cm, the wound base is red and moist with no exudate and the surrounding skin is intact. Which of the following coverings is MOST appropriate for this wound?

A) Transparent dressing

B) Dry sterile dressing with antibiotic ointment

C) Wet to dry dressing

D) Occlusive moist dressing

Review Information: The correct answer is:

D) Occlusive moist dressing.

This wound has granulation tissue present and must be protected. The use of a moisture retentive dressing is the best choice because moisture supports wound healing.

Rodeheaver, G., Baharestani M., Byrd, I., Salzberg, A., Scherer, P., Vogelpohl T. (1994).

Focus on Debridement.

Advances in Wound Care. 7, 22-36.

Haimowitz, T. & Margolis, D. (1997).

"Moist Wound Healing" chapter in Chronic Wound Care: A Clinical Source Book for Healthcare Professionals. In Krasner, D., Kane, D., (eds.).

Wayne, PA: Health Management Publications, Inc.

Question 2

Physical dependence is accompanied by what symptoms when alcohol consumption is first reduced or ended?

A) Seizures

B) Withdrawal

C) Craving

D) Marked tolerance

Review Information: The correct answer is:

B) Withdrawal.

The early signs of alcohol withdrawal develop within a few hours after cessation or reduction of ETOH intake.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 3

The mother of a 15 month-old child asks the nurse to explain her child's lab results and how they show her child has iron deficiency anemia. The nurse's BEST response is

A) "Although the results are here, your doctor will explain them later."

B) "Your child has less red blood cells that carry oxygen."

C) "The blood cells that carry nutrients to the cells are too large."

D) "There are not enough blood cells in your child's circulation."

Review Information: The correct answer is:

B) "Your child has less red blood cells that carry oxygen.".

The results of a complete blood count in clients with iron deficiency anemia will show decreased red blood cell levels, low hemoglobin levels and microcytic, hypochromic red blood cells. A simple but clear explanation is appropriate.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 4

While assessing a 2 year-old child with a tentative diagnosis of Wilm's tumor, the nurse would be MOST concerned about the mother's report that

A) The child has lost 3 pounds in the last month

B) Urinary output has apparently decreased

C) Clothing has become tight around the waist

D) The child prefers some foods more than others

Review Information: The correct answer is:

C) Clothing has become tight around the waist.

Parents often recognize the increasing abdominal girth first. This is an early sign of Wilm''s tumor.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 5

A victim of domestic violence states to the nurse, "If only I could change and be how my spouse wants me to be, I know things would be different." Which ofthe following would be the BEST response by the nurse?

A) "The violence is temporarily caused by unusual circumstances, don't stop hoping for a change."

B) "Perhaps, if you understood the need to abuse, you could stop the violence."

C) "No one deserves to be beaten. Are you doing anything to provoke your spouse into beating you?"

D) "Batterers lose self-control because of their own internal reasons, not because of what their partner did or did not do."

Review Information: The correct answer is:

D) "Batterers lose self-control because of their own internal reasons, not because of what their partner did or did not do.".

Only the perpetrator has the ability to stop the violence. A change in the victim's behavior will not cause the abuser to become nonviolent.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 6

The father of an eight month-old infant asks the nurse if his infant's vocalizations are normal for his age. Which of the following would the nurse expect at this age?

A) Cooing

B) Imitation of Sounds

C) Throaty sounds

D) Laughter

Review Information: The correct answer is:

B) Imitation of Sounds.

Imitation of sounds such as "da-da" is expected at this time.

Berger, K.S. (1994).

The Developing Person Through the Lifespan.

New York: Worth.

Hoffman, L., Paris, S., & Hall, E. (1994).

Developmental Psychology Today.

New York: McGraw-Hill.

Question 7

The nurse is planning to administer otic drops to a six year-old child. Which of the following is the correct procedure?

A) Hold the pinna up and back to instill the drops

B) Place several drops in the outer ear

C) Insert cotton in the outer ear after giving medication

D) Assist the child to lie on the affected side afterwards

Review Information: The correct answer is:

A) Hold the pinna up and back to instill the drops.

The external auditory canal should be straightened by gently pulling the pinna up and back for otic drop administration. In children who are under 3 years of age, the pinna should be pulled down and back.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 8

A pre-term newborn is to be fed breast milk through nasogastric tube. The nurse recognizes that breast milk is preferred to formula because it

A) Contains less lactose

B) Is higher in calories/ounce

C) Provides antibodies

D) Has less fatty acid

Review Information: The correct answer is:

C) Provides antibodies.

Breast milk is ideal for the preterm baby who needs additional protection against infection through maternal antibodies.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Mahan, L.K. & Escott-Strump, S. (1996).

Krause''s Food Nutrition and Diet Therapy.

Philadelphia: W. B. Saunders Company.

Question 9

The nursing history for a newborn suspected of having pyloric stenosis would MOST likely reveal

A) Absence of gastrointestinal peristalsis

B) Frequent vomiting of bile-stained fluid

C) Mild emesis progressing to projectile vomiting

D) Cyanosis and vomiting immediately after feedings

Review Information: The correct answer is:

C) Mild emesis progressing to projectile vomiting.

Mild regurgitation or emesis that progresses to projectile vomiting is a pattern of vomiting associated with pyloric stenosis.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 10

At the day treatment center a client diagnosed with Schizophrenia - Paranoid Type sits alone alertly watching the activities of clients and staff. The client is hostile when approached and asserts that the doctor gives her medication to control her mind. The client's behavior most likely indicates

A) Anxiety related to paranoia

B) Social isolation related to altered thought processes

C) Sensory perceptual alteration related to withdrawal from environment

D) Impaired verbal communication related to impaired judgment

Review Information: The correct answer is:

B) Social isolation related to altered thought processes.

Hostility and absence of involvement are data supporting a diagnosis of social isolation. Her psychiatric diagnosis and her idea about the purpose of medication suggests altered thinking processes.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Question 11

The nurse is teaching administration of albuterol inhalation to an asthmatic adult. The PRIORITY is

A) "Use this medication at bedtime to promote rest."

B) "Discontinue the inhalation if you are dizzy."

C) "Inhale this medication after other asthma sprays."

D) "Notify the physician if you need the drug more often."

Review Information: The correct answer is:

D) "Notify the physician if you need the drug more often.".

If the client notices that the albuterol inhalation is used more frequently, the physician should be notified so that a change in dose or medication can be ordered.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 12

A client is experiencing hallucinations that are markedly increased at night. The client is very frightened by the hallucinations. The client's spouse asked to stay a few hours beyond the visiting time, in the client's private room. What would be the BEST response by the nurse demonstrating emotional support for the client?

A) "It would be best if you brought the client some reading material that she could read at night."

B) "No, your presence may cause the client to become more anxious."

C) "Yes, staying with the client and orienting her to her surroundings may decrease her anxiety."

D) "Yes, would you like to spend the night when the client's behavior indicates that she is frightened?"

Review Information: The correct answer is:

C) "Yes, staying with the client and orienting her to her surroundings may decrease her anxiety.".

Encouraging the family or a close friend to stay with the client in a quiet surrounding can help increase orientation and minimize confusion and anxiety.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Question 13

To which of the following nursing home residents could the nurse safely administer tricyclic antidepressants without questioning the physician's order, a client with

A) Narrow-angle glaucoma

B) Benign prostatic hypertrophy

C) Mild hypertension

D) Coronary artery disease

Review Information: The correct answer is:

C) Mild hypertension.

Tricyclics can be safely administered to the hypertensive client.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 14

A client is admitted with the diagnosis of meningitis. Which of the following assessments would the nurse expect to find in assessing this client?

A) Hyperextension of the neck with passive shoulder flexion

B) Flexion of the hip and knees with passive flexion of the neck

C) Flexion of the legs with rebound tenderness

D) Hyperflexion of the neck with rebound flexion of the legs

Review Information: The correct answer is:

B) Flexion of the hip and knees with passive flexion of the neck.

A positive Brudzinski's signflexion of hip and knees with passive flexion of the neck; a positive Kernig's signinability to extend the knee to more than 135 degrees, without pain behind the knee, while the hip is flexed usually establishes the diagnosis of meningitis.

Springhouse. (1997).

Diseases. (2nd ed.).

Springhouse PA: Springhouse Corporation.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 15

A mother asks the nurse if she should be concerned about the tendency of her child to stutter. What assessment data will be MOST useful in counseling the parent?

A) Age of the child

B) Sibling position in family

C) Stressful family events

D) Parental discipline strategies

Review Information: The correct answer is:

A) Age of the child.

During the preschool period children are using their rapidly growing vocabulary faster than they can produce their words. This failure to master sensorimotor integrations results in stuttering. This dysfluency in speech pattern is a normal characteristic of language development. Therefore, knowing the child''s age is most important in determining if any true dysfunction might be occurring.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 16

The nurse is planning to give a three year-old child oral digoxin. Which of the following is the BEST approach by the nurse?

A) "Do you want to take this pretty red medicine?"

B) "You will feel better if you take your medicine."

C) "This is your medicine, and you must take it all right now."

D) "Would you like to take your medicine from a spoon or a cup?"

Review Information: The correct answer is:

D) "Would you like to take your medicine from a spoon or a cup?".

At three years of age, a child often feels a loss of control when hospitalized. Giving a choice about how to take the medicine will allow the child to express an opinion and have some control.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 17

The nurse assesses delayed gross motor development in a three year-old child. Which of the following observations confirms this finding? The child cannot

A) Stand on one foot

B) Catch a ball

C) Skip on alternate feet

D) Ride a bicycle

Review Information: The correct answer is:

A) Stand on one foot.

At this age, gross motor development allows a child to balance on one foot.

Pillitteri, A. (1995).

Maternal Child Health Nursing.

Philadelphia: Lippincott-Raven Publishers.

Boynton, R. et al. (1994).

Manual of Ambulatory Pediatrics.

Philadelphia: Lippincott-Raven Publishers.

Question 18

The nurse is discussing accident prevention with parents. Which of the following should the nurse emphasize is at HIGHEST risk for poisoning?

A) Nine month-old who stays with a sitter five days a week

B) Twenty month-old who has just learned to climb stairs

C) Ten year-old who occasionally stays at home unattended

D) Fifteen year-old who likes to repair bicycles

Review Information: The correct answer is:

B) Twenty month-old who has just learned to climb stairs.

Toddlers are at most risk for poisoning because they are increasingly mobile, need to explore and engage in autonomous behavior.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 19

The nurse is caring for a client who has developed cardiac tamponade. Which of the following assessments would the nurse anticipate finding?

A) Widening pulse pressure

B) Pleural friction rub

C) Distended neck veins

D) Bradycardia

Review Information: The correct answer is:

C) Distended neck veins.

In cardiac tamponade, intrapericardial pressures rise to a point at which venous blood cannot flow into the heart. As a result, venous pressure rises and the neck veins become distended.

AHA (1997).

Textbook of ACLS. (4th ed.).

AHA.

Long, B., Phipps, W. & Cassmeyer, V. (1993).

Medical-Surgical Nursing: A Nursing Process Approach. (3rd ed.).

St. Louis: Mosby Year-Book.

Question 20

Immediately following an acute battering incident in a violent relationship, the batterer may respond to the partner's injuries by

A) Seeking medical help for the victim's injuries

B) Minimizing the episode and underestimating the victim's injuries to hide the victim's injuries

C) Contacting a close friend and asking for help

D) Being very remorseful and assisting the victim with medical care

Review Information: The correct answer is:

B) Minimizing the episode and underestimating the victim's injuries to hide the victim''s injuries.

Many abusers lack an understanding of the effect of their behavior on the victim and use excessive minimization and denial.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 21

The nurse is talking to parents about nutrition in school aged children. Which of the following is the MOST common nutritional disorder in this age group?

A) Bulimia

B) Anorexia

C) Obesity

D) Malnutrition

Review Information: The correct answer is:

C) Obesity.

Many factors contribute to the high rate of obesity in school aged children. These include heredity, sedentary lifestyle, social and cultural factors and poor knowledge of balanced nutrition.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 22

At the geriatric day care program a client is crying and repeating "I want to go home. Call my daddy to come for me." The nurse should

A) Invite the client to join the exercise group

B) Tell the client you will call someone to come for her

C) Give the client simple information about what she will be doing

D) Firmly direct the client to her assigned group activity

Review Information: The correct answer is:

C) Give the client simple information about what she will be doing.

The distressed disoriented client should be gently oriented to reduce fear and increase the sense of safety and security. Environmental changes provoke stress and fear.

Fortinash, K. & Holoday-Worret, P. (1995).

Psychiatric Nursing Care Plan.

St. Louis: C.V. Mosby.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Question 23

First-time parents bring their 5 day-old infant to the pediatrician's office because they are extremely concerned about its breathing pattern. The nurse assesses the baby and finds that the breath sounds are clear with equal chest expansion. The respiratory rate is 38-42 breaths per minute with occasional periods of apnea lasting 10 seconds in length. The nurse's accurate analysis is

A) The pediatrician must examine the baby

B) Emergency equipment should be available

C) This breathing pattern is normal

D) A future referral may be indicated

Review Information: The correct answer is:

C) This breathing pattern is normal.

Respiratory rate in a newborn is 30-60 breaths/minute and periods of apnea often occur, lasting up to 15 seconds.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

ediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 24

A mother wants to switch her 9 month-old infant from an iron-fortified formula to whole milk because of the expense. Upon further assessment, the nurse finds that the baby eats table foods well,but drinks less milk than before. The advice by the nurse should be to

A) Change the baby to whole milk

B) Add chocolate syrup to the bottle

C) Continue with the present formula

D) Offer fruit juice frequently

Review Information: The correct answer is:

C) Continue with the present formula.

The recommended age for switching from formula to whole milk is 12 months.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 25

The nurse is caring for a client who is in the late stage of multiple myeloma. Which of the following should be included in the plan of care?

A) Monitor for hyperkalemia

B) Place in protective isolation

C) Precautions in assisting client to change positions

D) Administer diuretics as ordered

Review Information: The correct answer is:

C) Precautions in assisting client to change positions.

Because multiple myeloma is a condition in which neoplastic plasma cells infiltrate the bone marrow resulting in osteoporosis, client's are at high risk for pathological fractures.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Smeltzer, S.G., Bare, B.G. (1999).

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing. (8th ed.).

New York: Lipppincott.

Question 26

A client is receiving nitroprusside IV for the treatment of acute heart failure with pulmonary edema. What diagnostic lab value should the nurse monitor in relation to this medication?

A) Potassium

B) Arterial blood gasses

C) Blood urea nitrogen

D) Thiocyanate

Review Information: The correct answer is:

D) Thiocyanate.

Thiocyanate levels rise with the metabolism if nitroprusside and can cause cyanide toxicity.

Question 27

The nurse is caring for a child receiving chest physiotherapy (CPT). Which of the following actions by the nurse would be appropriate?

A) Schedule the therapy thirty minutes after meals

B) Teach the child not to cough during the treatment

C) Confine the percussion to the rib cage area

D) Place the child in a prone position for the therapy

Review Information: The correct answer is:

C) Confine the percussion to the rib cage area.

Percussion (clapping) should be only done in the area of the rib cage.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 28

A four year-old child is recovering from chicken pox (varicella). The parents would like to have the child return to day care as soon as possible. In order to ensure that the illness is no longer communicable, the nurse would assess for

A) All lesions crusted

B) Elevated temperature

C) Rhinorrhea and coryza

D) Presence of vesicles

Review Information: The correct answer is:

A) All lesions crusted.

The rash begins as a macule, with fever, and progresses to a vesicle that breaks open and then crusts over. When all lesions are crusted, the child is no longer in a communicable stage.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 29

Which nursing action is a PRIORITY as the plan of care is developed for a seven year-old child hospitalized for acute glomerulonephritis?

A) Assess for generalized edema

B) Monitor for increased urinary output

C) Encourage rest during hyperactive periods

D) Note patterns of increased blood pressure

Review Information: The correct answer is:

D) Note patterns of increased blood pressure.

Hypertension is a key assessment in the course of the disease.

Pillitteri, A. (1995).

Maternal Child Health Nursing.

Philadelphia: Lippincott.

Berry, P. & Brewer, E. (1990).

"Glomerulonephritis and Nephrotic Syndrome." In Oski, F., et al. Principles and Practice of Pediatrics.

Philadelphia: Lippincott

Question 30

The nurse is caring for a pregnant woman with pregnancy induced hypertension receiving magnesium sulfate intravenously. In assessing the client, it is noted that respirations are 12, pulse and blood pressure have dropped significantly, and 8 hour output is 200 ml. What should the nurse do FIRST?

A) Administer calcium gluconate

B) Call the physician immediately

C) Discontinue the magnesium sulfate

D) Perform additional assessments

Review Information: The correct answer is:

C) Discontinue the magnesium sulfate.

The assessments strongly suggest magnesium sulfate toxicity. The nurse must discontinue the IV immediately and take measures to ensure the safety of the client.

Babcock, I., Lowdermilk, D., and Jensen, M. (1995).

Maternity nursing.

St. Louis: Mosby.

Wong, D. and Perry, S. (1998).

Maternal child nursing care.

St. Louis: Mosby.

Question 31

Which of the following nursing assessments in an infant is MOST valuable in identifying serious visual defects?

A) Red reflex test

B) Visual acuity

C) Pupil response to light

D) Cover test

Review Information: The correct answer is:

A) Red reflex test.

A brilliant, uniform red reflex is an important sign because it virtually rules out almost all serious defects of the cornea, aqueous chamber, lens, and vitreous chamber.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 32

When evaluating a client, the nurse focuses on

A) All signs and symptoms of physical and psychosocial stressors

B) Client status, progress toward goal achievement, and ongoing re-evaluation

C) Setting short and long-term goals to insure continuity of care

D) Choosing interventions that are measurable and achievable

Review Information: The correct answer is:

B) Client status, progress toward goal achievement, and ongoing re-evaluation.

Evaluation process of the nursing process focuses on client status, progress toward goal achievement and ongoing re-evaluation of the plan of care.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

Philadelphia: J.B. Lippincott Co.

Varcarolis, E.(1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders. pp. 174.

Question 33

The nurse is talking with a client. The client abruptly says to the nurse, "The moon is full. Astronauts walk on the moon. Walking is a good health habit." The client's behavior MOST likely indicates

A) Neologisms

B) Dissociation

C) Flight of ideas

D) Word salad

Review Information: The correct answer is:

C) Flight of ideas.

Flight of ideas - defines nearly continuous flow of speech, jumping from one topic to another.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 34

The nurse is making a home visit to a client with chronic obstructive pulmonary disease (COPD). The client tells the nurse that he used to beable to walk from the house to the mailbox without difficulty. Now, he has to pause to catch his breath halfway through the trip. Which of the following nursing diagnoses would be MOST appropriate for this client based on this assessment?

A) Activity intolerance caused by fatigue related to chronic tissue hypoxia

B) Impaired mobility related to chronic obstructive pulmonary disease

C) Self care deficit caused by fatigue related to dyspnea

D) Ineffective airway clearance related to increased bronchial secretions

Review Information: The correct answer is:

A) Activity intolerance caused by fatigue related to chronic tissue hypoxia.

Activity intolerance describes a condition in which the client''s physiological capacity for activities is compromised.

Carpenito, L.J. (1995).

Handbook of Nursing Diagnosis. (6th ed.).

Philadelphia: JB Lippincott.

Springhouse. (1997).

Mastering Medical-Surgical Nursing.

Philadelphia: Springhouse Corporation.

Question 35

A 2 1/2 year-old child is admitted to the hospital unit. Which of the following toys would be appropriate for the nurse to select from the toy room for this child?

A) Cartoon stickers

B) Large wooden puzzle

C) Blunt scissors and paper

D) Beach ball

Review Information: The correct answer is:

B) Large wooden puzzle.

Appropriate toys for this child''s age include items such as push-pull toys, blocks, pounding board, toy telephone, puppets, wooden puzzles, finger paint, thick crayons.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 36

A nurse is doing preconceptual counseling with a woman who is planning a pregnancy. Which of the following statements suggests that the client understands the connection between alcohol consumption and fetal alcohol syndrome?

A) "I understand that a glass of wine with dinner is healthy."

B) "Beer is not really hard alcohol, so I guess I can drink some."

C) "If I drink, my baby may be harmed before I know I am pregnant."

D) "Drinking with meals reduces the effects of alcohol."

Review Information: The correct answer is:

C) "If I drink, my baby may be harmed before I know I am pregnant.".

Alcohol has the greatest teratogenic effect during organogenesis, in the first weeks of pregnancy. Therefore women considering a pregnancy should not drink.

Streissguth, A. & Finnegan, L P. (1996).

Effects of Prenatal Alcohol and Drugs.

In Kinney, J. (Ed.). Clinical Manual of Substance Abuse. (2nd ed.).

St. Louis: Mosby.

McKay, S. & Scavnicky-Mylant, M. (1991).

Substance Abuse During Childbearing Years. In Bennett, E. & Woolf, D. (Eds.). Substance Abuse. (2nd ed.).

St. Louis: Mosby.

Question 37

Post-procedure nursing interventions for electroconvulsive therapy include

A) Applying hard restraints if seizure occurs

B) Expecting client to sleep for 4 to 6 hours

C) Remaining with client until oriented

D) Expecting long-term memory loss

Review Information: The correct answer is:

C) Remaining with client until oriented.

Client awakens post-procedure 20-30 minutes after treatment and appears groggy and confused. The nurse remains with the client until the client is oriented and able to engage in self care.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

Philadelphia: J.B. Lippincott Co.

Varcarolis, E.(1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 38

The nurse is caring for a client with an unstable spinal cord injury at the T7 level. Which of the following interventions should take PRIORITY in planning care?

A) Increase fluid intake to prevent dehydration

B) Place client on a pressure reducing support surface

C) Use skin care products designed for use with incontinence

D) Increase caloric intake

Review Information: The correct answer is:

B) Place client on a pressure reducing support surface.

This client is at greatest risk for skin breakdown because of immobility and decreased sensation. The first action should be to choose and then place the client on the best support surface to relieve pressure, shear and friction forces.

Colwell J. (1997).

Chronic Care: A Clinical Source Book for Healthcare Professionals.

Wayne, PA: Health Management Publications.

Aronovitch, S. (1993).

The Use of an Asessment Tool in Managing Placement on Pressure Relief Surfaces.

Ostomy/Wound Management, 39(4)

Question 39

Which type of accidental poisoning would the nurse expect to occur in children under age six?

A) Oral ingestion

B) Topical contact

C) Inhalation

D) Eye splashes

Review Information: The correct answer is:

A) Oral ingestion.

The greatest risk for young children is from oral ingestion. While children under age six may come in contact with other poisons or inhale toxic fumes, these are not common.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 40

The nurse assesses a client who has been re-admitted to the psychiatric in-client unit for schizophrenia. His symptoms have been managed for several months with fluphenazine (Prolixin). Which of the following should be a FIRST assessment?

A) Stressors in the home

B) Medication compliance

C) Exposure to hot temperatures

D) Alcohol use

Review Information: The correct answer is:

B) Medication compliance.

Prolixin is an antipsychotic / neuroleptic medication useful in managing the symptoms of Schizophrenia. Compliance with daily doses is a critical assessment.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 1

A victim of domestic violence states, "If I were better, I would not have been beat." Which of the following feelings BEST describes what the victim may be experiencing?

A) Fear

B) Helplessness

C) Self-blame

D) Rejection

Review Information: The correct answer is:

C) Self-blame.

Self-blame victims may be immobilized by a variety of affective responses, one being self-blame. The victim believes that a change in their behavior will cause the abuser to become nonviolent, which is a myth.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 2

The nurse would expect the cystic fibrosis client to receive supplemental pancreatic enzymes along with a diet

A) High in carbohydrates and proteins

B) Low in carbohydrates and proteins

C) High in carbohydrates, low in proteins

D) Low in carbohydrates, high in proteins

Review Information: The correct answer is:

A) High in carbohydrates and proteins.

Provide a high-energy diet by increasing carbohydrates, protein and fat (possibly as high as 40%). A favorable response to the supplemental pancreatic enzymes is based on tolerance of fatty foods, decreased stool frequency, absence of steatorrhea, improved appetite and lack of abdominal pain.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 3

A client is admitted with a diagnosis of hepatitis B. In reviewing the initial laboratory results, the nurse would expect to find elevation in which of the following values?

A) Blood urea nitrogen

B) Acid phosphatase

C) Bilirubin

D) Sedimentation rate

Review Information: The correct answer is:

C) Bilirubin.

In the laboratory data provided, the only elevated level expected is bilirubin. Additional liver function tests will confirm the diagnosis.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 4

In planning care for a child diagnosed with minimal change nephrotic syndrome, the nurse should understand the relationship between edema formation and

A) Increased retention of albumin in the vascular system

B) Decreased colloidal osmotic pressure in the capillaries

C) Fluid shift from interstitial spaces into the vascular space

D) Reduced tubular reabsorption of sodium and water

Review Information: The correct answer is:

B) Decreased colloidal osmotic pressure in the capillaries.

The increased glomerular permeability to protein causes a decrease in serum albumin which results in decreased colloidal osmotic pressure.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 5

A client who has been drinking for 5 years states that he drinks when he gets upset about "things" such as being unemployed or feeling like life is not leading anywhere. The client is using alcohol as a way to deal with

A) Meeting recreational and social needs

B) Repressing feelings of anger

C) Coping with life's stressors

D) Dealing with issues of guilt and disappointment

Review Information: The correct answer is:

C) Coping with life's stressors.

Alcohol is used by some people to manage anxiety and stress. The overall intent is to decrease negative feelings and increase positive feelings.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 6

A victim of domestic violence tells the batterer she needs a little time away. How might the batterer respond?

A) With acceptance and views the victim's comment as an indication that their marriage is in trouble

B) With increased rage toward the victim

C) With a new commitment to seek counseling to assist with their marital problems

D) With relief, and welcomes the separation as a means to have some personal time

Review Information: The correct answer is:

B) With increased rage toward the victim.

The fear of rejection and loss only serve to increase the batterer's rage at his partner.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 7

A client with emphysema visits the clinic. While teaching about proper nutrition, the nurse should emphasize

A) Eating foods high in sodium increases sputum liquefaction

B) Using oxygen during meals improves gas exchange

C) Performing exercise after respiratory therapy enhances appetite

D) Cleansing the mouth of dried secretions reduces risk of infection

Review Information: The correct answer is:

B) Using oxygen during meals improves gas exchange.

Clients with emphysema breathe easier when using oxygen while eating.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 8

A client is admitted for treatment of a frontal lobe brain tumor. Which of the following assessments would the nurse expect to find?

A) Respiratory depression

B) Emotional lability

C) Hormonal imbalance

D) Visual field deficits

Review Information: The correct answer is:

B) Emotional lability.

The frontal lobe of the brain controls affect, judgment and emotions. Dysfunction in this area results in symptoms such as emotional lability, inattentiveness, flat affect and inappropriate behavior.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Smeltzer, S.G., Bare, B.G. (1999).

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing. (8th ed.).

New York: Lipppincott

Question 9

The nurse is caring for a toddler with atopic dermatitis. The nurse should instruct the parents to

A) Dress the child warmly to avoid chilling

B) Keep the child away from other children for the duration of the rash

C) Clean the affected areas with tepid water and detergent

D) Wrap the child's hand in mittens or socks to prevent scratching

Review Information: The correct answer is:

D) Wrap the child''s hand in mittens or socks to prevent scratching.

A toddler with atopic dermatitis need to have fingernails cut short and covered so the child will not be able to scratch the skin lesions, thereby causing new lesions and possible a secondary infection.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 10

The client who is receiving enteral nutrition through a gastrostomy tube has had four diarrhea stools in the past 24 hours. The nurse should

A) Review the medications the client is receiving

B) Increase the formula infusion rate

C) Increase the amount of water used to flush the tube

D) Attach a rectal bag to protect the skin

Review Information: The correct answer is:

A) Review the medications the client is receiving.

Antibiotics and medications containing sorbital may induce diarrhea.

Perry, A. G. & PPotter, P. A. (1998).

Clinical Nursing Skills and Techniques. (4th ed.).

St. Louis: Mosby.

Eisenberg, P. (1994).

Gastrostomy and Jujunostomy Tubes.

RN, 57(11), 54-59.

Eisenberg, P. (1993).

Question 11

The school nurse suspects that a third grade child might have Attention Deficit Hyperactivity Disorder. Prior to referring the child for further evaluation, the nurse should

A) Observe the child's behavior on at least two occasions

B) Consult with the teacher about how to control impulsivity

C) Compile a history of behavior patterns and developmental accomplishments

D) Compare the child's behavior with classic signs and symptoms

Review Information: The correct answer is:

C) Compile a history of behavior patterns and developmental accomplishments.

A complete behavioral, and developmental history plays an important role in determining the diagnosis.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 12

Which of the following statements by a parent would alert the nurse to assess for iron deficiency anemia in a 14 month-old child?

A) "I know there is a problem since my baby is always constipated."

B) "My child doesn't like many fruits and vegetables, but she really loves her milk."

C) "I can't understand why my child is not eating as much as she did 4 months ago."

D) "My child doesn't drink a whole glass of juice or water"

Review Information: The correct answer is:

B) "My child doesn''t like many fruits and vegetables, but she really loves her milk.".

About 2 to 3 cups of milk a day are sufficient for the young child''s needs. Sometimes excess milk intake, a habit carried over from infancy, may exclude many solid foods from the diet. As a result, the child may lack iron and develop a so-called milk anemia. Although the majority of infants with iron deficiency are underweight, many are overweight because of excessive milk ingestion.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 13

Alcohol and drug abuse impairs judgment and increases risk taking behavior. What nursing diagnosis BEST applies?

A) Risk for injury

B) Risk for knowledge deficit

C) Altered thought process

D) Disturbance in self-esteem

Review Information: The correct answer is:

A) Risk for injury.

Accidents increase as a result of intoxication. Studies indicate alcohol as a factor in 50% of motor vehicle fatalities, 53% of all deaths from accidental falls, 64% of fatal fires, and 80% of suicides.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 14

In taking the history of a pregnant woman, which of the following would the nurse recognize as the PRIMARY contraindication for breast feeding?

A) Age 40 years

B) Lactose intolerance

C) Family history of breast cancer

D) Uses cocaine on weekends

Review Information: The correct answer is:

D) Uses cocaine on weekends.

Binge use of cocaine can be just as harmful to the breast fed newborn as regular use.

Streissguth, A. & Finnegan, L P. (1996).

Effects of Prenatal Alcohol and Drugs.

In Kinney, J. (Ed.).

Clinical Manual of Substance Abuse. (2nd ed.).

St. Louis: Mosby

Olds, S., London, M., & Ladewig, P. (1996).

Maternal-Newborn Nursing: A Family-Centered Approach. (5th ed.).

New York: Addison-Wesley.

Question 15

The nurse is preparing a five year-old for a scheduled tonsillectomy and adenoidectomy. The parents are anxious and concerned about the child's reaction to impending surgery. Which nursing intervention would be BEST to prepare the child?

A) Introduce the child to all staff the day before surgery

B) Explain the surgery one week prior to the procedure

C) Arrange a tour of the operating and recovery rooms

D) Encourage the child to bring a favorite toy to the hospital

Review Information: The correct answer is:

B) Explain the surgery one week prior to the procedure.

A five year-old can understand the surgery, and should be prepared well before the procedure. Most of these procedures are "same day" surgeries and do not require an overnight stay.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 16

The nurse is talking by telephone with a parent of a four year-old child who has chickenpox. Which of the following is appropriate teaching?

A) Chewable aspirin is the preferred analgesic

B) Topical cortisone ointment relieves itching

C) Papules, vesicles, and crusts will be present at one time

D) The illness is only contagious prior to lesion eruption

Review Information: The correct answer is:

C) Papules, vesicles, and crusts will be present at one time.

All three stages of the chicken pox lesions will be present on the child''s body at one time.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 17

A postpartum Hispanic client refuses the hospital food because it is "cold." The BEST initial action by the nurse is to

A) Send the food to be reheated

B) Ask the client what foods are acceptable

C) Tell her she must eat for strength

D) Consult with the dietitian

Review Information: The correct answer is:

B) Ask the client what foods are acceptable.

Many Hispanic women subscribe to the balance of hot and cold foods in the post partum period. What defines "cold" can best be explained by the client or family.

Spector, R. (1999).

Cultural Diversity in Health and Illness.

Stamford, CT: Appleton & Lange.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: Lippincott.

Question 18

The nurse, assisting in applying a cast to a client with a broken arm, knows that

A) The cast material should be dipped several times into the warm water

B) The cast should be covered until it dries

C) The wet cast should be handled with the palms of hands

D) The casted extremity should be placed on a cloth-covered surface

Review Information: The correct answer is:

C) The wet cast should be handled with the palms of hands.

Handle cast with palms of the hands and lift at 2 points of the extremity. This will prevent stress at the injury site and pressure areas on the cast.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 19

An eighteen month-old has been brought to the emergency room with irritability, lethargy over two days, dry skin and increased pulse. Based upon the evaluation of these initial findings, the nurse would assess the child for additional signs/symptoms of

A) Septicemia

B) Dehydration

C) Hypokalemia

D) Hypercalcemia

Review Information: The correct answer is:

B) Dehydration.

Clinical signs/symptoms of dehydration include lethargy, irritability, dry skin, and increased pulse.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 20

The nurse sees a substance abusing client occasionally in the outpatient clinic. In evaluating the client's progress, the nurse recognizes that the MOST revealing resistant behavior is

A) Recurring crises

B) Continuing drug use

C) Rationalizing comments

D) Missing appointments

Review Information: The correct answer is:

B) Continuing drug use.

Continuing to use the drug demonstrates lack of commitment to the treatment program. This fact must be understood by the nurse as part of the disease of addiction.

Weiner, S. (1992).

Perinatal Impact of Substance Abuse. March of Dimes Continuing Education Module # 3.

White Plains: March of Dimes.

McKay, S. & Scavnicky-Mylant, M. (1991).

Substance Abuse During Childbearing Years.

In Bennett, E. & Woolf, D.Substance Abuse. (2nd ed.).

St. Louis: Mosby.

Question 21

The nurse is caring for a client who develops pulmonary edema and is exhibiting anxiety, diaphoresis, and crackles. Which of the following nursing interventions should be performed FIRST?

A) Take the client's vital signs

B) Place the client in a sitting position with legs dangling

C) Contact the physician

D) Administer diuretic medication

Review Information: The correct answer is:

B) Place the client in a sitting position with legs dangling.

Place the client in a sitting position with legs dangling, because airway is a priority. Blood will pool in the legs, which will help to diminish venous return.

AHA. (1997).

Textbook of ACL. (4th ed.).

AHA.

Ignatavicius, D. (1995).

Medical-Surgical Nursing: A Nursing Process Approach. (3rd ed.).

Philadelphia: W.B. Saunders.

Question 22

A recovering alcoholic asked the nurse, "Will it be ok for me to just drink at special family gatherings?" Which of the following initial responses by the nurse would be BEST?

A) "A recovering person has to be very careful not to lose control, therefore, confine your drinking just at family gatherings."

B) "At your next AA meeting discuss the possibility of drinking with your sponsor."

C) "A recovering person needs to get in touch with their feelings. Do you want a drink?"

D) "A recovering person cannot return to drinking without starting the addiction process over."

Review Information: The correct answer is:

D) "The recovering person cannot return to drinking without starting the addiction process over."

Recovery is total abstinence from all drugs.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 23

While working with an obese adolescent, it is important for the nurse to recognize that obesity in adolescents is most often associated with

A) Sexual promiscuity

B) Poor body image

C) Dropping out of school

D) Drug experimentation

Review Information: The correct answer is:

B) Poor body image.

As the adolescent gains weight, there is a lessening sense of self esteem and poor body image.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 24

A woman diagnosed with bipolar disorder is to take lithium (Lithane) as part of the treatment. The nurse should discuss with the client

A) Risks of oral contraceptives

B) Reduction in exercise program

C) Avoidance of alcohol

D) Cessation of smoking

Review Information: The correct answer is:

C) Avoidance of alcohol.

Alcohol potentiates the effects of lithium, and is to be avoided.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 25

The nurse is giving instructions to the mother of a newborn infant with oral candidiasis. Which of the following statements by the mother would indicate the need for FURTHER teaching?

A) "Nystatin should be given 4 times a day after my baby eats."

B) "I will boil the nipples and pacifiers for twenty minutes."

C) "I should be taking the medication prescribed for this infection."

D) "The therapy can be discontinued when the spots disappear."

Review Information: The correct answer is:

D) "The therapy can be discontinued when the spots disappear.".

The therapy should be continued for a week, even if lesions have disappeared within a few days.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby

Question 26

The nurse auscultates bibasilar inspiratory crackles in a newly admitted 68 year-old client with a diagnosis of congestive heart disease. Which of the following symptoms is MOST likely to occur?

A) Chest pain

B) Peripheral edema

C) Nail clubbing

D) Lethargy

Review Information: The correct answer is:

B) Peripheral edema.

When crackles are heard bibasilarly, congestive heart failure is suspected. This is often accompanied by peripheral edema secondary to fluid overload caused by ineffective cardiac pumping.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 27

The nurse is providing instructions to a new mother on the proper techniques for breast feeding her infant. The nurse would identify the need for additional instruction if the mother stated

A) "I should position my baby completely facing me with my baby's mouth in front of my nipple."

B) "The baby should latch onto the nipple and areola areas."

C) "There may be times that I will need to manually express milk."

D) "I will give the baby a pacifier."

Review Information: The correct answer is:

D) "I will give the baby a pacifier.".

Babies adapt more quickly to the breast when they aren''t confused about what is put into their mouths and its purpose. Artificial nipples do not lengthen and compress the way the human nipples (areola) do. The use of an artificial nipple weakens the baby''s suck as the baby decreases the sucking pressure to slow fluid flow. Pacifiers should not be given during the learning stage of breast feeding.

Clarke, Linda L., Deutsch, Melodee J. (1997).

Becoming Baby-Friendly.

Lifelines: Association of Women''s Health, Obstetric and Neonatal Nurses.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby

Question 28

Based on principles of teaching and learning, what is the best INITIAL approach to pre-op teaching for a client scheduled for coronary artery bypass?

A) Touring the coronary intensive unit

B) Mailing a video tape to the home

C) Assessing the client's learning style

D) Administering a written pre-test

Review Information: The correct answer is:

C) Assessing the client''s learning style.

As with any anticipatory teaching, assess the client''s level of knowledge and learning style first.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 29

The nurse is assessing a child for clinical manifestations of iron deficiency anemia. Which of the following would the nurse recognize as cause for the symptoms?

A) Decreased cardiac output

B) Tissue hypoxia

C) Cerebral edema

D) Reduced oxygen saturation

Review Information: The correct answer is:

B) Tissue hypoxia.

When the hemoglobin falls sufficiently to produce clinical manifestations, the signs and symptoms are directly attributable to tissue hypoxia, a decrease in the oxygen carrying capacity of the blood.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 30

The nurse enters a 2 year-old child's hospital room in order to administer an oral medication. When the child is asked if he is ready to take his medicine, he immediately says, "No!". What would be the MOST appropriate next action?

A) Leave the room and return 5 minutes later and give the medicine

B) Explain to the child that the medicine must be taken now

C) Give the medication to the father and ask him to give it

D) Mix the medication with ice cream or applesauce

Review Information: The correct answer is:

A) Leave the room and return 5 minutes later and give the medicine.

Since the nurse gave the child a choice about taking the medication, the nurse must comply with the child''s response in order to build or maintain trust. Since toddlers do not have an accurate sense of time, leaving the room and coming back later is another episode to the toddler.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Bowden, V., Dickey, S. & Greenberg, C. (1998).

Children and Their Families: The Continuum of Care.

Philadelphia: Saunders.

Question 31

A mother asks about expected motor skills for a 3 year-old child. Which of the following would the nurse emphasize as normal at this age?

A) Jumping rope

B) Tying shoelaces

C) Riding a tricycle

D) Playing hopscotch

Review Information: The correct answer is:

C) Riding a tricycle.

Coordination is gained through large muscle use. A child of three has the ability to ride a tricycle.

Pillitteri, A. (1995).

Maternal Child Health Nursing.

Philadelphia: Lippincott-Raven Publishers.

Boynton, R. et al. (1994).

Manual of Ambulatory Pediatrics.

Philadelphia: Lippincott-Raven Publishers.

Question 32

The nurse is discussing the appropriate amount of milk intake with the parents of an 18 month child. It is important to stress that the child

A) May drink as much milk as desired

B) Can have milk mixed with other foods

C) Will benefit from fat free cow's milk

D) Should be limited to 3-4 cups of milk daily

Review Information: The correct answer is:

D) Should be limited to 3-4 cups of milk daily.

More than 32 ounces of milk a day considerably limits the intake of solid foods, resulting in a deficiency of dietary iron, as well as other nutrients.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 33

The nurse is providing instructions for a client with pneumonia. What is the MOST important information to convey to the client?

A) "Take at least 2 weeks off from work."

B) "You will need another chest x-ray in 6 weeks."

C) "Take your temperature every day."

D) "Complete all of the antibiotic even if your symptoms decrease."

Review Information: The correct answer is:

D) "Complete all of the antibiotic even if your symptoms decrease.".

To avoid a recurrence of the pneumonia the client must complete the prescribed doses at the prescribed dosing intervals.

Dettenmeier, P.A. (1992).

Pulmonary Nursing Care.

St. Louis: Mosby.

Ford, L.C. (1996).

Nurse Practitioner''s Drug Handbook.

Springhouse, PA: Springhouse.

Question 34

A home health nurse is caring for a client with a pressure sore that is red, with serous drainage, is 2 inches in diameter with loss of subcutaneous tissue. The appropriate dressing for this wound is

A) A transparent film dressing

B) Wet dressing with debridement granules

C) Wet to dry with hydrogen peroxide

D) Moist saline dressing

Review Information: The correct answer is:

D) Moist saline dressing.

This wound is a stage III pressure ulcer. The wound is red (granulation tissue) and does not require debridement. The wound must be protected for granulation tissue to proliferate. A moist dressing allows epithelial tissues to migrate more rapidly.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 35

The nurse is performing an assessment on a child with severe airway obstruction. Which of the following would the nurse anticipate finding?

A) Retractions in the soft tissues of the thorax

B) Chest pain aggravated by respiratory movement

C) Cyanosis and mottling of the skin

D) Rapid, shallow respirations

Review Information: The correct answer is:

A) Retractions in the soft tissues of the thorax.

Slight intercostal retractions are normal. However in disease states, especially in severe airway obstruction, retractions becomes extreme.

Ball, J. and Bindler, R. (1995).

Pediatric Nursing: Caring for Children.

Norwalk, CN: Appleton and Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 36

An ambulatory client reports edema during the day in his feet and ankles that disappears while sleeping at night. Which of the following is the most appropriate follow-up question for the nurse to ask?

A) "Have you had a recent heart attack?"

B) "Do you become short of breath during your normal daily activities?"

C) "How many pillows do you use at night to sleep comfortably?"

D) "Do you smoke?"

Review Information: The correct answer is:

B) "Do you become short of breath during your normal daily activities?".

These are the symptoms of right-sided heart failure, which causes increased pressure in the systemic venous system. To equalize this pressure, the fluid shifts into the interstitial spaces causing edema. Because of gravity, the lower extremities are first affected in an ambulatory patient. This question would elicit information to confirm the nursing diagnosis of activity intolerance and fluid volume excess both associated with right-sided heart failure.

Springhouse. (1998).

Handbook of Medical -Surgical Nursing. (2nd ed.).

Springhouse PA: Springhouse Corporation.

Springhouse. (1997).

Diseases. (2nd ed.).

Springhouse PA: Springhouse Corporation.

Question 37

The nurse is monitoring the contractions of a woman in labor. Acontraction is recorded as beginning at 10:00 A.M. and ending at 10:01 A.M.. Another begins at 10:15 A.M. The nurse recognizes that the frequency of the contractions is

A) 14 minutes

B) 10 minutes

C) 15 minutes

D) 9 minutes

Review Information: The correct answer is:

C) 15 minutes.

Frequency is the time from the beginning of one contraction to the beginning of the next contraction.

Babcock, I., Lowdermilk, D., and Jensen, M. (1995).

Maternity nursing.

St. Louis: Mosby.

Wong, D. and Perry, S. (1998).

Maternal child nursing care.

St. Louis: Mosby.

Question 38

The nurse is planning care for a ten month-old infant with bacterial meningitis. Which of the following nursing measures would be appropriate for the nurse to do?

A) Measure head circumference

B) Place in contact isolation

C) Provide active range of motion

D) Provide an over-the-crib mobile

Review Information: The correct answer is:

A) Measure head circumference.

In meningitis, assessment of neurological signs should be done frequently. Head circumference is measured because subdural effusions and obstructive hydrocephalus can develop as a complication of meningitis.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 39

In evaluating growth of a 12 month-old child, the nurse expects to find that the infant has

A) Increased 10% in height

B) Two deciduous teeth

C) Tripled the birth weight

D) Equal head, chest circumferences

Review Information: The correct answer is:

C) Tripled the birth weight.

The infant usually triples his birth weight by the end of the first year of life.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 40

The nurse is performing a physical assessment on an infant with roseola. Which of the following characteristics of the skin lesions would the nurse expect to find?

A) Macule that rapidly progresses to papule and then vesicles

B) Discrete rose pink macules will appear first on the trunk and fade when pressure is applied

C) Erythema on the face, primarily on cheeks giving a "slapped face" appearance

D) Koplick spots appear first followed by a rash that appears first on the face and spreads downward

Review Information: The correct answer is:

B) Discrete rose pink macules will appear first on the trunk and fade when pressure is applied.

The characteristic rash of an infant with roseola will appear as discrete rose pink macules. These macules will first be seen on the trunk and will fade when pressure is applied.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 1

A nurse admits a 3 week-old infant to the special care nursery with a diagnosis of bronchopulmonary dysplasia. As the nurse reviews the birth history, which data would be MOST consistent with this diagnosis?

A) Gestational age assessment suggested growth retardation

B) Meconium was cleared from the airway at delivery

C) Phototherapy was used to treat Rh incompatibility

D) The infant received mechanical ventilation for 2 weeks

Review Information: The correct answer is:

D) The infant received mechanical ventilation for 2 weeks.

Bronchopulmonary dysplasia is an iatrogenic disease caused by therapies such as use of positive-pressure ventilation used to treat lung disease.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Bowden, V., Dickey, S. & Greenberg, C. (1998).

Children and Their Families: The Continuum of Care.

Philadelphia: Saunders.

Question 2

The nurse is planning care for a client during the acute phase of a sickle cell vaso-occlusive crisis. Which of the following actions would be MOST appropriate?

A) Fluid restriction 1000cc per day

B) Ambulate in hallway four times a day

C) Administer analgesic therapy as ordered

D) Encourage increased caloric intake

Review Information: The correct answer is:

C) Administer analgesic therapy as ordered.

The main general objectives in the treatment of a sickle cell crisis is bed rest, hydration, electrolyte replacement, analgesics for pain, blood replacement and antibiotics to treat any existing infection.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 3

A new nurse manager is seeking a mentor for the role. Which of the following BEST describes what is ideal for a positive experience with a mentor?

A) The new nurse manager clearly asks for information needed

B) The mentor serves as an invested teacher-coach

C) The new nurse manager accepts feedback objectively

D) The mentor is randomly assigned by administration

Review Information: The correct answer is:

B) The mentor serves as an invested teacher-coach.

Both the mentor and nurse manager need to be open to a positive learning experience. The teacher-coach is the ideal relationship.

Marquis. B. L. & Huston, C. J. (1999).

Leadership Roles and Management Functions in Nursing.

Philadelphia: Lippincott-Raven Publishers.

Yoder Wise, P. S. (1995).

Leading and Managing in Nursing.

St. Louis: Mosby.

Question 4

The nurse is caring for a client with a pressure ulcer on the heel that is covered with black hard tissue. Which of the following would be an appropriate goal in planning care for this client?

A) Protection for the granulation tissue

B) Heal infection

C) Debride eschar

D) Leave alone

Review Information: The correct answer is:

D) Leave alone.

If the black tissue, (eschar) is dry and intact no treatment is necessary. If the area changes (cellulitis, pain) this is a sign of infection, requiring debridement.

Bates-Jensen, B.M. (1997).

"Pressure Ulcer Assessment and Documentation: The Pressure Sore Status Tool." In Krasner, D. & Kane (eds.).

Chronic Wound Care: A Clinical Source Book for Healthcare Professionals

Wayne, PA: Health Management Publications Inc.

Question 5

The nurse is assessing a healthy child at the 2 year check up. Which of the following should the nurse report IMMEDIATELY to the physician?

A) Height and weight percentiles vary widely

B) Growth pattern appears to have slowed

C) Recumbent and standing height are different

D) Short term weight changes are uneven

Review Information: The correct answer is:

A) Height and weight percentiles vary widely.

On the growth curve, height and weight should be close in percentiles at this age. The wide difference may indicate a problem.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 6

A client is admitted with low T3 and T4 levels and an elevated TSH level. On initial assessment, the nurse would anticipate which of the following assessment findings?

A) Lethargy

B) Heat intolerance

C) Diarrhea

D) Skin eruptions

Review Information: The correct answer is:

A) Lethargy.

In hypothyroidism the metabolic activity of all cells of the body decreases, reducing oxygen consumption, decreasing oxidation of nutrients for energy, and producing less body heat. Therefore, the nurse can expect the client to complain of constipation, lethargy and inability to get warm.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 7

The parents of a two year-old child report that he has been holding his breath whenever he has temper tantrums. The BEST response of the nurse would be to

A) Teach the parents how to perform cardiopulmonary resuscitation

B) Recommend that the parents give in when he holds his breath to prevent anoxia

C) Advise the parents to ignore breath holding because breathing will begin as a reflex

D) Instruct the parents on how to reason with the child about possible harmful effects

Review Information: The correct answer is:

C) Advise the parents to ignore breath holding because breathing will begin as a reflex.

If temper tantrums are accompanied by breath holding, the parents need to know that this behavior will not result in harm to the child. Ignoring the breath holding is best, knowing that breathing will begin again by reflex.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 8

The MAJOR developmental task that the mother must accomplish during the first trimester of pregnancy is

A) Acceptance of the pregnancy

B) Acceptance of the termination of the pregnancy

C) Acceptance of the fetus as a separate and unique being

D) Satisfactory resolution of fears related to giving birth

Review Information: The correct answer is:

A) Acceptance of the pregnancy.

During the first trimester the maternal focus is directed toward acceptance of the pregnancy and adjustment to the minor discomforts.

Olds, S., London, M., Ladewig, P. (1996).

Maternal-Newborn Nursing.

CA: Addison-Wesley.

May, K., Neeson, J. (1986).

Comprehensive Maternity Nursing.

Philadelphia: J.B. Lippincott Co.

Question 9

Delirium tremors could BEST be described as

A) Disorganized thinking, feelings of terror and non-purposeful behavior

B) A generalized shaking of the body accompanied by repetitive thoughts

C) An excited state accompanied by disorientation, hallucination and tachycardia

D) Single or multiple jerks caused by rapid contracting muscles

Review Information: The correct answer is:

C) An excited state accompanied by disorientation, hallucination and tachycardia.

During DTS, the person experiences confusion, disorientation, hallucinations, tachycardia, hypertension, extreme tremors, agitation, diaphoresis and fever.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 10

The nurse is caring for several hospitalized children. Which of the following childhood disorders is likely to result in metabolic acidosis?

A) Severe diarrhea

B) Acute asthma

C) Pulmonary edema

D) Vomiting

Review Information: The correct answer is:

A) Severe diarrhea.

Severe diarrhea can lead to metabolic acidosis if untreated.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 11

The emergency room nurse admits a child who experienced a seizure at school. The father comments that this is the first occurrence, and denies any family history of epilepsy. What is the BEST response by the nurse?

A) "Do not worry. Epilepsy can be treated with medications."

B) "The seizure may or may not mean your child has epilepsy."

C) "Since this was the first convulsion, it may not happen again."

D) "Long term treatment will prevent future seizures."

Review Information: The correct answer is:

B) "The seizure may or may not mean your child has epilepsy.".

There are many possible causes for a childhood seizure. These include fever, central nervous system conditions, trauma, metabolic alterations and idiopathic (unknown).

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 12

When providing nursing measures to relieve a 102 degree Fahrenheit fever in a toddler with an infection, the nurse knows that the MOST effective intervention is to

A) Use medications to lower the temperature set point

B) Apply extra layers of clothing to prevent shivering

C) Immerse the child in a tub containing cool water

D) Give a tepid sponge bath prior to giving an antipyretic

Review Information: The correct answer is:

A) Use medications to lower the temperature set point.

Conditions such as infection, malignancy, allergy, central nervous system lesion and radiation cause the temperature set-point to be raised. Because the temperature set point is normal in hyperthermia and elevated in fever, different measures must be taken in order to be effective. The most effective intervention in the management of fever is the administration of antipyretics which lower the set point.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Betz, C., Hunsberger, M. & Wright, S. (1994).

Family-Centered Nursing Care of Children. (2nd ed.).

Philadelphia: Saunders.

Question 13

The nurse is discussing negativism with the parents of a 30 month-old child. The nurse should tell the parents that their BEST response to this behavior would be to

A) Reprimand the child and give a 15 minute "time out"

B) Maintain a permissive attitude for this behavior

C) Use patience and a sense of humor to deal with this behavior

D) Assert authority over the child through limit setting

Review Information: The correct answer is:

C) Use patience and a sense of humor to deal with this behavior.

The nurse should help the parents see the negativism as a normal growth of autonomy in the toddler. They can best handle the negative toddler by using patience and humor.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 14

The nurse is assessing the mental status of a recently admitted psychiatric client. Which of the following questions will BEST assess the memory function for recall of events?

A) "Name the year." "What season is this?" "What day and month is this?" (pause for answer after each question)

B) "Subtract 7 from 100 and then subtract 7 from that." (pause for answer) "Now continue to subtract 7 from the new number."

C) "I am going to say the names of 3 things and I want you to repeat them after me: blue, ball, pen."

D) "What is this on my wrist?" (point to your watch)

Review Information: The correct answer is:

C) "I am going to say the names of 3 things and I want you to repeat them after me: blue, ball, pen.".

Recent memory is the ability to recall events in the immediate past and up to two weeks previously.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 15

The nurse is assessing a client in the emergency room. Which of the following statements suggests that the problem is acute angina?

A) "My pain is deep in my chest behind my sternum."

B) "When I sit up the pain gets worse."

C) "As I take a deep breath the pain gets worse."

D) "The pain is right here in my stomach area."

Review Information: The correct answer is:

A) "My pain is deep in my chest behind my sternum.".

The pain of angina is usually localized chest pain.

Black, J., Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing: Clinical Management for Continuity of Care (5th ed.).

Philadelphia: Saunders.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical-Surgical nursing: Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 16

The nurse is teaching diet restrictions for a client with Addison's disease. The client would indicate an understanding of the diet by stating

A) "I will increase sodium and fluids and restrict potassium."

B) "I will increase potassium and sodium and restrict fluids."

C) "I will increase sodium, potassium and fluids."

D) "I will increase fluids and restrict sodium and potassium."

Review Information: The correct answer is:

A) "I will increase sodium and fluids and restrict potassium.".

The manifestation of Addison''s disease due to mineralocorticoid deficiency resulting from renal sodium wasting and potassium retention include dehydration, hypotension, hyponatremia, hyperkalemia and acidosis.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 17

A nurse and client are talking about the client's progress toward understanding his behavior under stress. This is typical of which phase in the therapeutic relationship?

A) Pre-interaction

B) Orientation

C) Working

D) Termination

Review Information: The correct answer is:

C) Working.

During the working phase alternative behaviors and techniques are explored. The nurse and the client discuss the meaning behind the behavior.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 18

The nursing care plan for a toddler diagnosed with Kawasaki Disease (mucocutaneous lymph node syndrome) should be based on the high risk for development of

A) Chronic arthritis

B) Pulmonary embolism

C) Vesicular rash

D) Coronary artery aneurysms

Review Information: The correct answer is:

D) Coronary artery aneurysms.

Kawasaki Disease involves all the small and medium-sized blood vessels. There is progressive inflammation of the small vessels which progresses to the medium-sized muscular arteries, potentiallydamaging the walls and leading to coronary artery aneurysms.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 19

The nurse is caring for a client with COPD who becomes dyspneic. The nurse should

A) Instruct the client to breathe into a paper bag

B) Place the client in a high Fowler's position

C) Assist the client with pursed lip breathing

D) Administer oxygen at 6L/minute via nasal cannula

Review Information: The correct answer is:

C) Assist the client with pursed lip breathing.

Use pursed-lip breathing during periods of dyspnea to control rate and depth of respiration and improve respiratory muscle coordination.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Luckmann, Joan. (1997).

Saunders Manual of Nursing Care.

Philadelphia: W.B.Saunders Company.

Question 20

In planning care for an infant, the nurse is aware that the six month-old infant's development of trust is met PRIMARILY by providing

A) Food

B) Warmth

C) Security

D) Comfort

Review Information: The correct answer is:

C) Security.

While the infant has many physical needs, it must be touched, loved, and stimulated to develop security and trust.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 21

A nurse is eating in the hospital cafeteria when a toddler at a nearby table chokes on a piece of food and appears slightly blue. The appropriate INITIAL action should be to

A) Begin mouth to mouth resuscitation

B) Give the child water to help in swallowing

C) Perform 5 abdominal thrusts

D) Call for the emergency response team

Review Information: The correct answer is:

C) Perform 5 abdominal thrusts.

At this age, the most effective way to clear the airway of food is to perform abdominal thrusts.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 22

Parents of a 6 month-old breast fed baby ask the nurse about increasing the baby's diet. Which of the following should be added FIRST?

A) Cereal

B) Eggs

C) Meat

D) Juice

Review Information: The correct answer is:

A) Cereal.

The guidelines of the American Academy of Pediatrics recommend that one new food be introduced at a time, beginning with strained cereal.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 23

A 35 year-old client with sickle cell crisis is talking on the telephone but stops as the nurse enters the room to request something for pain. The nurse should

A) Administer a placebo

B) Encourage increased fluid intake

C) Administer the prescribed analgesia

D) Recommend relaxation exercises for pain control

Review Information: The correct answer is:

C) Administer the prescribed analgesia.

Relief of pain is the expected outcome for treatment of sickle cell crisis. Pain may be present even without overt signs.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Smeltzer, S.G., Bare, B.G. (1999).

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing. (8th ed.).

New York: Lippincott.

Question 24

A nurse has just received a medication order which is not legible. Which statement BEST reflects assertive communication?

A) "Dr., I cannot give this medication as you have written it."

B) "Dr., would you please clarify what you have written so I am sure I am reading it correctly?"

C) "Dr., I am having difficulty reading your handwriting. It would save me time if you would be more careful."

D) "Dr., please print in the future so I do not have to spend extra time trying to read your writing."

Review Information: The correct answer is:

B) "Dr., would you please clarify what you have written so I am sure I am reading it correctly?".

Assertive communication respects the rights and responsibilities of both parties. This statement is an honest expression of concern for safe practice and a request for clarification without self-depreciation. It reflects the right of the professional to give and receive information.

Marquis. B. L. and Huston, C. J. (1996)

Leadership roles and management functions in nursing p. 324-325.

Balzer-Riley, J. (1996)

Communications in nursing.

St. Louis: Mosby. p. 216.

Question 25

The nurse is caring for a 10 month-old infant who is receiving oxygen through a nasal cannula. It is important for the nurse to monitor the child for

A) Hypothermia

B) Mouth breathing

C) Accumulation of moisture on face

D) Aspiration of vomitus

Review Information: The correct answer is:

B) Mouth breathing.

If an infant breathes through their mouth, it is difficult to control oxygen concentrations.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 26

A client with bipolar disorder is reluctant to take lithium (Lithane) as prescribed. The MOST therapeutic response by the nurse to his refusal is

A) "You need to take your medicine, this is how you get well."

B) "If you refuse your medicine, we'll just have to give you a shot."

C) "What is it about the medicine that you don't like?"

D) "I can see that you are uncomfortable right now, I'll wait until tomorrow."

Review Information: The correct answer is:

C) "What is it about the medicine that you don't like?".

Nursing interventions for clients with psychotic disorders are aimed at establishing a trusting relationship, establishing clear communications, presenting reality and reinforcing appropriate behavior.

Shives, L. (1998).

Basic Concepts of Psychiatric-Mental Health Nursing.

New York: J.B. Lippincott Co.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 27

The nurse is teaching parents how to reduce risks in the home, the most important consideration is

A) Age and knowledge level of the parents

B) Proximity to emergency services

C) Number of children in the home

D) Age of children in the home

Review Information: The correct answer is:

D) Age of children in the home.

Age and developmental level of the child are most important in providing a framework for anticipatory guidance.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 28

Following surgery for placement of a ventriculoperitoneal (VP) shunt as treatment for hydrocephalus, the parents question why the infant has a small abdominal incision. The BEST response by the nurse would be to explain that the incision was made in order to

A) Pass the catheter into the abdominal cavity

B) Place the tubing into the urinary bladder

C) Visualize abdominal organs for catheter placement

D) Insert the catheter into the stomach

Review Information: The correct answer is:

A) Pass the catheter into the abdominal cavity.

The preferred procedure in the surgical treatment of hydrocephalus is placement of a ventriculoperitoneal shunt. This shunt procedure provides primary drainage of the cerebrospinal fluid from the ventricles to an

extracranial compartment, usually the peritoneum. A small incision is made in the upper quadrant of the abdomen so the shunt can be guided into the peritoneal cavity.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Bowden, V., Dickey, S. & Greenberg, C. (1998).

Children and Their Families: The Continuum of Care.

Philadelphia: Saunders.

Question 29

While caring for a toddler with croup, which of the following signs requires the nurse's IMMEDIATE attention?

A) Respiratory rate of 30

B) Lethargy

C) Apical pulse of 54 in toddler

D) Coughing up copious secretions

Review Information: The correct answer is:

A) Respiratory rate of 30.

Signs of impending airway obstruction include increased pulse and respiratory rate; substernal, suprasternal and intercostal retractions; flaring nares; and increased restlessness.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 30

The nurse is caring for a client with a deep vein thrombosis. Which of the following symptoms would require the nurse's IMMEDIATE attention?

A) Temperature of 102 degrees Fahrenheit

B) Pulse rate of 98 beats per minute

C) Respiratory rate of 32

D) Blood pressure of 90/50

Review Information: The correct answer is:

C) Respiratory rate of 32.

Clients with deep vein thrombosis are at risk for the development of pulmonary embolism. The most common symptoms are tachypnea, dyspnea, and chest pain.

McCance, K.L. & Huether, S.E. (1994).

Pathophysiology: The Biologic Process for Disease in Adults and Children. (2nd ed.).

St. Louis: Mosby.

Miller, G.H., & Feied, C.F. (1995).

Suspected pulmonary embolism, the difficulties of diagnostic evaluation.

Postgraduate Medicine, 97(1)

Question 31

The nurse should initiate discharge planning for a client

A) When the client or family demonstrate readiness to learn self care modalities

B) When informed by the physician that a date for discharge has been determined

C) Upon admission to the hospital

D) When the client's condition is stabilized

Review Information: The correct answer is:

C) Upon admission to the hospital.

With decreasing lengths of stay, discharge planning must be incorporated into the initial plan of care.

Otto, S.E.

Oncology Nursing 3rd Ed.

Mosby, St. Louis, 1997; 681.

Smeltzer, S.G., Bare, B.G.,

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing 8th Ed.

Lipppincott, N.Y.,1996; 19

Question 32

The nurse is speaking to a group of parents and school teachers of children about care for children with rheumatic fever. It is a PRIORITY to emphasize that

A) Home schooling is preferred to classroom instruction

B) Children may remain strep carriers for years

C) Most play activities will be restricted indefinitely

D) Clumsiness and behavior changes should be reported

Review Information: The correct answer is:

D) Clumsiness and behavior changes should be reported.

A major manifestation of rheumatic fever that reflects central nervous system involvement is chorea. Early symptoms of chorea include behavior changes and clumsiness. Chorea is characterized by sudden, aimless, irregular movements of the extremities, involuntary facial grimaces, speech disturbances, emotional lability, and muscle weakness. Chorea is transitory and all manifestations eventually disappear.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 33

A client has been admitted with complaints of lower abdominal pain, difficulty swallowing, nausea, dizziness, headache and fatigue. The client is agitated, fearful, tachycardic and complains of being "too sick to return to work." The client is diagnosed as having somatoform disorder. In formulating a plan of care, the nurse must consider that the client's behavior

A) Is controlled by their subconscious mind

B) Is manipulative to avoid work responsibilities

C) Would respond to psychoeducational strategies

D) Could be modified through reality therapy

Review Information: The correct answer is:

A) Is controlled by their subconscious mind.

Persons with somatoform disorder do not intend to feign illness; their complaints are not under their conscious control. To intend so is called "malingering" or a factitious disorder.

Shives, L. R. (1998)

Basic Concepts of Psychiatric-Mental Health Nursing (4th ed)

Philadelphia: Lippincott

Barry, P. (1998).

Mental Health & Mental Illness (6th ed.)

Philadelphia: Lippincott.

Question 34

In counseling a six year-old who experiences secondary enuresis, the school nurse must understand that this is a problem that

A) Has no clear etiology

B) May be associated with sleep phobia

C) Has a definite genetic link

D) Is a sign of willful misbehavior

Review Information: The correct answer is:

A) Has no clear etiology.

Although predictive factors associated with enuresis have been identified, no clear etiology has been determined.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Bowden, V., Dickey, S. & Greenberg, C. (1998).

Children and Their Families: The Continuum of Care.

Philadelphia: Saunders.

Question 35

The nurse is caring for a pre-adolescent client in skeletal Dunlop traction. Which of the following nursing interventions is appropriate for this child?

A) Make certain the child is maintained in correct body alignment.

B) Be sure the traction weights touch the end of the bed.

C) Adjust the head and foot of the bed for the child's comfort

D) Release the traction for 15-20 minutes every six hours prn.

Review Information: The correct answer is:

A) Make certain the child is maintained in correct body alignment..

Observe for correct body alignment with emphasis on alignment of shoulders, hips and legs.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 36

A six year-old child diagnosed with acute glomerulonephritis (AGN) is experiencing anorexia, moderate edema and elevated blood urea nitrogen (BUN) levels. He requests a peanut butter sandwich for lunch. What would be the nurse's BEST response to this request?

A) "That's a good choice, and I know it is your favorite. You can have it today."

B) "I'm sorry, that is not a good choice, but you could have pasta."

C) "I know that is your favorite, but let me help you pick another lunch."

D) "You cannot have the peanut butter until you are feeling better."

Review Information: The correct answer is:

C) "I know that is your favorite, but let me help you pick another lunch.".

Children with AGN who have edema, hypertension oliguria and azotemia may have dietary restrictions limiting sodium, fluids, protein and potassium. Giving the child a short explanation and offering to talk about an alternative is appropriate for this age.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 37

A mother calls the clinic, concerned that her 5 week-old infant is "sleeping more than her brother did." The nurse's best INITIAL response would be

A) "Do you remember his sleep patterns?"

B) "How old is your other child?"

C) "Why do you think this a concern?"

D) "Does the baby sleep after feeding?"

Review Information: The correct answer is:

C) "Why do you think this a concern?".

Open ended questions encourage further discussion and conversation, thereby eliciting further information.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 38

Dual diagnosis indicates that there is a substance abuse problem as well as a

A) Cross addiction

B) Mental disorder

C) Disorder of any type

D) Medical problem

Review Information: The correct answer is:

B) Mental disorder.

Dual diagnosis is the concurrent presence of a major psychiatric disorder and chemical dependence.

Fontaine, K. & Fletcher, J. (1998).

Essentials of Mental Health Nursing.

Menlo Park, CA: Addison- Wesley.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 39

The nurse is teaching a client with metastatic bone disease about measures to prevent hypercalcemia. It would be important for the nurse to emphasize

A) The need to have at least 5 servings of dairy products daily

B) The need to restrict fluid intake to less than one liter per day

C) The importance of walking

D) Early recognition of tetany

Review Information: The correct answer is:

C) The importance of walking.

Mobility must be emphasized to prevent demineralization and breakdown of bones.

Beare, P.G., Myers, J.L. (1998).

Adult Health Nursing. (3rd ed.).

New York-St. Louis: Mosby.

Smeltzer, S.G., Bare, B.G. (1999).

Brunner and Suddarth''s Textbook of Medical - Surgical Nursing. (8th ed.).

New York: Lippincott.

Question 40

A nine year-old is taken to the emergency room with right lower quadrant pain and vomiting. While the nurse prepares the child for an emergency appendectomy, it is expected that the child's greatest fear is related to

A) Change in body image

B) An unfamiliar environment

C) Perceived loss of control

D) Guilt over being hospitalized

Review Information: The correct answer is:

C) Perceived loss of control.

For school age children, major fears are loss of control and separation from friends/peers.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 1

Nominal group technique for decision making is described by which of the following?

A) A technique that allows each group member the opportunity for input into the decision-making process

B) A technique to control dominant group members

C) A technique which honors individual differences and allows members to pass

D) A technique which is time-consuming and thus not cost-effective

Review Information: The correct answer is:

A) A technique that allows each group member the opportunity for input into the decision-making process.

With nominal group technique, individuals can give input in comfortable ways and with equal participation. Although it can be time consuming, the quality of decisions made may be higher than with quicker methods.

Marquis, B. & Huston, C. (1996).

Leadership roles and management functions in nursing.

Philadelphia: Lippincott, pages 94-99.

Yoder Wise, P. (1995).

Leading and managing in nursing.

St. Louis: Mosby

Question 2

A client with considerable painasks the nurse's opinion regarding acupuncture as a drug-free method for alleviating pain. The nurse responds, "I'd forget about it as those weird non-Western treatments can be scary." The nurse's response is an example

A) Prejudice

B) Discrimination

C) Ethnocentrism

D) Cultural insensitivity

Review Information: The correct answer is:

C) Ethnocentrism.

Ethnocentrism, the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways, can be a major barrier to providing culturally conscious care. Ethnocentrism perpetuates an attitude that beliefs that differ greatly from one''s own are strange, bizarre, or unenlightened, and therefore wrong. Ethnocentrism refers to the unconscious tendency to look at others through the lens of one''s own cultural norms and customs and to take for granted that one''s own values are the only objective reality. At a more complex level, the ethnocentrist regards others as inferior or immoral and believes his or her own ideas are intrinsically good, right, necessary, and desirable, while remaining unaware of his or her own value judgments.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Question 3

Which of the following entries on a client's progress notes is the MOST complete?

A) Demerol 75mg administered for severe abdominal pain

B) Client seems anxious about low salt diet

C) 100 cc of dark green drainage from Nasogastric tube

D) Client's urinary output adequate

Review Information: The correct answer is:

C) 100 cc of dark green drainage from Nasogastric tube.

Entries in client records need to be complete, accurate and factual. Records can only be used by third party payers if they are accurate, reliable and valid.

Martin, KS. (1997, April).

Collecting Clinical Data.

Home Health FOCUS, 3(11), 82.

Martin, KS. (in press).

Home Health Care.

In GA Harkness and JR. Dincher (Eds.), Medical-Surgical Nursing: Total client Care.

St. Louis: Mosby.

Question 4

A 65-year-old Catholic Hispanic-Latino client with prostate cancer adamantly refuses pain medication because he believes that suffering is part of life and that his life is in God's hands. The BEST action for the nurse to take is to

A) Report the situation to the physician

B) Discuss the situation with the client's family

C) Ask the client if he'd like to talk with a priest

D) Document the situation

Review Information: The correct answer is:

C) Ask the client if he''d like to talk with a priest.

Beliefs regarding pain are one of the oldest culturally related research areas in health care. Astute observations and careful assessments must be completed to determine the level of pain a person can tolerate. Health-care practitioners must investigate the meaning of pain to each person within a cultural explanatory framework.

Juarez, G. (1997).

Quality of Life: A Nursing Challenge.

Culture and Pain. 4(4), 86-90.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Question 5

The nurse is planning care for a two year-old hospitalized child. Which of the following is the MAJOR stressor of hospitalization for this age?

A) Separation anxiety

B) Fear of pain

C) Loss of control

D) Bodily injury

Review Information: The correct answer is:

A) Separation anxiety.

While a toddler will experience all of the stresses, separation from parents is the major stressor.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Question 6

As a nurse manager, you are considering changing staff assignments from 8 hour shifts to 12 hour shifts. A staff-selected planning committee has approved the change, yet staff are complaining. As a change agent, you should first

A) Support the planning committee and post the new schedule

B) Explore how the planning committee evaluated barriers to the plan

C) Design a different approach to deliver care with fewer staff

D) Retain the previous staffing pattern for another six months

Review Information: The correct answer is:

B) Explore how the planning committee evaluated barriers to the plan.

The manager is ultimately responsible for delivery of care and yet has given a committee chosen by staff the right to approve or disapprove thechange. Planned change involves exploring barriers and restraining forces before implementing change. To smooth acceptance of the change, restraining factors need to be evaluated. The manager wants to build the staff''s skills at implementing change. Helping the committee evaluate its decision-making is a useful step before rejecting or implementing the change. When possible all effected by the change should be involved in the planning. The question is whether staff input has been thoroughly taken into consideration.

Marquis, B. L. and Huston, C. J. (1999)

Leadership roles and management functions in nursing.

Philadelphia, PA: Lippincott. pp 76-86. See page 85

Yoder Wise, P. S. (1995)

Leading and managing in nursing.

St. Louis: Mosby.

pp 87-95. See p 95

Question 7

An American Indian Chief visits his newborn son and performs a traditional ceremony that involves feathers and chanting. The attending nurse tells a colleague "I wonder if he has any idea how ridiculous he looks -- he's a grown man!" The nurse's response is an example of

A) Discrimination

B) Stereotyping

C) Ethnocentrism

D) Prejudice

Review Information: The correct answer is:

D) Prejudice.

Prejudice is a hostile attitude toward individuals simply because they belong to a particular group presumed to have objectionable qualities. Prejudice refers to preconceived ideas, beliefs, or opinions about an individual, group, or culture that limit a full and accurate understanding of the individual, culture, gender, race, event, or situation.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Leininger, M. (1995).

Transcultural Nursing: Concepts, Theories, Research & Practice.

New York: McGraw- Hill.

Question 8

A 24 year-old male is admitted with a diagnosis of testicular cancer. The nurse would expect the client to have

A) Scrotal discoloration

B) Sustained painful erection

C) Inability to achieve erection

D) Heaviness in the affected testicle

Review Information: The correct answer is:

D) Heaviness in the affected testicle.

The feeling of heaviness in the scrotum is related to testicular cancer and not epididymitis. Sexual performance and related issues are not affected at this time.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1997).

Mosby''s Clinical Nursing. (4th ed.).

St. Louis: Mosby.

Nettina, Sandra (1996).

The Lippincott Manual of Nursing Practice. (6th ed).

Philadelphia: Lippincott-Raven Publishers.

Question 9

To obtain data for the nursing assessment, the nurse should:

A) Observe carefully the client's nonverbal behaviors

B) Adhere to pre-planned interview goals and structure

C) Allow clients to talk about whatever they want

D) Elicit clients' description of their experiences, thoughts and behaviors

Review Information: The correct answer is:

D) Elicit clients'' description of their experiences, thoughts and behaviors.

The nurse's understanding of the client rests the comprehensiveness of assessment data obtained by listening to the client's self revelation.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Carson, V.B. & Arnold, E.N. (1996).

Mental Health Nursing: The Nurse-client & Journey.

Philadelphia: W.B. Saunders.

Question 10

A nurse is caring for a client with peripheral arterial insufficiency of the lower extremities. Which one of the following should be included in the plan of care to reduce leg pain?

A) Elevate the legs above the heart

B) Increase ingestion of caffeine products

C) Apply cold compresses

D) Lower the legs to a dependent position

Review Information: The correct answer is:

D) Lower the legs to a dependent position.

Ischemic pain is relieved by placing feet in a dependent position. This position improves peripheral perfusion.

Black, J. & Matassarin-Jacobs, E. (1997).

Medical-Surgical Nursing, Clinical Management for Continuity of Care. (5th ed.).

Philadelphia: Saunders.

Lewis, S, Collier, I., & Heitkemper, M (1996). Medical-Surgical nursing; Assessment and management of clinical problems. (4th ed).

St. Louis: Mosby

Question 11

The nurse detects blood-tinged fluid leaking from the nose and ears of a head trauma client. The appropriate nursing action would be to

A) Pack the nose and ears with sterile gauze

B) Apply pressure to the injury site

C) Apply bulky, loose dressing to nose and ears

D) Apply an ice pack to the back of the neck

Review Information: The correct answer is:

C) Apply bulky, loose dressing to nose and ears.

Applying a bulky, loose dressing to the nose and ears permits the fluid to drain and provides a visual reference for the amount of drainage.

Nettina, Sandra (2000).

The Lippincott Manual of Nursing Practice.

Philadelphia-New York: Lippincott.

Springhouse. (1997).

Diseases. (2nd ed.).

Springhouse PA: Springhouse Corporation.

Question 12

A nurse consistently ignores the call lights of gay and lesbian clients. The nurse's behavior is an example of

A) Discrimination

B) Prejudice

C) Stereotyping

D) Cultural insensitivity

Review Information: The correct answer is:

A) Discrimination.

The differential treatment of individuals because they belong to a minority group. Generally refers to the limiting of opportunities, choices, or life experiences because of prejudices about individuals, cultures, or social groups.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Leininger, M. (1995).

Transcultural Nursing: Concepts, Theories, Research & Practice.

New York: McGraw- Hill.

Question 13

The nurse is assessing a seven year-old after several days of treatment for a documented strep throat. Which of the following statements suggests that FURTHER teaching is needed?

A) "Sometimes I take my medicine with fruit juice."

B) "My mother makes me take my medicine right after school."

C) "Sometimes I take the pills in the morning and at night."

D) "I am feeling much better than I did last week."

Review Information: The correct answer is:

C) "Sometimes I take the pills in the morning and at night.".

Inconsistency in taking the prescribed medication indicates more teaching is needed.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Ashwill, J. W. & Droske, S. C. (1997).

Nursing Care of Children: Principles and Practice.

Philadelphia: W. B. Saunders.

Question 14

A nurse arranges for a interpreter to facilitate communication between the health care team and a non-English speaking client. To promote therapeutic communication, the FIRST thing for the nurse to remember when working with an interpreter is to

A) Promote verbal and nonverbal communication with both the client and the interpreter

B) Speak only a few sentences at a time

C) Plan that the encounter will take more time than if the client spoke English

D) Ask the client to speak slowly

Review Information: The correct answer is:

A) Promote verbal and nonverbal communication with both the client and the interpreter.

The nurse should communicate with the client and the family, not with the interpreter. Culturally appropriate eye contact, gestures, and body language toward the client and family are important factors to enhance rapport and understanding. Maintain eye contact with both the client and interpreter to elicit feedback and read nonverbal cues.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Question 15

Which of the following types of traction can the nurse expect to be used on a 7 year-old with a fractured femur and extensive skin damage?

A) Ninety-ninety

B) Buck's

C) Bryant

D) Russell

Review Information: The correct answer is:

A) Ninety-ninety.

Ninety degree-ninety degree traction is used for fractures of the femur or tibia. A skeletal pin or wire is surgically placed through the distal part of the femur, while the lower part of the extremity is in a boot cast. Traction ropes and pulleys are applied.

Ball, J. & Bindler, R. (2000).

Pediatric Nursing: Caring for Children.

Norwalk: Appleton & Lange.

Wong, D. (1999).

Whaley & Wong''s Nursing Care of Infants and Children..

St. Louis: Mosby.

Question 16

Hospital staff requests that the parents of a hospitalized Greek infant remove the amulet from around the child's neck, yet the parents refuse. The nurse understands that the parents may be concerned about

A) Fallen fontanel

B) Evil eye

C) Evil

D) Fright

Review Information: The correct answer is:

B) Evil eye.

Matiasma, "BAD eye or evil eye " results from the envy or admiration of others. While the eye is able to harm a wide variety of things including inanimate objects, children are particularly susceptible to attack.

Greeks employ a variety of preventive mechanisms to thwart the effects of envy, including protective charms in the form of amulets consisting of blessed wood or incense.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Question 17

The nurse is caring for a client with a T-tube following a cholecystectomy, one-day postoperatively. The nurse would EXPECT which the following color of drainage from the client's T-tube

A) Brown

B) Yellow

C) Green

D) Orange

Review Information: The correct answer is:

C) Green.

Bile, which is green, is the expected drainage from a T-tube.

Nettina, S. (1996).

Lippincott''s Pocket Manual of Nursing Practice.

New York: Lippincott Raven Publishers.

Hirsch, J., McFarland, G., & Thompson, J. (1997).

Mosby's Clinical Nursing. (4th ed.).

St. Louis: Mosby-YearBook.

Question 18

Which of the following management styles BEST demonstrates the end of the continuum of management behaviors referred to by Douglas McGregor as theory Y

A) The manager is responsible for motivating employees toward organizational goals because employees are passive about organizational needs and are more focused on personal needs

B) The manager assumes employees are self-motivated and want to work toward organizational and personal goals

C) The manager takes a hands-off attitude and makes no decisions for employees

D) The manager organizes teams of staff and gives compensation to team rather than individual success

Review Information: The correct answer is:

B) The manager assumes employees are self-motivated and want to work toward organizational and personal goals.

McGregor''s theory placed management behaviors on a continuum, with Y being a set of propositions that describes managers as supporting people who naturally work for organizational and personal goals.

Marquis, B. & Huston, C. (1996).

Leadership Roles and Management Functions in Nursing.

Philadelphia: Lippincott.

Yoder Wise, P. (1995).

Leading and Managing in Nursing.

St. Louis: Mosby.

Question 19

The nurse is caring for several 70-80 year-old clients on bed rest. What is the MOST important measure to prevent skin breakdown?

A) Massage legs frequently

B) Frequent turning

C) Moisten skin with lotions

D) Apply moist heat to reddened areas

Review Information: The correct answer is:

B) Frequent turning.

Frequent turning will prevent skin breakdown.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 20

The nurse is caring for a client with a chest tube. The nurse knows that this client MUST have what type of dressing?

A) Transparent

B) Occlusive

C) Debriding

D) Non-adhesive

Review Information: The correct answer is:

B) Occlusive.

An occlusive dressing is necessary to prevent air from entering the thorax.

Nettina, S. (1996).

Lippincott''s Pocket Manual of Nursing Practice.

New York: Lippincott Raven Publishers.

Hirsch, J., McFarland, G., & Thompson, J. (1997).

Mosby's Clinical Nursing. (4th ed.).

St. Louis: Mosby-YearBook.

Question 21

A client calls the nurse with a complaint of sudden deep throbbing leg pain. What is the appropriate FIRST action by the nurse?

A) Suggest isometric exercises

B) Maintain the client on bed rest

C) Ambulate for several minutes

D) Apply ice to the extremity

Review Information: The correct answer is:

B) Maintain the client on bed rest.

The symptom suggests deep vein thrombosis. The client must be maintained on bed rest and the physician notified immediately.

Potter, P. & Perry, A. (2000).

Fundamentals of Nursing: Concepts, Process and Practice.

St. Louis: Mosby.

Thompson, J., McFarland, G., Hirsch, J., & Tucker, S. (1993).

Mosby''s Clinical Nursing. (3rd ed.).

St. Louis: Mosby.

Question 22

The nurse is caring for a client with a pneumothorax. The nurse expects the client to have a chest tube inserted because

A) It will drain the purulent drainage from the empyema that caused it

B) It is the appropriate post-operative treatment for a pneumothorax

C) It will increase the intrathoracic pressure, restoring it back to normal

D) It will drain air out of the thorax, restoring normal intrathoracic pressure

Review Information: The correct answer is:

D) It will drain air out of the thorax, restoring normal intrathoracic pressure.

With a pneumothorax, which is not the result of a surgical procedure, normal intrathoracic pressure increases as a result of the opening in the thorax which allows outside air to rush in and "collapse" the lung; therefore, draining the air out of the thoracic cage reduces that increased intrathoracic pressure and restores it to normal - essentially re-inflating the collapsed lung.

Nettina, S. (1996).

Lippincott''s Pocket Manual of Nursing Practice.

New York: Lippincott Raven Publishers.

Hirsch, J., McFarland, G., & Thompson, J. (1997).

Mosby's Clinical Nursing. (4th ed.).

St. Louis: Mosby-YearBook.

Question 23

While conducting the initial physical assessment on a client who is a Vietnamese immigrant, the nurse notices small, circular, ecchymotic areas on the client's knees. The BEST action for the nurse to take is to

A) Ask the client for more information about the nature of the bruises

B) Report the bruising to the physician

C) Report the bruising to the head nurse

D) Document the information

Review Information: The correct answer is:

A) Ask the client for more information about the nature of the bruises.

"Cupping" is practiced by Vietnamese. The principle is to create a vacuum inside a special cup by igniting alcohol-soaked cotton inside the cup. When the flame extinguishes, the cup is immediately applied to the skin of the painful site. The belief: the suction exudes the noxious element. The greater the bruise, the greater the seriousness of the illness.

Andrews, M. & Boyle, J. (1998).

Transcultural Concepts in Nursing Care.

Philadelphia: J.B. Lippincott.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Question 24

After successful alcohol detoxification, a client remarked to a friend, "I've tried to stop drinking but I just can't, I can't even work without having a drink." The client's belief that he needs alcohol indicates his dependence is primarily

A) Psychological

B) Physical

C) Biological

D) Social-cultural

Review Information: The correct answer is:

A) Psychological.

With psychological dependence, it is the client 's thoughts and attitude toward alcohol that produces craving and compulsive use.

Haber, J., Krainovich-Miller,B., McMahon, A. & Price-Hoskins, P. (1997).

Comprehensive Psychiatric Nursing.

St. Louis: Mosby.

Varcarolis, E. (1998).

Foundations of Psychiatric Mental Health Nursing.

Philadelphia: W.B. Saunders.

Question 25

A client admits to benzodiazepine dependence for several years. She is now in an outpatient detoxification program. The nurse must understand that a PRIORITY during withdrawal is

A) Avoid alcohol use during this time

B) Observe the client for hypotension

C) Abrupt discontinuation of the drug

D) Assess for mild physical symptoms

Review Information: The correct answer is:

A) Avoid alcohol use during this time.

Central nervous system depressants interact with alcohol. The client will gradually reduce the dosage, under the physician''s direction. During this time, alcohol must be avoided.

Weiner, S. (1992).

Perinatal Impact of Substance Abuse. March of Dimes Continuing Education Module # 3.

White Plains: March of Dimes.

McKay, S. & Scavnicky-Mylant, M. (1991).

Substance Abuse During Childbearing Years.

In Bennett, E. & Woolf, D.Substance Abuse. (2nd ed.).

St. Louis: Mosby.

Question 26

The nurse assesses a newborn whose Apgar score was 8 and 9. The MOST common reason for this score is

A) Heart rate

B) Muscle tone

C) Cry

D) Color

Review Information: The correct answer is:

D) Color.

Acrocyanosis (blue hands and feet) is the most common Apgar score deduction, and is a normal adaptation in the newborn.

Babcock, I., Lowdermilk, D., and Jensen, M. (1995).

Maternity Nursing.

St. Louis: Mosby.

Wong, D. and Perry, S. (1998).

Maternal Child Nursing Care.

St. Louis: Mosby.

Question 27

A nurse has asked a second staff nurse to sign for a wasted narcotic, which was not witnessed by another person. This seems to be a recent pattern of behavior. What is the appropriate INITIAL action?

A) Report this immediately to the nurse manager

B) Confront the nurse of suspected drug use

C) Sign the narcotic sheet but document the incident

D) Counsel the colleague about the risky behaviors

Review Information: The correct answer is:

A) Report this immediately to the nurse manager.

The incident must be reported to the appropriate supervisor, for both ethical and legal reasons. This is not an incident that a co-worker can resolve without referring to a manager.

Potter, P. & Perry, A. (2000).

Fundamentals of nursing: Concepts, process and practice.

St. Louis: Mosby.

Hughes, T.& Smith, L (1994).

Is your colleague chemically dependent?

AJN September, pages 31-35.

Question 28

Which of the following should be obtained from a client PRIOR to having electroconvulsive therapy?

A) Jaw x-ray

B) Chest x-ray

C) Pelvic x-ray

D) Spinal x-ray

Review Information: The correct answer is:

D) Spinal x-ray.

Spinal x-rays must be obtained. In addition, blood and urine samples and a signed consent form must also be obtained.

Keltner, N. & Folks, D. (1997).

Psychotropic Drugs.

St. Louis: C.V. Mosby.

Antai-Otong, B. (1995).

Psychiatric Nursing: Biological & Behavioral Concepts.

Philadelphia: W.B. Saunders.

Question 29

During the two-month well-baby visit, the mother complains that formula seems to stick to her baby's mouth and tongue. Which of the following would provide the MOST valuable nursing assessment?

A) Inspect the baby's mouth and throat

B) Obtain cultures of the mucous membranes

C) Flush both sides of the mouth with normal saline

D) Use a soft cloth to attempt to remove the patches

Review Information: The correct answer is:

D) Use a soft cloth to attempt to remove the patches.

Candidiasis can be distinguished from coagulated milk when attempts to remove the patches with a soft cloth are unsuccessful.

Question 30

A client informs you that he does not want to be interrupted for breakfast because it interferes with his meditation time. What is the BEST course of action for the nurse to take?

A) Contact the client's physician

B) Contact the nutritionist

C) Report the behavior to the head nurse

D) Talk with the client to workout how the practice of meditation can be incorporated into the breakfast schedule

Review Information: The correct answer is:

D) Talk with the client to workout how the practice of meditation can be incorporated into the breakfast schedule.

Respect for differences must be incorporated into a client''s plan of care.

Question 31

The nurse will administer liquid medicine to a nine month-old child. Which of the following methods is appropriate?

A) Allow the infant to drink the liquid from a medicine cup

B) Administer the medication with a syringe next to the tongue

C) Mix the medication with the infant's formula in the bottle

D) Hold the child upright and administer the medicine by spoon

Review Information: The correct answer is:

B) Administer the medication with a syringe next to the tongue.

Using a needle-less syringe to give liquid medicine to an infant is often the safest method. If the nurse directs the medicine toward the side or the back of the mouth, gagging will be reduced.

Question 32

A client has just joined an HMO asks for information about the payment obligations with this plan. The MOST accurate description of health care costs is that the client will be charged

A) Only for services provided by specialists

B) A flat rate for each service rendered

C) A pre-determined fee for all services

D) The usual and customary fee for services

Review Information: The correct answer is:

C) A pre-determined fee for all services.

An HMO plan is a plan that provides for all services based on a flat rate. During the specified period of enrollment, all health care services are provided with no additional fees.

Question 33

A nurse aide is taking care of a 2 year-old child with Wilm's tumor. The nurse aide asks the nurse why there is a sign above the bed that says DO NOT PALPATE THE ABDOMEN? The response by the nurse would be

A) "Touching the abdomen could cause cancer cells to spread."

B) "Examining the area would be very painful to the child."

C) "Pushing on the stomach might lead to the spread of infection."

D) "Placing any pressure on the abdomen may cause bleeding."

Review Information: The correct answer is:

A) "Touching the abdomen could cause cancer cells to spread.".

Manipulation of the abdomen can lead to dissemination of cancer cells to nearby and distant areas. Bathing and turning the child should be done carefully.

Question 34

The nurse is caring for a client with a hemopneumothorax. The client has a chest tube. The nurse would EXPECT which of the following color of drainage

A) Red

B) Yellow

C) Clear

D) Brown

Review Information: The correct answer is:

A) Red.

"Hemo" implies a bloody pneumothorax, therefore red drainage.

Question 35

A 65-year-old Hispanic-Latino client with prostate cancer rates his pain as a 6 on a 0-to-10 scale. He refuses all pain medication other than Motrin, which does not relieve his pain. The BEST action for the nurse to take is to

A) Ask the client for more information about why he refuses medication that would lessen his pain

B) Talk with the client's family about the situation

C) Report the situation to the physician

D) Document the situation

Review Information: The correct answer is:

A) Ask the client for more information about why he refuses medication that would lessen his pain.

Beliefs regarding pain are one of the oldest culturally related research areas in health care. Astute observations and careful assessments must be completed to determine the level of pain a person can tolerate. Health-care practitioners must investigate the meaning of pain to each person within a cultural explanatory framework.

Question 36

An HIV+ gay client confides in the nurse that his physician avoids touching him. The nurse recognizes the physician's behavior suggests

A) Prejudice

B) Discrimination

C) Stereotyping

D) Ethnocentrism

Review Information: The correct answer is:

B) Discrimination.

The differential treatment of individuals because they belong to a minority group. Generally refers to the limiting of opportunities, choices, or life experiences because of prejudices about individuals, cultures, or social groups.

Question 37

Which of the following BEST describes strategies that help build personal power in an organization?

A) Use of longevity in an organization with social ties to people in power and a history as someone who does not back down in conflict

B) Use of networking, mentoring, and coalition building to meet goals

C) Use of confrontational style to maintain high visibility and formal power

D) Use of professional dress and demeanor to lend credibility to one's position

Review Information: The correct answer is:

B) Use of networking, mentoring, and coalition building to meet goals.

Networking, mentoring, and coalition building are positive uses of personal power to meet goals.

Question 38

Which of the following describes the use of a decision grid for decision-making?

A) It is both a visual and a quantitative method of decision making

B) It is the fastest way for group decision making

C) It allows the data to be graphed for easy interpretation

D) It is the only truly objective way to make a decision in a group

Review Information: The correct answer is:

A) It is both a visual and a quantitative method of decision making.

A decision grid allows the group to visually examine alternatives and evaluate them quantitatively with weighting.

Question 39

A client refuses to take the medication prescribed for him because he prefers to take his own herbal preparation. What is the FIRST action the nurse should take?

A) Report the behavior to the charge nurse

B) Talk with the client to find out about the preferred herbal preparation

C) Contact the client's physician

D) Explain the importance of the medication to the client

Review Information: The correct answer is:

B) Talk with the client to find out about the preferred herbal preparation.

Respect for differences is demonstrated by incorporating traditional cultural practices for staying healthy into professional prescriptions and interventions. The challenge for the health-care provider is to understand the client''s perspective. "Culture care preservation or maintenance refers to those assistive, supporting, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values to that they can maintain their well-being, recover from illness or face handicaps and/or death".

Question 40

A nurse states that she dislikes caring for African-American clients because "they're all so hostile." The nurse's statement is an example of

A) Prejudice

B) Discrimination

C) Stereotyping

D) Racism

Review Information: The correct answer is:

C) Stereotyping.

Stereotyping refers to placing people and institutions, mentally or by attitudes, into a narrow, fixed trait, rigid pattern, or within inflexible "boxlike" characteristics. Stereotyping is one of the most common concerns of nurses when they begin to study different cultures and learn about transcultural nursing.

Question 1

A client is admitted for a possible pacemaker insertion. The nurse must know that the sinoatrial (SA) node, known as the heart's pacemaker, has an intrinsic rate of

A) 30-50 beats/minute

B) 60-100 beats/minute

C) 20-60 beats/minute

D) 90-100 beats/minute

Review Information: The correct answer is:

B) 60-100 beats/minute.

The intrinsic rate of the SA node is within the range of 60-100 beats per minute.

Question 2

A client is admitted with the diagnosis of testicular cancer. Which of the following factors in the client's history would be associated with the disease?

A) Seminal vesiculitis

B) Undescended testis

C) Epididymitis

D) Sexual relations at an early age

Review Information: The correct answer is:

B) Undescended testis.

A history of undescended testis or cryptorchidism is a known risk factor.

Question 3

A 66 year-old client is admitted for mitral valve replacement surgery. The client has a history of mitral valve regurgitation and mitral stenosis since her teenage years. During the admission assessment, the nurse should ask the client if as a child she had

A) Measles

B) Rheumatic fever

C) Hay fever

D) Encephalitis

Review Information: The correct answer is:

B) Rheumatic fever.

Clients that present with mitral stenosis have a history of rheumatic fever or bacterial endocarditis.

Question 4

Which of the following statements made by a client indicates a need for ADDITIONAL assessment of the impact of body-image alteration following mastectomy?

A) "It really isn't much of a problem for me, I never had large breasts anyway."

B) "I plan to volunteer to work with others who have had mastectomies in Reach for Recovery."

C) "I guess it's time for me to quit wearing a bikini at my age anyway."

D) "I can't bear to look at myself in the mirror. What will my husband think?"

Review Information: The correct answer is:

D) "I can''t bear to look at myself in the mirror. What will my husband think?".

Recognizing the client''s anxiety and helping her identify the anxiety and assault to self image by describing feelings will improve anxiety level.

Question 5

A client is admitted with a diagnosis of nodal bigeminy. The nurse knows that the atrioventricular (AV) node has an intrinsic rate of

A) 60-100 beats/minute

B) 10-30 beats/minute

C) 40-70 beats/minute

D) 20-50 beats/minute

Review Information: The correct answer is:

C) 40-70 beats/minute.

The intrinsic rate of the AV node is within the range of 40-70 beats per minute.

Question 6

A client is admitted with the diagnosis of Myocardial Infarction. Which of the following lab values would be consistent with this diagnosis

A) Low serum albumin

B) High serum cholesterol

C) Abnormally low white blood cell count

D) Elevated CPK (creatinine phosphokinase)

Review Information: The correct answer is:

D) Elevated CPK (creatinine phosphokinase).

An elevated CPK is a common finding in the client with an MI. An elevated CPK can also be seen when other muscle injury occurs. In the client with an MI, the CPK Isoenzymes is further examined for CPK-MB's. These are specific to myocardial damage and rise in response to an MI.

Question 7

A client in respiratory distress is admitted with arterial blood gas results of: PH 7.30; PO2 58, PCO 34; and HCO3 19. The nurse determines that the client is in

A) Metabolic acidosis

B) Metabolic alkalosis

C) Respiratory acidosis

D) Respiratory alkalosis

Review Information: The correct answer is:

A) Metabolic acidosis.

These lab values indicate metabolic acidosis; The PH is low, PCO2 normal; and bicarbonate level is low.

Question 8

A client is admitted with a distended bladder due to the inability to void. The nurse obtains an order to catheterize the client knowing that gradual emptying is preferred over complete emptying because it

A) Reduces the potential for renal collapse

B) Reduces the potential for shock

C) Reduces the intensity of bladder spasms

D) Prevents bladder atrophy

Review Information: The correct answer is:

B) Reduces the potential for shock.

Complete, rapid emptying can cause shock and hypotension due to sudden changes in the abdominal cavity.

Question 9

A client has bilateral knee pain from osteoarthritis. In addition to taking the prescribed NSAID, the nurse should instruct the client to

A) Start a regular exercise program

B) Rest the knees as much as possible to decrease inflammation

C) Avoid foods high in citrus acid

D) Keep legs elevated when sitting

Review Information: The correct answer is:

A) Start a regular exercise program.

A regular exercise program is beneficial in treating osteoarthritis. It can restore self-esteem and improve physical functioning.

Question 10

You are caring for a client with deep vein thrombosis who is on heparin IV. The latest APTT is 50. If the laboratory normal range is 16-24 seconds, you would anticipate

A) Maintaining the current heparin dose

B) Increasing the heparin as it does not appear therapeutic.

C) Giving protamine sulfate as an antidote.

D) Repeating the blood test one hour after giving heparin.

Review Information: The correct answer is:

A) Maintaining the current heparin dose.

The range for a therapeutic APTT is 1.5-2 times the control. Therefore the client is receiving a therapeutic dose of heparin.

Question 11

The nurse is teaching a client about the healthy use of ego defense mechanisms. An appropriate goal for this client would be

A) Reduce fear and protect self-esteem

B) Eliminate anxiety and apprehension

C) Avoid conflict and unpleasant consequences

D) Foster independence and communicate better

Review Information: The correct answer is:

A) Reduce fear and protect self-esteem.

Ego defense mechanisms are unconscious proactive barriers that are used to manage instinct and affect the presence of stressful situations. Healthy reactions are those in which the client admits that they are feeling various emotions.

Question 12

All nurses are licensed to practice by their

A) Local board of nursing

B) State governmental agency

C) Federal governmental agency

D) Federal nursing association

Review Information: The correct answer is:

B) State governmental agency.

Only the state governmental agency licenses nurses.

Question 13

Clients with mitral stenosis would likely manifest symptoms associated with congestion in the

A) Pulmonary circulation

B) Descending aorta

C) Superior vena cava

D) Bundle of His

Review Information: The correct answer is:

A) Pulmonary circulation.

Congestion occurs in the pulmonary circulation due to the inefficient emptying of the left ventricle and the lack of a competent valve to prevent back flow into the pulmonary vein.

Question 14

Postoperative orders for a client undergoing a mitral valve replacement include monitoring pulmonary artery pressure together with pulmonary capillary wedge pressure with a pulmonary artery catheter. This action by the nurse will assess

A) Right ventricular pressure

B) Left ventricular end-diastolic pressure

C) Acid-Base balance

D) Coronary artery stability

Review Information: The correct answer is:

B) Left ventricular end-diastolic pressure.

The pulmonary capillary wedge pressure is reflective of left ventricular end-diastolic pressure. Pulmonary artery pressures are an assessment tool used to determine the ability of the heart to receive and pump blood effectively.

Question 15

Following mitral valve replacement surgery a client develops PVC's. The physician orders a bolus of Lidocaine followed by a continuous Lidocaine infusion at a rate of 2 mgm/minute. The IV solution contains 2 grams of Lidocaine in 500 cc's of D5W. The infusion pump delivers 60 microdrops/cc. What rate would deliver 4 mgm of Lidocaine/minute?

A) 60 microdrops/minute

B) 20 microdrops/minute

C) 30 microdrops/minute

D) 40 microdrops/minute

Review Information: The correct answer is:

A) 60 microdrops/minute.

2 gm=2000 mgm

2000 mgm/500 cc = 4 mgm/x cc

2000x = 2000

x= 2000/2000 = 1 cc of IV solution/minute

CC x 60 microdrops = 60 microdrops/minute

Question 16

A client is admitted for hemodialysis. Which abnormal lab value would the nurse anticipate not being improved by hemodialysis?

A) Low hemoglobin

B) Hypernatremia

C) High serum creatinine

D) Hyperkalemia

Review Information: The correct answer is:

A) Low hemoglobin.

Although hemodialysis improves or corrects electrolyte imbalances it has not effect on improving anemia.

Question 17

An elderly client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. The nurse suggests a spacer to

A) Decrease the time it takes for the administration of the medication

B) Increase client compliance

C) Improve the aerosol delivery from the MDI in clients who can't coordinate the MDI

D) Prevent exacerbation of COPD

Review Information: The correct answer is:

C) Improve the aerosol delivery from the MDI in clients who can''t coordinate the MDI.

Inhalers improve the medication delivery in clients who are unable to coordinate the MDI.

Question 18

Which one of the following tasks, if delegated by the new charge nurse to a nursing assistant, would require intervention by the nurse manager?

A) Helping an elderly client to the bathroom.

B) Emptying a foley catheter bag.

C) Bathing a woman with internal radon seeds.

D) Feeding a two year-old with a broken arm.

Review Information: The correct answer is:

C) Bathing a woman with internal radon seeds..

A client with internal radiation is complex and not suitable for care by a nursing assistant. Additionally, the client would not receive a complete bath because of the radiation risks.

Question 19

A client is scheduled for a Percutaneous Transluminal Coronary Angioplasty (PTCA). The nurse knows that a PTCA is the

A) Surgical repair of a diseased coronary artery

B) Placement of an automatic internal cardiac defibrillator

C) Procedure that compresses plaque against the wall of the diseased coronary artery to improve blood flow

D) Non-invasive radiographic examination of the heart

Review Information: The correct answer is:

C) Procedure that compresses plaque against the wall of the diseased coronary artery to improve blood flow.

PTCA is performed to improve coronary artery blood flow in a diseased artery. It is performed during a cardiac catheterization. Aorta Coronary Bypass Graft is the surgical procedure to repair a diseased coronary artery.

Question 20

Privacy and confidentiality of all client information is legally protected. In which of the following situations would the nurse make an exception to this practice?

A) When a family member offers information about their loved one

B) When the client threatens self-harm and harm to others

C) When the nurse decides that the family has a right to know the client's diagnosis

D) When a visitor insists that he has been given permission by the client

Review Information: The correct answer is:

B) When the client threatens self-harm and harm to others.

Privacy and confidentiality of all client information is protected with the exception of the client who threatens self harm or endangering the public.

Question 21

A client is diagnosed with gastroesophageal reflux disease (GERD). The nurse's instruction to the client regarding diet should be to

A) Avoid all raw fruit and vegetables

B) Increase intake of milk products

C) Decrease intake of fatty foods

D) Focus on three average size meals a day

Review Information: The correct answer is:

C) Decrease intake of fatty foods.

GERD may be aggravated by a fatty diet. A diet low in fat would decrease the symptoms of GERD. Otheragents which should also be decreased are: cigarette smoking, caffeine, alcohol, chocolate, and meriperidine (Demerol).

Question 22

A client is admitted with a diagnosis of Myocardial Infarction (MI). The client is complaining of chest pain. The nurse knows that pain related to an MI is due to

A) Insufficient oxygenation of the cardiac muscle

B) Potential circulatory overload

C) Left ventricular overload

D) Electrolyte imbalance

Review Information: The correct answer is:

A) Insufficient oxygenation of the cardiac muscle.

Due to ischemia to the heart muscle, the client experiences pain. This happens because an MI can block or interfere with the normal cardiac circulation.

Question 23

In a client with mitral regurgitation the nurse would expect to see which of the following signs and symptoms?

A) Low red blood cell count

B) Exertional dyspnea

C) Crushing chest pain

D) Elevated white blood cell count

Review Information: The correct answer is:

B) Exertional dyspnea.

Fluid retention and diminished heart function cause exterional dyspnea in clients with mitral regurgitation as heart failure worsens. This is due to a rise in left atrial pressure and subsequent pulmonary and venous congestion.

Question 24

A client diagnosed with depression is scheduled for electroconvulsive therapy treatments (ECT). One hour before the first treatment is scheduled, he becomes anxious and states he does not wish to go through with ECT. Which of the following is the nurse's MOST appropriate response?

A) "I'll go with you and will be there with you during the treatment."

B) "You'll be asleep and won't remember anything."

C) "You have the right to change your mind. You seem anxious about the treatment. Can we talk about it?"

D) "I'll call the doctor and let him know that you have changed your mind about the treatment."

Review Information: The correct answer is:

C) "You have the right to change your mind. You seem anxious about the treatment. Can we talk about it?".

This response indicates acknowledgment of the client's rights and the opportunity for the client to clarify and ventilate concerns.

Question 25

A 19 year-old client is paralyzed in a car accident. Which of the following statements used by the client would indicate to the nurse that the client was using the mechanism "suppression"?

A) "I don't remember anything about what happened to me."

B) "I'd rather not talk about it right now."

C) "It's all his fault! He was going 90 miles an hour on the freeway."

D) "My mother is heartbroken about this."

Review Information: The correct answer is:

A) "I don''t remember anything about what happened to me.".

Suppression is willfully putting an unacceptable thought or feeling out of one's mind. A deliberate exclusion "voluntary forgetting" is generally used to protect one's own self esteem.

Question 26

A 74 year-old male is admitted due to inability to void. He has a history of an enlarged prostate and has not voided in 14 hours. When assessing for bladder distention, the BEST method for the nurse to use is to assess for

A) Rebound tenderness

B) Left lower quadrant dullness

C) Rounded swelling above the pubis

D) Urinary discharge

Review Information: The correct answer is:

C) Rounded swelling above the pubis.

Swelling above the pubis is representative of a distended bladder in the male client.

Question 27

During change-of-shift report the tending nurse notes a Catholic client will soon be admitted for the delivery of her ninth child. The tending nurse comments angrily to a colleague, "Doesn't she know there's such a thing as birth control?" The nurse's attitude is an example of

A) Ethnocentrism

B) Discrimination

C) Stereotyping

D) Prejudice

Review Information: The correct answer is:

D) Prejudice.

Prejudice is a hostile attitude toward individuals simply because they belong toa particular group presumed to have objectionable qualities. Prejudice refers to preconceived ideas, beliefs, or opinions about an individual, group, or culture that limit a full and accurate understanding of the individual, culture, gender, race, event, or situation.

Question 28

A client with testicular cancer has had an orchiectomy. Prior to discharge the client expresses his fears related to his prognosis. The nurse should base the response on the knowledge that

A) Testicular cancer has a cure rate of 90% with early diagnosis

B) Testicular cancer has a cure rate of 50% with early diagnosis

C) Intensive chemotherapy is the treatment of choice

D) Testicular cancer is usually fatal

Review Information: The correct answer is:

A) Testicular cancer has a cure rate of 90% with early diagnosis.

With aggressive treatment and early detection/diagnosis the cure rate is 90%.

Question 29

Which of the following classifications of medications would be MOST often used for clients with schizophrenia?

A) Anti-depressants

B) Mood stabilizers

C) Anxiolytics

D) Neuroleptics

Review Information: The correct answer is:

D) Neuroleptics.

Neuroleptics are antipsychotic drugs which are most beneficial in treating the signs and symptoms of schizophrenia; any of the other meds might also be used, but neuroleptics are the most widely used.

Question 30

During urinary catheterization in the male client it is important to lubricate the tip of the catheter prior to insertion to

A) Reduce friction within the urethra

B) Prevent bladder distention

C) Prevent infection

D) Reduce leakage of urine around the catheter

Review Information: The correct answer is:

A) Reduce friction within the urethra.

Lubrication reduces friction and eases insertion. Due to the tortuous nature of the male urethra lubrication also reduces potential trauma.

Question 31

If a nurse is uncertain about whether he or she is licensed to perform certain tasks, it is BEST to check

A) The state nurse practice act

B) With a nursing colleague

C) With the employer

D) The ANA certificate

Review Information: The correct answer is:

A) The state nurse practice act.

The state nurse practice act is the governing document.

Question 32

The nurse is teaching a client with dysrhythmia about the electrical pathway of an impulse as it travels through the heart. The nurse knows that the normal pathway is

A) AV node, SA node, Bundle of His, Purkinje fibers

B) Purkinje fibers, SA node, AV node, Bundle of His

C) Bundle of His, Purkinje fibers, SA node , AV node

D) SA node, AV node, Bundle of His, Purkinje fibers

Review Information: The correct answer is:

D) SA node, AV node, Bundle of His, Purkinje fibers.

The pathway of a normal electrical impulse through the heart is: SA node, AV node, Bundle of His, Purkinje fibers.

Question 33

Which one of the following statements, if made by the client, indicates teaching about Inderal (propranolol) has been effective. "I should not stop taking the Inderal suddenly because it may cause

A) seizures."

B) decreased blood pressure."

C) nervousness."

D) a heart attack."

Review Information: The correct answer is:

D) a heart attack."

Discontinuing beta blockers suddenly can cause angina, hypertension, dysrhythmias, or an MI.

Question 34

A client with testicular cancer is scheduled for a right orchiectomy. The nurse knows that an orchiectomy is the

A) Surgical removal of the entire scrotum

B) Surgical removal of a testicle

C) Dissection of related lymph nodes

D) Partial surgical removal of the penis

Review Information: The correct answer is:

B) Surgical removal of a testicle.

The affected testicle is surgically removed along with its tunica and spermatic cord.

Question 35

A client has received her first dose of fluphenazine (Prolixin) 2 hours ago. She suddenly experiences torticollis and involuntary spastic muscle movement. In addition to administering the ordered anticholinergic drug, the nurse should:

A) Have respiratory support equipment available

B) Immediately place her in the seclusion room

C) Assess the client for anxiety and agitation

D) Administer prn dose of I.m. antipsychotic medication

Review Information: The correct answer is:

A) Have respiratory support equipment available.

Persons receiving neuroleptic medication experiencing torticollis and involuntary muscle movement are demonstrating side effects that could lead to respiratory failure.

Question 36

An 82 year-old client complains of chronic constipation. To improve bowel function, the nurse should FIRST suggest

A) Increasing fiber intake to 20-30 grams daily

B) Daily use of laxatives

C) Avoidance of binding foods such as cheese and chocolate

D) Monitoring a balance between activity and rest

Review Information: The correct answer is:

A) Increasing fiber intake to 20-30 grams daily.

The incorporation of high fiber into the diet is an effective way to promote bowel elimination in the elderly.

Question 37

The nurse is teaching a client with cardiac disease about the anatomy and physiology of the heart. The nurse identifies the pathway of blood flow through the heart as

A) Right ventricle, left ventricle, right atrium, left atrium

B) Left ventricle, right ventricle, left atrium, right atrium

C) Right atrium, right ventricle, left atrium, left ventricle

D) Right atrium, left atrium, right ventricle, left ventricle

Review Information: The correct answer is:

C) Right atrium, right ventricle, left atrium, left ventricle.

The pathway of blood flow through the heart is right atrium, right ventricle, left atrium, left ventricle.

Question 38

The nurse is performing a cardiac assessment on a client. The nurse knows that the correct order of blood flow through the valves of the heart is

A) Tricuspid, pulmonary, mitral, aortic

B) Aortic, mitral, tricuspid, pulmonary

C) Pulmonary, aortic, mitral, tricuspid

D) Mitral, pulmonary, tricuspid, aortic

Review Information: The correct answer is:

A) Tricuspid, pulmonary, mitral, aortic.

The correct pathway of blood flow through the valves of the heart is: tricuspid, pulmonary, mitral, aortic.

Question 39

A 67 year-old client is admitted with substernal chest pain with radiation to the jaw. His admitting diagnosis is Acute Myocardial Infraction (MI). The PRIORITY nursing diagnosis for this client during the immediate 24 hours is

A) Constipation related to immobility

B) High risk for infection

C) Impaired gas exchange

D) Fluid volume deficit

Review Information: The correct answer is:

C) Impaired gas exchange.

In the immediate post MI period impaired gas exchange related to oxygen supply and demand is a major problem.

Question 40

A confused client has been placed in physical restraints by order of the physician. Which one of the following tasks could be assigned to an unlicensed Assistive Personnel (UAP)?

A) Assist with activities of daily living

B) Evaluate the clients safety

C) Assess basic comfort needs

D) Document mental status

Review Information: The correct answer is:

A) Assist with activities of daily living.

The person to whom the activity is delegated must be capable of performing it . The UAP is capable of assisting clients with basic needs.

Black, J., Hawks, J., & Keene, A. (2001).

Medical-surgical nursing: Clinical management for positive outcomes.

Philadelphia: W.B. Saunders., p. 1921

Shea, C., Pelletier, L., Poster, E., Stuart, G.& Verhey, M. (1999).

Advanced practice nursing in psychiatric and mental health care.

St. Louis: Mosby. p. 176

Question 1

In discharge teaching, the nurse should emphasize that which of the following is a common side effect of clozapine (Clozaril) therapy?

A) Dry mouth

B) Rhinitis

C) Dry skin

D) Extreme salivation

Review Information: The correct answer is:

D) Extreme salivation.

A significant number of clients receiving Clozapine (Clozaril) therapy experience extreme salivation.

Townsend, M. (2000).

Psychiatric Mental Health Nursing: Concepts of Care.

Philadelphia: F.A. Davis Co.

Physician's Desk Reference (2001).

Montvale, N.J.: Medical Economics.

Question 2

The nurse is instructing a 65 year-old female client diagnosed with osteoporosis. The MOST important instruction regarding exercise would be to

A) Exercise doing weight bearing activities

B) Exercise to reduce weight

C) Avoid exercise activities that increase the risk of fracture

D) Exercise to strengthen muscles and thereby protect bones

Review Information: The correct answer is:

A) Exercise doing weight bearing activities.

Weight bearing exercises are beneficial in the treatment of osteoporosis. Although loss of bone cannot be substantially reversed, further loss can be greatly reduced if the client includes weight bearing exercises along with estrogen replacement and calcium supplements in their treatment protocol.

Kessenich, C. (1997).

Obtaining a Diagnosis of Postmenopausal Osteoporosis.

Primary Care Practice, 2, 474-484.

Kessenich, C. (1996).

Osteoporosis Cycle.

Advance for Nurse Practitioners,17-26.

Question 3

A post-operative client is admitted to the post-anesthesia recovery room. The anesthetist reports that malignant hyperthermia occurred during surgery. You recognize that this complication is related to:

A) Allergy to general anesthesia

B) Pre-existing bacterial infection

C) A genetic predisposition

D) Selected surgical procedures

Review Information: The correct answer is:

C) A genetic predisposition.

Malignant hyperthermia is a rare, potentially fatal adverse reaction to inhaled anesthetics. There is a genetic predisposition to this disorder.

Question 4

A client confides in the RN that a friend has told her the medication she takes for depression, Wellbutrin, was taken off the market because it caused seizures. An appropriate response would be to tell the client

A) Ask your friend about the source of this information.

B) Omit the next doses until you talk with the doctor.

C) There were problems, but the recommended dose is changed.

D) Your physician knows the best drug for your condition.

Review Information: The correct answer is:

C) There were problems, but the recommended dose is changed..

Wellbutrin was introduced in the U.S. in 1985 and then withdrawn because of the occurrence of seizures in some patients taking the drug. The drug was reintroduced in 1989 with specific recommendations regarding dose ranges to limit the occurrence of seizures. The risk of seizure appears to be strongly associated with dose.

Kaplan, H., & Sadock, B. (1996).

Pocket Handbook of Psychiatric Drug Treatment.

Baltimore, Maryland: Williams and Wilkins. P. 63

America Online Rx List Monographs, (2001) Bupropion, p. 1

Question 5

A newly admitted client has a diagnosis of depression. She complains of "twitching muscles"and a "racing heart", and states she stopped taking Zoloft a few days ago because it was not helping her depression. Instead, she began to take her husband's Parnate. The nurse should immediately assess for:

A) Pulmonary edema

B) Atrial fibrillation

C) Mental status changes

D) Muscle weakness

Review Information: The correct answer is:

C) Mental status changes.

Use of serotonergic agents may result in Serotonin Syndrome with confusion, nausea, palpitations, increased muscle tone with twitchingmuscles, and agitation. Serotonin syndrome is most often reported in patients taking two or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, SSRIs, and the tricyclic antidepressants.

Bezchlibnyk-Butler, K., & Jeffries, J. (2000).

Clinical Handbook of Psychotropic Drugs.

Toronto, Canada: Hoegrefe & Huber

Nolan, & Scoggin, J. (2001)

U.S. Pharmacist, Vol. 23:2, pp. 1-9.

Question 6

You are caring for a client with a diagnosis of schizophrenia who has been treated with Quetiapine (Seroquel) for one month. Today the client is increasingly agitated and complains of muscle stiffness. Critical assessments to report are:

A) Elevated temperature and sweating.

B) Decreased pulse and blood pressure.

C) Mental confusion and general weakness.

D) Muscle spasms and seizures.

Review Information: The correct answer is:

A) Elevated temperature and sweating..

Neuroleptic malignant syndrome (NMS) is a rare disorder characterized by muscular rigidity, tachycardia, hyperthermia, sweating, altered consciousness, autonomic dysfunction, and increase in CPK. This is a life-threatening complication that can occur anytime during the course of antipsychotic treatment.

Bezchlibnyk-Butler, K., & Jeffries, J. (2000).

Clinical Handbook of Psychotropic Drugs.

Toronto, Canada: Hoegrefe & Huber.

Kaplan, H., & Sadock, B. (1996).

Pocket Handbook of Psychiatric Drug Treatment.

Baltimore, Maryland: Williams and Wilkins.

Question 7

A 55 year-old woman is taking Prednisone and Aspirin as part of her treatment for rheumatoid arthritis. Which one of the following would be an appropriate intervention for the nurse?

A) Assess the pulse rate q 4 hours.

B) Monitor her level of consciousness q shift.

C) Test her stools for occult blood.

D) Discuss fiber in the diet to prevent constipation.

Review Information: The correct answer is:

C) Test her stools for occult blood..

Both Prednisone and ASA can lead to GI bleeding, therefore monitoring for bleeding would be appropriate.

LeMone, P. & Burke, K. (2000)

Medical-Surgical Nursing Critical Thinking in Client Care (2nd ed.).

Upper Saddle River, NJ: Prentice Hall

Beare, P. & Myers, J. (1998)

Adult Health Nursing (3rd ed.).

St. Louis: Mosby.

Question 8

A nurse has been named in a lawsuit. The BEST evidence a nurse can use to protect herself in a court of law is

A) Clinical certification in a nursing specialty

B) Documentation of nursing actions on client record

C) Proficiency reports prepared by nurse manager

D) Verification of physician's orders for plan of care

Review Information: The correct answer is:

B) Documentation of nursing actions on client record.

Documentation is the key to protecting yourself if a lawsuit is filed; include all pertinent data with times, dosages and sites of your actions, patient assessment data, your response to change in condition, specific actions you took, if and when you notified the physician or other health care team members, and what their responses were.

Skidmore-Roth, Linda.(2001)

Mosby''s Nursing Drug Reference 2002.

Mosby-Year Book, St. Louis, MO. 1998. Page 357-358..

Springhouse. Illustrated Handbook of Nursing Care.

Springhouse Corporation. Springhouse, PA. Page 23.

Question 9

A client is scheduled for an intravenous pylogram (IVP). After the contrast material is injected, which of the following client reactions should be reported immediately?

A) Feeling warm

B) Face flushing

C) Salty taste

D) Hives

Review Information: The correct answer is:

D) Hives.

This is a sign of anaphylaxis and should be reported immediately. The reactions are considered normal and the client should be informed that they may occur.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical Surgical Nursing: Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby Publishing Co.

Beare, P. & Myers, J. (1998).

Adult Health Nursing. (3rd ed.).

St. Louis: Mosby

Question 10

The nurse is caring for a client with a new order for Bupropion (Wellbutrin) for treatment of depression. The physician's order reads "175 mg. BID x 4 days". What is the appropriate action?

A) Give the medication as ordered.

B) Question this medication dose.

C) Observe the client for mood swings.

D) Monitor neuro signs frequently.

Answers Correct B

Student's B

Review Information: The correct answer is:

B) Question this medication dose..

Bupropion (Wellbutrin) should be administered in doses of no more than 150 mg and should be given at least 4 hours apart, because of the risk of seizures.

Kaplan, H., & Sadock, B. (1996).

Pocket Handbook of Psychiatric Drug Treatment.

Baltimore, Maryland: Williams and Wilkins. P. 63

Townsend, M. (2000).

Psychiatric Mental Health Nursing: Concepts of Care.

Philadelphia: F.A. Davis Co. p. 264

Question 11

The nurse is caring for a client with abruptio placenta. Which of the following nursing interventions would be MOST beneficial to the fetus?

A) Administer oxygen

B) Ambulate client

C) Turn client every 1/2 hour

D) Give pain medication

Review Information: The correct answer is:

A) Administer oxygen.

Administering oxygen in this situation would increase the circulating oxygen in the mother's circulation to the fetus's circulation.

Ladewig, P., London, M. & Olds, S. (1998).

Maternal-Newborn Nursing Care.

Menlo park, CA; Addison-Wesley.

Sherwen, L. (1995).

Nursing Care of the Childbearing Family.

Norwalk, Connecticut: Appleton & Lang.

Question 12

A 72 year-old client is admitted for possible dehydration. The nurse knows that older adults are particularly at risk for dehydration because they have

A) An increased need for extravascular fluid

B) A decreased sensation of thirst

C) An increased diaphoresis

D) A higher metabolic demands

Review Information: The correct answer is:

B) A decreased sensation of thirst.

The elderly have a reduction in thirst sensation causing them to consume less fluid. Other risk factors may include fear of incontinence, inability to drink fluids independently and lack of motivation.

Weinberg A., Pals J., McGlinchey-Berroth R., Minaker K. (1994).

Indices of Dehydration Among Frail Nursing Home clients: Highly Variable But Stable Over Time.

JAGS 1994;42:1070-1073.

Anderson, S. (1997).

Nephrology/Fluid and Electrolyte Disorders. In Cassell, C., Cohen, H., Larson, E., Meier, D., Resnick, N., Rubenstein, L., and Sorensen. (Eds.)

Geriatric Medicine.

New York: Spring-Verlag.

Question 13

A client has had a positive reaction to PPD. The client asks the nurse what this means. The nurse should indicate that the client

A) Has active tuberculosis

B) Has been exposed to mycobacterium tuberculosis

C) Never had tuberculosis

D) Has never been infected with mycobacterium tuberculosis

Review Information: The correct answer is:

B) Has been exposed to mycobacterium tuberculosis.

The PPD skin test is used to determine the presence of tuberculosis antibodies and a positive result indicates that the person has been exposed to Mycobacterium tuberculosis. Additional tests are needed to determine if active tuberculosis is present.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical Surgical Nursing: Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby Publishing Co.

Beare, P. & Myers, J. (1998).

Adult Health Nursing. (3rd ed.).

St. Louis: Mosby

Question 14

The nurse practicing in a long term care facility recognizes that elderly clients are at greater risk for drug toxicity than younger adults because they:

A) Absorb drugs more readily from the GI tract

B) Have less body water and more fat

C) Have more rapid hepatic metabolism

D) Are often malnourished and anemic

Review Information: The correct answer is:

B) Have less body water and more fat.

Because elderly persons have decreased lean body tissue/water in which to distribute medications, more drug remains in the circulatory system with potential for drug toxicity. Increased body fat results in greater amounts of fat-soluble drugs being absorbed, leaving less in circulation, thus increasing the duration of action of the drug

Question 15

You are providing care for a comatose diabetic on IV insulin therapy. Which task would be most appropriate to delegate to a certified nursing assistant?

A) Assessing the patient's level of consciousness

B) Obtaining regular blood glucose readings

C) Regulating the insulin infusion rate

D) Teaching the wife about plan of care

Review Information: The correct answer is:

B) Obtaining regular blood glucose readings.

A certified nursing assistant can safely obtain blood glucose readings.

Question 16

Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction is ordered oxygen. The nurse knows that the MAJOR reason that oxygen is administered in this situation is to

A) Saturate the red blood cells

B) Relieve dyspnea

C) Decrease cyanosis

D) Increase oxygen level in the myocardium

Review Information: The correct answer is:

D) Increase oxygen level in the myocardium.

Anoxia of the myocardium occurs in myocardial infarction. Oxygen administration will help relieve dyspnea and cyanosis associated with the condition but the major purpose is to increase the oxygen concentration in the damaged myocardium tissue.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical Surgical Nursing: Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby Publishing Co.

Beare, P. & Myers, J. (1998).

Adult Health Nursing. (3rd ed.).

St. Louis: Mosby

Question 17

After surgery, a client with a nasogastric tube complains of nausea. What action would the nurse take?

A) Call the physician

B) Administer an antiemetic

C) Put the bed in Fowler's position

D) Check the patency of the tube

Review Information: The correct answer is:

D) Check the patency of the tube.

An indication that the nasogastric tube is obstructed is a client's complaint of nausea. Nasogastric tubes may become obstructed with mucus or sediment.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical Surgical Nursing: Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby Publishing Co.

Beare, P. & Myers, J. (1998).

Adult Health Nursing. (3rd ed.).

St. Louis: Mosby

Question 18

The charge nurse on the medical-surgical unit makes assignments for the team consisting of one RN, an LPN and a nursing assistant. Which one of the following clients should be assigned to the RN?

A) A 56 year-old with atrial fibrillation receiving digoxin.

B) A 60 year-old client with COPD on oxygen at 1 L/min.

C) A 24 year-old post-op diabetic preparing for discharge.

D) An 80 year-old client recovering from a hip replacement.

Review Information: The correct answer is:

C) A 24 year-old post-op diabetic preparing for discharge..

The RN can not delegate discharge teaching.

Hansten, R. & Washburn, M. (1994).

Clinical Delegation Skills.

Gaithersburg, MD : Aspen.

Yoder-Wise, P. (1999)

Leading and Managing in Nursing,.

St. Louis: Mosby.

Question 19

The nurse is caring for a client with a hip prosthesis one-day post operatively. The nurse should position the client to

A) Prevent internal rotation and abduction of the affected leg

B) Prevent internal rotation and adduction of the affected leg

C) Prevent external rotation and abduction of the affected leg

D) Prevent external rotation and adduction of the affected leg

Review Information: The correct answer is:

B) Prevent internal rotation and adduction of the affected leg.

This position should be prevented in order to prevent dislodgment of the hip prosthesis.

Lewis, S., Collier, I., & Heitkemper, M. (1996).

Medical Surgical Nursing: Assessment and Management of Clinical Problems. (4th ed.).

St. Louis: Mosby Publishing Co.

Beare, P. & Myers, J. (1998).

Adult Health Nursing. (3rd ed.).

St. Louis: Mosby

Question 20

A 70 year-old post-operative client has elevated serum BUN, Hct, Cl, and Na+. Creatinine and K+ are within normal limits. The nurse should perform additional assessments to confirm that an actual problem is:

A) Impaired gas exchange

B) Metabolic acidosis

C) Renal insufficiency

D) Fluid volume deficit

Review Information: The correct answer is:

D) Fluid volume deficit.

In fluid volume deficit, serum BUN, Na+ and hematocrit may be elevated secondary to hemoconcentration.

Question 21

A client with a history of heart disease takes prophylactic aspirin daily. The nurse should monitor which of the following to prevent aspirin toxicity?

A) Serum potassium

B) Protein intake

C) Lactose tolerance

D) Serum albumin

Review Information: The correct answer is:

D) Serum albumin.

When highly protein-bound drugs are administered to patients with low serum albumin (protein) levels, excess free (unbound) drug can cause exaggerated and dangerous effects.

Question 22

The nurse is caring for clients over the age of 70. The nurse knows that due to age-related changes, the elderly clients tolerate diets that are

A) High protein

B) High carbohydrates

C) Low fat

D) High calories

Review Information: The correct answer is:

C) Low fat.

Due to age related changes, the diet of the elderly should reflect a lower quantity and higher quality of food. Fewer carbohydrates and fats are required in their diets.

Ouslander, J., Osterweil, D., and Morley, J. (1998).

Medical Care in the Nursing Home.

Su, E., Hofstein, J., and Koval, K. (1998).

The Role of Nutrition in Care of the Elderly.

Archives of the American Academy of Orthopaedic Surgeons, 2,

Question 23

The nurse is caring for clients over the age of 70. The nurse is aware that when giving medications to older clients, it is BEST to

A) Start low, go slow

B) Avoid stopping a medication entirely

C) Avoid drugs with side effects that impact cognition

D) Review the drug regimen yearly

Review Information: The correct answer is:

A) Start low, go slow.

Due to physiological changes in the elderly, as well as conditions such as dehydration, hyperthermia, immobility and liver disease, the metabolism of drugs may decrease. As a result, drugs can accumulate to toxic levels and cause serious adverse reactions.

Brummel-Smith, K. (1998).

Polypharmacy and the Elderly client.

Archives of the American Academy of Orthopaedic Surgeons, 2, 39-44.

Chuka, D., Evans, J., Fleming, K., and Mikkelson, K. (1995).

Symposium on Geriatrics: Part I: Drug Prescribing for Elderly clients.

Mayo Clinical Process

Question 24

In preparing medications for a client with a gastrostomy tube, the nurse should contact the physician before administering which of the following drugs through the tube?

A) Cardizem SR tablet (diltiazem)

B) Lanoxin liquid

C) Os-cal tablet (calcium carbonate)

D) Tylenol liquid (acetaminophen

Review Information: The correct answer is:

A) Cardizem SR tablet (diltiazem).

Cardizem SR is a "sustained-release" drug form. Sustained release (controlled-release; long-acting) drug formulations are designed to release the drug over an extended period of time. If crushed, as would be

required for gastrostomy tube administration, sustained-release properties and blood levels of the drug will be altered. The physician must substitute another medication.

Question 25

The physician orders an IV aminophyllin infusion at 30 mg/hr. The pharmacy sends a 1,000 ml bag of D5W containing 500 mg of aminophyllin. In order to administer 30 mg per hour, the RN will set the infusion rate at:

A) 20 ml per hour

B) 30 ml per hour

C) 50 ml per hour

D) 60 ml per hour

Review Information: The correct answer is:

D) 60 ml per hour.

Using the ratio method to calculate infusion rate: mg to be given (30) : ml to be infused (X) :: mg available (500) : ml of solution (1,000). Solve for X by cross-multiplying: 30 x 1,000 = 500 x X (or cancel), 30,000 = 500 X, X = 30,000/500, X = 60

Question 26

A client is receiving and IV antibiotic infusion and is scheduled to have blood drawn at 1:00 pm for a"peak" antibiotic level measurement. The nurse notes that the IV infusion is running behind schedule and will not be competed by 1:00. The nurse should:

A) Notify the client's physician

B) Stop the infusion at 1:00 pm

C) Reschedule the laboratory test

D) Increase the infusion rate

Review Information: The correct answer is:

C) Reschedule the laboratory test.

If the antibiotic infusion will not be completed at the time the peak blood level is due to be drawn, the nurse should ask that the blood sampling time be adjusted

Question 27

A client tells the RN she has decided to stop taking Sertaline (Zoloft) because she doesn't like the nightmares, sex dreams and obsessions she's experiencing since starting on the medication. An appropriate response is to caution the client that

A) It is unsafe to abruptly stop taking any prescribed medication.

B) Side effects and benefits should be discussed with her physician.

C) This medication should be continued despite unpleasant symptoms.

D) Many medications have potential side effects.

Review Information: The correct answer is:

A) It is unsafe to abruptly stop taking any prescribed medication..

Abrupt withdrawal may occasionally cause a syndrome consisting of lethargy, nausea, headache, fever, sweating and chills. A slow withdrawal may be prescribed with Sertraline to avoid dizziness, nausea, vomiting and diarrhea.

Question 28

A male client is admitted with a spinal cord injury at level C4. The client asks the nurse how the injury is going to affect his sexual function. The nurse would respond

A) "Normal sexual function is not possible."

B) "Sexual functioning will not be impaired at all."

C) "Erections will be possible."

D) "Ejaculation will be normal."

Review Information: The correct answer is:

C) "Erections will be possible.".

Erections can be stimulated by stroking the genitalia because it is a reflex action.

Question 29

You are assigned to care for a client newly diagnosed with angina. As part of discharge teaching, it is important to remind the client to remove the nitroglycerine patch after 12 hours in order to prevent:

A) Skin irritation

B) Drug tolerance

C) Severe headaches

D) Postural hypotension

Review Information: The correct answer is:

B) Drug tolerance.

Removing a nitroglycerine patch for a period of 10-12 hours daily prevents tolerance to the drug, which can occur with continuous patch use.

Question 30

A confused client is ordered arterial blood gases. The respiratory therapist draws the blood and then asks the nurse to apply pressure to the area so the therapist can take the specimen to the lab. How long should the nurse apply pressure to the area?

A) 3 minutes

B) 5 minutes

C) 8 minutes

D) 10 minutes

Review Information: The correct answer is:

B) 5 minutes.

It is necessary to apply pressure to the area for 5 minutes to prevent bleeding and the formation of hematomas.

Question 31

A client receiving chemotherapy has developed sores in his mouth. He asks the nurse why this happened. The nurse's BEST response would be

A) "It is a sign that the medication is working."

B) "You need to have better oral hygiene."

C) "The cells in the mouth are sensitive to the chemotherapy."

D) "This always happens with chemotherapy."

Review Information: The correct answer is:

C) "The cells in the mouth are sensitive to the chemotherapy."

The epithelial cells in the mouth are very sensitive to chemotherapy due to their high rate of cell turnover.

Question 32

The nurse has just received report on a group of patients and plans to delegate care of several of the patients to an LPN (licensed practical nurse). The first thing the RN should do before delegating care is

A) Provide a time-frame for completing patient care

B) Assure the LPN that the RN will be available for assistance

C) Ask about prior experience with similar patients

D) Review the specific procedures unique to the assignment

Review Information: The correct answer is:

C) Ask about prior experience with similar patients.

The first step in delegation is determining the qualifications of the person to whom one is delegating. By asking about the LPN''s prior experience with similar patients/tasks, the RN can determine whether the LPN has the requisite experience to care for the assigned patients.

Question 33

A post-operative client has a prescription for acetaminophen with codeine. The nurse recognizes that a primary effect of this combination is to:

A) Enhance pain relief

B) Minimize side effects

C) Prevent drug tolerance

D) Speed onset of action

Review Information: The correct answer is:

A) Enhance pain relief.

Combination of analgesics with different mechanisms of action can afford greater pain relief.

Question 34

The nurse discusses nutrition with a pregnant woman who is iron deficient and follows a vegetarian diet. The selection of which foods indicate the woman has learned sources of iron?

A) cereal and dried fruits

B) whole grains and yellow vegetables

C) leafy green vegetables and oranges

D) fish and dairy products

Review Information: The correct answer is:

A) cereal and dried fruits.

Both of these foods would be a good source of iron.

Question 35

You are caring for a depressed client with a new prescription for an SSRI antidepressant. In reviewing the admission history and physical, which of the following should lead you to question the safety of this medication?

A) History of obesity

B) Prescribed use of an MAO inhibitor

C) Diagnosis of vascular disease

D) Takes antacids frequently

Review Information: The correct answer is:

B) Prescribed use of an MAO inhibitor.

SSRIs should not be taken concurrently with MAO inhibitors because serious, life-threatening reactions may occur with this combination of drugs.

Question 36

A four year-old child is admitted with burns on his legs and lower abdomen. When assessing the child's hydration status, which of the following indicates a less than adequate fluid replacement?

A) Decreasing hematocrit and increasing urine volume

B) Rising hematocrit and decreasing urine volume

C) Falling hematocrit and decreasing urine volume

D) Stable hematocrit and increasing urine volume

Review Information: The correct answer is:

B) Rising hematocrit and decreasing urine volume.

A rising hematocrit indicates a decreased total blood volume.

Question 37

A client diagnosed with gouty arthritis is admitted with severe pain and edema in the right foot. When the nurse develops a plan of care, which of the following should be included?

A) High protein diet

B) Salicylates

C) Hot compresses to affected joints

D) Intake of at least 3000cc/day

Review Information: The correct answer is:

D) Intake of at least 3000cc/day.

Fluid intake should be increased to prevent precipitation of urate in the kidneys.

Question 38

A client is prescribed an inhaler. When teaching how to use the inhaler, the nurse would instruct the client to breath in the medication

A) As quickly as possible

B) As slowly as possible

C) Deeply for 3-4 seconds

D) Until hearing whistling by the spacer

Review Information: The correct answer is:

C) Deeply for 3-4 seconds.

The client should be instructed to breath in the medication for 3-4 seconds in order to receive the correct dosage of medication.

Question 39

The nurse enters the room of a client diagnosed with COPD. The client's skin is pink, and respirations are 8/minute. The client's oxygen is running at 6L/minute. What should be the nurse's FIRST action?

A) Call the physician

B) Put the client in Fowler's position

C) Lower the oxygen rate

D) Take the vital signs

Review Information: The correct answer is:

C) Lower the oxygen rate.

In client's diagnosed with COPN, the drive to breath is hypoxia. If oxygen is delivered at too high of a concentration, this drive will be eliminated and the client's depth and rate of respirations will decrease. Therefore the first action should be to lower the oxygen rate.

Question 40

A diabetic client asks the nurse why the physician ordered a glycolsylated hemoglobin (HbA) measurement, since a blood glucose reading was just performed. You will explain to the client that the HbA test:

A) Provides a more precise blood glucose value than self-monitoring

B) Is performed to detect complications of diabetes

C) Measures circulating levels of insulin

D) Reflects an average blood sugar for several months

Review Information: The correct answer is:

D) Reflects an average blood sugar for several months.

Glycosolated hemoglobin values reflect the average blood glucose (hemoglobin-bound) for the previous 3-4 months and is used to monitor client adherence to the therapeutic regimen.

Question 1

A client's admission urinalysis shows the specific gravity value of 1.039. Which of the following assessment data would the nurse expect to find when assessing this client?

A) Moist mucous membranes

B) Urinary frequency

C) Poor skin turgor

D) Increased blood pressure

Review Information: The correct answer is:

C) Poor skin turgor.

The specific gravity value is high, indicating dehydration. Poor skin turgor (tenting of the skin) is consistent with this problem.

Question 2

The nurse is caring for a 75 year old client in congestive heart failure. Which of the following symptoms suggest that digitalis levels should be reviewed?

A) Extreme fatigue

B) Increased appetite

C) Intense itching

D) Constipation

Review Information: The correct answer is:

A) Extreme fatigue.

Extreme fatigue and weakness are common, early signs of digitalis toxicity, which would be evident in lab data

Question 3

A client being discharged form the cardiac step-down unit following an MI is given a prescription for a beta-clocking drug. A nursing student asks the clinical specialist why this drug would be used by a client who is not hypertensive. An appropriate response by the nurse is:

A) "Most people develop hypertension following an MI."

B) "A beta-Blocker will prevent orthostatic hypotension."

C) "This drug will decrease the workload on his heart."

D) "Beta-blockers increase the strength of heart contractions."

Review Information: The correct answer is:

C) "This drug will decrease the workload on his heart."

One action of beta-blockers is to decrease systemic vascular resistance by dilating arterioles. This is useful for the client with coronary artery disease, and will reduce the risk of another MI or sudden death.

Question 4

Which of the following activities can the registered nurse ask a Unlicensed Assistive Personnel (UAP) to perform?

A) Taking a history on a newly admitted client

B) Adjusting the rate of an intravenous medication

C) Checking the blood pressure of a post operative client

D) Assessing a client receiving chemotherapy

Review Information: The correct answer is:

C) Checking the blood pressure of a post operative client.

Unlicensed nursing personnel must be assigned tasks that require no nursing judgment. Vital signs on stable patients are commonly assigned to unlicensed staff.

Question 5

You are caring for a hypertensive client with a new order for captopril (Capoten). Which information should the nurse include in patient teaching

A) Avoid green leafy vegetables

B) Restrict fluids to 1000cc/day

C) Avoid the use of salt substitutes

D) Take the medication with meals

Review Information: The correct answer is:

C) Avoid the use of salt substitutes.

Captopril can cause an accumulation of potassium or hyperkalemia. Patients should avoid the use of salt substitutes, which are generally potassium-based.

Question 6

An unlicensed assistive personnel (UAP), who usually works on a surgical unit is assigned to float to a pediatric unit. Which one of these questions by the charge nurse would be most appropriate when making delegation decisions?

A) "How long have you been a UAP?"

B) "What type of care do you give on the surgical unit?"

C) "Are you comfortable caring for children?"

D) "Can we review your competency checklist?"

Review Information: The correct answer is:

D) "Can we review your competency checklist?".

The UAP must be competent to accept the delegated task.

Question 7

After assessing a 70 year-old male client's laboratory results during a routine clinic visit, which one of the following findings would indicate an area in which teaching is needed:

A) Serum albumin 2.5g/dl

B) LDL Cholesterol 140mg/dl

C) Serum glucose 90mg/dl

D) RBCs 5.0 million/mm3

Review Information: The correct answer is:

A) Serum albumin 2.5g/dl.

Serum albumin level is low, indicating nutritional counseling is needed.

Question 8

The nurse notes an abrupt onset of confusion in an elderly patient. Which of the following recently-ordered medications would most likely contribute to this change?

A) Anticoagulant

B) Liquid antacid

C) Antihistamine

D) Cardiac glycoside

Review Information: The correct answer is:

C) Antihistamine.

Elderly people are susceptible to the side effect of anticholinergic drugs, such as antihistamines. Especially at high doses, antihistamines often cause confusion in the elderly.

Question 9

Which of the following laboratory results would suggest to the emergency room nurse that a client admitted after a severe motor vehicle accident is in acidosis?

A) Hemoglobin 15 gm/dl

B) Chloride 100 mEq/L

C) Sodium 130 mEq/L

D) Carbon dioxide 20 mEq/L

Review Information: The correct answer is:

D) Carbon dioxide 20 mEq/L.

Serum carbon dioxide is an indicator of acid-base status. This result would indicate acidosis.

Question 10

An older adult client is to receive and antibiotic, gentamicin. What diagnostic finding indicates the client may have difficult excreting the medication?

A) High gastric pH

B) High serum creatinine

C) Low serum albumin

D) Low serum blood urea nitrogen

Review Information: The correct answer is:

B) High serum creatinine.

An elevated serum creatinine indicates reduced renal function. Reduced renal function will delay the excretion of many mediations.

Question 11

A terminally ill hospice client has been receiving high doses of an opiod analgesic for the past month. As death approaches and the client becomes unresponsive to verbal stimuli, the nurse would expect that the physician will:

A) Decrease the analgesic dosage by half

B) Discontinue the analgesic

C) Continue the same analgesic dosage

D) Prescribe a less potent drug

Review Information: The correct answer is:

C) Continue the same analgesic dosage.

Dying patients who have been in chronic pain will probably continue to experience pain even though unresponsive. Pain medication should be continued at the same dose, if effective

Question 12

A 36 year-old female client has a hemoglobin level of 14 g/dl and a hematocrit of 42% following a D&C. Which of the following would the nurse expect to find when assessing this client?

A) Capillary refill less than 3 seconds

B) Pale mucous membranes

C) Respirations 36 breaths per minute

D) Complaints of fatigue when ambulating

Review Information: The correct answer is:

A) Capillary refill less than 3 seconds.

Since the hemoglobin and hematocrit are normal for an adult female, addition assessments should be normal. Capillary refill is "normal" assessment data.

Question 13

The client with goiter is treated with potassium iodide preoperatively. The nurse recognizes that the purpose of this medication is to:

A) Reduce vascularity of the thyroid

B) Correct chronic hyperthyroidism

C) Destroy the thyroid gland function

D) Balance enzymes and electrolytes

Review Information: The correct answer is:

A) Reduce vascularity of the thyroid.

Potassium iodide solution, or Lugol''s solution may be used preoperatively to reduce the size and vascularity of the thyroid gland.

Question 14

A client is receiving Total Parenteral Nutrition (TPN) via Hickman catheter. The catheter accidentally becomes dislodged from the site. Which of the following actions by the nurse should take priority?

A) Check that the catheter tip is intact

B) Apply a pressure dressing to the site

C) Monitor respiratory status

D) Assess for mental status changes

Review Information: The correct answer is:

B) Apply a pressure dressing to the site.

The client is at risk of bleeding or the development of an air embolus if the catheter exit site is not covered immediately.

Question 15

The nurse is caring for a 69 year-old client with a diagnosis of hyperglycemia. Which one of the following tasks could the nurse delegate to the unlicensed assistive personnel (UAP)?

A) Test blood sugar every two hours

B) Teach signs of hyperglycemia

C) Observe for mental status changes

D) Assess circulation of extremities

Review Information: The correct answer is:

A) Test blood sugar every two hours.

The UAP can do standard unchanging procedures

Question 16

You are the charge nurse on the night shift at an urgent care center. Due to a large fire in the area, your facility is admitting clients of higher acuity than usual. Which style of leadership and decision-making would be best in this circumstance?

A) Assume a decision-making role

B) Seek input from staff

C) Use a non-directive approach

D) Shared decision-making with others

Review Information: The correct answer is:

A) Assume a decision-making role.

Authoritarian leadership assumes that decision-making is the role of the leader with little input by subordinates. This style is best used in emergency situations.

Question 17

An 80 year-old client is admitted with a diagnosis of malnutrition. In addition to physical assessments, which of the following lab tests should be closely monitored?

A) Urine protein

B) Urine creatinine

C) Serum calcium

D) Serum albumin

Review Information: The correct answer is:

D) Serum albumin.

Serum albumin is a valuable indicator of protein deficiency and nutritional status in adults.

Question 18

The nurse is monitoring a client receiving a thrombolitic agent, Alteplase (activasetissue plasminogen activator) for treatment of a myocardial infarction. What outcome indicates the client is receiving adequate therapy within the first hours of therapy?

A) Absence of a dysrhythmia (or arrhythmia)

B) Blood pressure reduction

C) Cardiac enzymes are within normal limits

D) Return of ST segment to baseline on ECG

Review Information: The correct answer is:

D) Return of ST segment to baseline on ECG.

Improved perfusion should result form this medication with the reduction ST segment elevation.

Question 19

The charge nurse on a surgical unit is making assignments for the day. There are two RNs, one LPN, and two unlicensed assistive personnel (UAPs). Which one of the following tasks could be assigned to the LPN:

A) Testing a stool specimen for occult blood

B) Assisting a client with ambulation

C) Irrigating and redressing a leg wound

D) Admitting a patient from the emergency room

Review Information: The correct answer is:

C) Irrigating and redressing a leg wound.

The LPN is a licensed provider and can perform this complex task

Question 20

A client has an order for antibiotic therapy after hospital treatment of a staph infection. Which of the following should the nurse emphasize?

A) Scheduling follow-up blood cultures

B) Completing the full course of medications

C) Visiting the physician in a few weeks

D) Monitoring for signs of recurrent infection

Review Information: The correct answer is:

B) Completing the full course of medications.

In order for antibiotic therapy to be effective in eradicating an infection, the patient must compete the entire course of prescribed therapy. When symptoms subside, stopping the medication may lead to recurrence or subsequent drug resistance.

Question 21

A nurse from the maternity unit is floated to the critical care unit because of staff shortage. Which one of the following patients would be appropriate to assign to this nurse:

A) A client on Dopamine with vital signs monitored every five minutes

B) A client who had an MI, but is free from pain and dysrhythmias

C) A client with a tracheotomy in some respiratory distress

D) A client with a pacemaker inserted this morning

Review Information: The correct answer is:

B) A client who had an MI, but is free from pain and dysrhythmias.

This patient is the most stable; the nurse can transfer assessment skills to care for this patient.

Question 22

The nurse is assigned to care for four clients. Which of the following should be assessed immediately after hearing the report?

A) The client with asthma who is now ready for discharge

B) The client with a peptic ulcer who has been vomiting all night

C) The client with chronic renal failure returning form dialysis

D) The client with pancreatitis who was admitted yesterday

Review Information: The correct answer is:

B) The client with a peptic ulcer who has been vomiting all night.

A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life threatening situation. The client should be assessed immediately and findings reported to the physician.

Question 23

Included in teaching the client with tuberculosis taking INH about follow-up home care, the nurse should emphasize that a laboratory appointment for which of the following lab tests is critical?

A) Liver function

B) Kidney function

C) Blood sugar

D) Cardiac enzymes

Review Information: The correct answer is:

A) Liver function.

INH can cause hepatocellular injury and hepatitis. This side effect is age-related and can be detected with regular assessment of liver enzymes, which are released into the blood from damaged liver cells.

Question 24

A hypertensive client is started on atenolol (Tenormin). The nurse instructs the client to immediately report:

A) Rapid breathing

B) Slow, bounding pulse

C) Jaundiced sclera

D) Weight gain

Review Information: The correct answer is:

B) Slow, bounding pulse.

Atenolol (Tenormin) is a beta-blocker that can cause side effects including bradycardia and hypotension.

Question 25

A client has been newly diagnosed with hypothyroidism and will take levothyroxine (Synthroid) 50 mcg/day by mouth. As part of the teaching plan, the nurse emphasizes that this medication:

A) Should be taken in the morning

B) May decrease the client's energy level

C) Must be stored in a dark container

D) Will decrease the client's heart rate

Review Information: The correct answer is:

A) Should be taken in the morning.

Thyroid supplement should be taken in the morning to minimize the side effects of insomnia

Question 26

A client is receiving a nitroglycerin infusion for unstable angina. What assessment would be PRIORITY for monitoring the effects of this medication?

A) Blood pressure

B) Cardiac enzymes

C) ECG analysis

D) Respiratory rate

Review Information: The correct answer is:

A) Blood pressure.

Since an effect of this drug is vasodilation, the client must be monitored for hypotension.

Question 27

Prior to administering TPA (altipase) to a client admitted for a cerebral vascular accident (CVA), it is critical that the nurse assess:

A) Neuro signs

B) Mental status

C) Blood pressure

D) PT/PTT

Review Information: The correct answer is:

D) PT/PTT.

TPA is a potent thrombolytic enzyme. Because bleeding is the most common side effect, it is most essential to evaluate clotting studies including PT, PTT,APTT, platelets, and hematocrit before beginning therapy.

Question 28

A client with anemia has a new prescription for ferrous sulfate. In teaching the client about diet and iron supplements, the nurse should emphasize that absorption of iron is enhanced if taken with

A) Acetaminophen

B) Orange juice

C) Low fat milk

D) An antacid

Review Information: The correct answer is:

B) Orange juice.

Ascorbic acid enhances absorption of iron.

Question 29

A client diagnosed with cirrhosis is started on lacutlose (Cephulac). The nurse understands the main purpose of the drug for this client is to:

A) Add dietary fiber

B) Reduce ammonia levels

C) Stimulate peristalsis

D) Control portal hypertension

Review Information: The correct answer is:

B) Reduce ammonia levels.

Lacutlose blocks the absorption of ammonia from the GI tract and secondarily stimulates bowel elimination.

Question 30

The nurse is teaching a group of women in a community clinic about prevention of osteoporosis. Which of the following over-the-counter medications should the nurse recognize as having the most elemental calcium per tablet?

A) Calcium chloride

B) Calcium citrate

C) Calcium gluconate

D) Calcium carbonate

Review Information: The correct answer is:

D) Calcium carbonate.

Calcium carbonate contains 400mg of elemental calcium in 1 gram of calcium carbonate.

Question 31

To prevent drug resistance common to tubercle bacilli, the nurse is aware that clients with tuberculosis are often treated with:

A) An anti-inflammatory agent

B) High doses of B complex vitamins

C) An aminoglycoside antibiotic

D) Two anti-tuberculosis drugs

Review Information: The correct answer is:

D) Two anti-tuberculosis drugs.

Resistance of the tubercle bacilli often occurs to a single antimicrobial agent. Therefore, therapy with multiple drugs over a long period of time helps to ensure eradication of the organism.

Question 32

The charge nurse is planning assignments on a medical unit. Which one of the following clients could be assigned to the certified nursing assistant?

A) A client who has difficulty swallowing after a stroke

B) A client needing enemas until clear prior to colonoscopy

C) A client with an order for a post-op dressing change

D) A client who will be discharged to a long term facility

Review Information: The correct answer is:

B) A client needing enemas until clear prior to colonoscopy.

The certified nursing assistant can be assigned tasks which have predictable outcomes.

Question 33

A client with tuberculosis is started on Rifampin. Which one of the following statements by the nurse would be appropriate to include in teaching? You may notice:

A) an orange-red color to your urine."

B) increased appetite for food and drink."

C) occasional sleep disturbances."

D) taking medication with food causes nausea."

Review Information: The correct answer is:

A) an orange-red color to your urine."

Discoloration of the urine and other body fluids may occur. It is a harmless response to the drug, but the patient needs to be aware it may happen.

Question 34

Which one of the following statements by the nurse is appropriate when asking an Unlicensed Assistive Personnel (UAP) to assist a 69 year-old surgical client to ambulate for the first time?

A) "Have the client sit on the side of the bed before helping him stand."

B) "If the client is dizzy on standing, ask him to take some deep breaths."

C) "Assist the client to the bathroom at least twice."

D) "After you assist him to the chair, let me know how he feels."

Review Information: The correct answer is:

A) "Have the client sit on the side of the bed before helping him stand.".

Give clear information to the UAP about what is expected for client safety.

Question 35

A client taking isoniazide (INH) for tuberculosis asks the nurse about side effects of the medication. The nurse should emphasize immediate report of:

A) Double vision and visual halos

B) Extremity tingling and numbness

C) Confusion and lightheadedness

D) Sensitivity of sunlight

Review Information: The correct answer is:

B) Extremity tingling and numbness.

Peripheral neuropathy is the most common side effect of INH and should be reported to the physician; it can be reversed.

Question 36

The nurse is teaching a client about the toxicity of digoxin. Which one of the following statements made by the client to the nurse indicates more teaching is needed? "I will report:

A) loss of appetite."

B) double vision."

C) nausea and vomiting."

D) slow, bounding pulse."

Review Information: The correct answer is:

D) slow, bounding pulse."

Slow heart rate is related to increased cardiac output and an intended effect of digoxin. The ideal heart rate is above 60 with digoxin. The client needs further teaching.

Question 37

The nursing student is discussing with a preceptor the delegation of tasks to an unlicensed assistive personnel (UAP). Which one of the following tasks, delegated to a UAP, indicates the student needs further teaching about the delegation process:

A) Assisting a patient to ambulate

B) Feeding a two year-old in traction

C) Providing discharge teaching

D) Collecting a sputum specimen

Review Information: The correct answer is:

C) Providing discharge teaching.

The UAP cannot do teaching or assessment needed at time of discharge.

Question 38

The nurse receives a report on an older adult client with middle stage dementia. What information suggests the nurse should do immediate follow up rather than delegate care to the nursing assistant? The client

A) Had difficulty recalling the names of staff

B) Went to the bathroom to void twice during the night

C) Was minimally responsive to voice and touch

D) Wandered in the halls several times

Review Information: The correct answer is:

C) Was minimally responsive to voice and touch.

A change in level of consciousness indicates delirium related to acute illness. This would require the assessment of a nurse.

Question 39

A client newly diagnosed with Type I Diabetes Mellitus asks the purpose of the test measuring glycosylated hemoglobin. The nurse should explain that the purpose of this test is to determine:

A) The presence of anemia often associated with Diabetes

B) The oxygen carrying capacity of the client's red cells

C) The average blood glucose for the past 2-3 months

D) The client's risk for cardiac complications

Review Information: The correct answer is:

C) The average blood glucose for the past 2-3 months.

By testing the portion of the hemoglobin that absorbs glucose, it is possible to determine the average blood glucose over the life span of the red cell, 120 days.

Question 40

You are teaching a client with atrial fibrillation about the use of Coumadin (warfarin) at home. You should emphasize that the client should avoid:

A) Large indoor gatherings

B) Exposure to sunlight

C) Active physical exercise

D) Foods rich in vitamin K

Review Information: The correct answer is:

D) Foods rich in vitamin K.

Vitamin K acts as an antidote to the pharmacologic action of Coumadin therapy, decreasing Coumadin''s effectiveness. Foods high in vitamin K include dark greens, tomatoes, bananas, cheese, and fish.

Question 41

A nurse is precepting a student in the emergency room. A client is treated for diabetic ketoacidosis and a glucose level of 650mg.D/L. In assessing the client, the student's review of which of the following tests suggests an understanding of this health problem?

A) Serum calcium

B) Serum magnesium

C) Serum creatinine

D) Serum potassium

Review Information: The correct answer is:

D) Serum potassium.

Potassium is lost in diabetic ketoacidosis during rehydration and insulin administration. Review of this data suggests the student has knowledge of this problem.

Question 42

The nursing assistant reports to the nurse that a client with cirrhosis who had a paracentesis yesterday has become more lethargic and has a musty smelling breath. A critical assessment for increasing encephalopathy is

A) Monitor the client's clotting status

B) Assess upper abdomen for bruits

C) Assess for flap like tremors of the hands

D) Measure abdominal girth changes

Review Information: The correct answer is:

C) Assess for flap like tremors of the hands.

A client with cirrhosis of the liver who develops subtle changes in the mental status and has a musty odor to the breath may be developing more advanced signs of encephalopathy.

Question 43

A client is to receive 3 doses of potassium chloride 10 mEq in 100cc normal saline to infuse over 30 minutes each. Which of the following is a priority assessment prior to giving this medication?

A) Oral fluid intake

B) Bowel sounds

C) Grip strength

D) Urine output

Review Information: The correct answer is:

D) Urine output.

Potassium chloride should only be administered after adequate urine output (>20cc for 2 consecutive hours) has been established. Impaired ability to excrete potassium via the kidneys can result in hyperkalemia.

Question 44

A client is admitted with complaints of chest pain three hours ago. The troponin level is reported as 10 mg/mL. Which of the following actions by the nurse is a priority?

A) Notify the physician of lab results

B) Maintain absolute bed rest

C) Administer oxygen via nasal cannula

D) Start intravenous fluids at KVO rate

Review Information: The correct answer is:

B) Maintain absolute bed rest.

The troponin levels are new markers for cardiac disease. These markers are specific to cardiac muscle function and begin to elevate within three to six hours after myocardial injury. The client should be placed on bed rest to decrease myocardial workload and further ischemic changes.

Question 45

A client is admitted to the hospital with a diagnosis of liver failure with ascites. The physician orders spirnolactone (aldactone). The nurse understands that this medication:

A) Promotes sodium and chloride excretion

B) Increases aldosterone levels

C) Depletes potassium reserves

D) Combines safely with antihypertensives

Review Information: The correct answer is:

A) Promotes sodium and chloride excretion.

Spirnolactone promotes sodium and chloride excretion while sparing potassium and decreasing aldosterone levels.

Question 46

The nurse is teaching a client with chronic renal failure (CRF) about medications. The client questions the purpose of aluminum hydroxide (Amphogel) in her medication regimen. What is the best explanation for the nurse to give the client for the use of this medication? This medication is given to

A) decrease serum phosphate

B) reduce serum calcium

C) increase urine output

D) control gastric acid secretion

Review Information: The correct answer is:

A) decrease serum phosphate.

Aluminum binds phosphates that tend to accumulate in the patient with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphogel are commonly used to accomplish this.

Question 47

During a routine check-up, an insulin-dependent diabetic hashis glycosylated hemoglobin checked. The results indicate a level of 11%. Based on this result, what teaching should the nurse emphasize?

A) Rotation of injection sties

B) Insulin mixing and preparation

C) Daily blood sugar monitoring

D) Regular high protein diet

Review Information: The correct answer is:

C) Daily blood sugar monitoring.

Normal hemoglobin A1C (glycosylated hemoglobin) level is 7-9%. Elevation indicates elevated glucose levels over time.

Question 48

A nurse has administered several blood transfusions over three days to a 12 year-old client with Thalassemia. What lab value should the nurse monitor closely during this therapy?

A) Hemoglobin

B) Red Blood Cell Indices

C) Platelet count

D) Neutrophil percent

Review Information: The correct answer is:

A) Hemoglobin.

Hemoglobin should be in a therapeutic range of approximately 10 g/dl (100gL). "This level is low enough to foster the patient''s own erythropoiesis without enlarging the spleen." (Lewis, p. 744)

Question 49

The nurse is performing an assessment on a client who is cachectic and has developed an enterocutaneous fistula following surgery to relieve a small bowel obstruction. The client's total protein level is reported as 4.5. Which of the following would the nurse anticipate?

A) Additional potassium will be given IV

B) Blood for coagulation studies will be drawn

C) Total Parenteral Nutrition will be started

D) Serum lipase levels will be evaluated

Review Information: The correct answer is:

C) Total Parenteral Nutrition will be started.

The client is not absorbing nutrients adequately as evidenced by the cachexia and low protein levels. (A normal total serum protein level is 6.0-8.0.) TPN will maintain a positive nitrogen balance in the client who is unable to digest and absorb nutrients adequately.

Question 50

A client on telemetry begins having premature ventricular beats (PVBs) at 12/minute. In reviewing the most recent laboratory results, which would require immediate action by the nurse?

A) Calcium 9mg/dl

B) Magnesium 2.5mg/dl

C) Potassium 2.5 mEq/L

D) PTT 70 seconds

Review Information: The correct answer is:

C) Potassium 2.5 mEq/L.

The patient is at risk for ventricular dysrhythmias when the potassium level is low.

Question 51

A client on warfarin therapy following coronary artery stent placement calls the clinic to ask if he can take Alka-Seltzer for an upset stomach. The nurse should tell this client:

A) Avoid Alka-Seltzer because it contains aspirin

B) Take Alka-Seltzer at a different time of day than the warfarin

C) Select another antacid that does not inactivate warfarin

D) Use on-half the recommended dose of Alka-Seltzer

Review Information: The correct answer is:

A) Avoid Alka-Seltzer because it contains aspirin.

Alka-Seltzer is an over-the-counter aspirin-antacid combination. Aspirin, an antiplatelet drug, will potentiate the anticoagulant effect of warfarin and may result in excess bleeding

Question 52

The nurse administers cimetidine (Tagamet) to a 79 year-old male with a gastric ulcer. Which one of the following may be affected by this drug, and should be closely monitored by the nurse?

A) Blood pressure

B) Liver function

C) Mental status

D) Hemoglobin and hematocrit

Review Information: The correct answer is:

C) Mental status.

The elderly are at risk for developing confusion when taking cimetidine.

Question 53

A client is receiving digoxin (Lanoxin) 0.25 mg. Daily. The physician has written a new order to give metoprolol (Lopressor) 25 mg. B.I.D. In assessing the client prior to administering the medications, which of the following should the nurse report immediately to the physician?

A) Blood pressure 94/60

B) Heart rate 76

C) Urine output 50 ml/hour

D) Respiratory rate 16

Review Information: The correct answer is:

A) Blood pressure 94/60.

Both medications decrease the heart rate. Metoprolol affects blood pressure. Therefore, the heart rate and blood pressure must be within normal range (HR 60-100; systolic B/P over 100) in order to safely administer both medications.

Question 54

A client has been taking furosemide (Lasix) for the past week. The nurse recognizes which of the following symptoms may indicate the client is experiencing a negative side effect from the medication?

A) Weight gain of 5 pounds

B) Edema of the ankles

C) Gastric irritability

D) Decreased appetite

Review Information: The correct answer is:

D) Decreased appetite.

Lasix causes a loss of potassium if a supplement is not taken. Signs and symptoms of hypokalemia include anorexia, fatigue, nausea, decreased GI motility, muscle weakness, dysrhythmias.

Question 1

A four year-old hospitalized child begins to have a seizure while playing with hard plastic toys in the hallway. Of the following nursing actions, which one should the nurse do FIRST?

A) Place the child in the nearest bed

B) Administer IV medication to slow down the seizure

C) Place a padded tongue blade in the child's mouth

D) Remove the child's toys from the immediate area

Review Information: The correct answer is:

D) Remove the child''s toys from the immediate area.

Nursing care for a child having a seizure includes, maintaining airway patency, ensuring safety, administering medications, and providing emotional support. Since the seizure has already started, nothing should be forced into the child''s mouth and they should not be moved. Of the choices given, first priority would be for safety.

Question 2

The nurse is teaching the mother of a 5 month-old about nutrition for her baby. Which of the following statements by the mother indicates the need for further teaching?

A) "I'm going to try feeding my baby some rice cereal."

B) "When he wakes at night for a bottle, I feed him."

C) "I dip his pacifier in honey so he'll take it."

D) "I keep formula in the refrigerator for 24 hours."

Review Information: The correct answer is:

C) "I dip his pacifier in honey so he''ll take it.".

Honey has been associated with infant botulism and should be avoided. Older children and adults have digestive enzymes that kill the botulism spores.

Question 3

Immediately following insertion of a central line, the client develops tachycardia, cyanosis and hypotension. The nurse would IMMEDIATELY place the client in the

A) Supine position with head of bed flat

B) Trendelenberg position

C) Right side position with head of bed 90 degrees

D) Left side position with head of bed lowered

Review Information: The correct answer is:

D) Left side position with head of bed lowered.

These symptoms indicate the possibility of an air embolism. Immediately clamp tubing and turn client on left side, with head of bed lowered, to trap air in the right atrium. Administer oxygen and call the health care provider.

Question 4

A three year-old child comes to the pediatric clinic after the sudden onset of symptoms that include irritability, thick muffled voice, croaking on inspiration, hot to touch, sit leaning forward, tongue protruding, drooling and suprasternal retractions. What should the nurse do first?

A) Prepare the child for x-ray of upper airways

B) Examine the child's throat

C) Collect a sputum specimen

D) Notify the physician of the child's status

Review Information: The correct answer is:

D) Notify the physician of the child''s status.

These symptoms suggest a medical emergency and may be due to epiglottises. Any child with an acute onset of an inflammatory response in the mouth and throat should receive immediate attention in a facility equipped to perform intubation or a tracheostomy in the event of further or complete obstruction.

Question 5

A nurse enters a client's room to discover that the client has no pulse or respirations. After calling for help, the FIRST action the nurse should take is

A) Start a peripheral IV

B) Initiate closed-chest massage

C) Establish an airway

D) Obtain the crash cart

Review Information: The correct answer is:

C) Establish an airway.

Establishing an airway is always the primary objective in a cardiopulmonary arrest.

Question 6

A client asks the nurse to explain the basic ideas of homeopathic medicine. The response that BEST explains this approach is that remedies

A) Destroy organisms causing disease

B) Maintain fluid balance

C) Boost the immune system

D) Increase bodily energy

Review Information: The correct answer is:

C) Boost the immune system.

The practitioner treats with minute doses of plant, mineral or animal substances which provide a gentle stimulus to the body's own defenses.

Question 7

A woman in her third trimester complains of severe heartburn. The nurse would appropriately teach the client to

A) Drink small amounts of liquids frequently

B) Eat the evening meal just before retiring

C) Take sodium bicarbonate after each meal

D) Sleep with head propped on several pillows

Review Information: The correct answer is:

D) Sleep with head propped on several pillows.

Heartburn is a burning sensation caused by regurgitation of gastric contents that is best relieved by sleeping position and eating small meals.

Question 8

A client who is receiving chemotherapy through a central line is admitted to the hospital with a diagnosis of sepsis. Which of the following nursing interventions should receive PRIORITY?

A) Inspect all sites that may serve as entry ports for bacteria

B) Place the client in reverse isolation

C) Change the dressing over the site of the central line

D) Restrict contact with persons having known or recent infections

Review Information: The correct answer is:

A) Inspect all sites that may serve as entry ports for bacteria.

Prompt recognition of source of infection and subsequent initiation of therapy will reduce morbidity and mortality.

Question 9

The nurse is caring for a client with insulin dependent diabetes mellitus. Which of the following information of the initial assessment factors is MOST predictive of potential for impaired skin integrity?

A) Administration of insulin in the lower extremities

B) Peripheral neuropathy

C) Unstable blood glucose levels

D) Poor foot hygiene

Review Information: The correct answer is:

B) Peripheral neuropathy.

Peripheral neuropathy can lead to lack of sensation in the lower extremities. Clients do not feel pressure and or pain and are at high risk for skin impairment.

Question 10

A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which of the following assessment findings would indicate to the nurse that the client may be having an adverse reaction to the medication?

A) Headache

B) Mood changes

C) Hyperkalemia

D) Palpitations

Review Information: The correct answer is:

B) Mood changes.

The nurse should assess the client for alterations in mental status such as mood changes. These symptoms should be reported promptly.

Question 11

A client has a Swan-Ganz catheter in place. The nurse understands that this is intended to measure

A) Right heart function

B) Left heart function

C) Renal tubule function

D) Carotid artery function

Review Information: The correct answer is:

B) Left heart function.

The Swan-Ganz catheter is placed in the pulmonary artery to obtain information about the left side of the heart. The pressure readings are inferred from pressure measurements obtained on the right side of the circulation. Right-sided heart function is assessed through the evaluation of the central venous pressures (CVP).

Question 12

The nurse is administering diltiazem (Cardizem) to a client. Prior to administration, it is important for the nurse to monitor the client's

A) Temperature

B) Blood pressure

C) Vision

D) Bowel sounds

Review Information: The correct answer is:

B) Blood pressure.

Diltiazem (Cardizem) is a calcium channel blocker that causes systemic vasodilation resulting in decreased blood pressure.

Question 13

While assessing a 1 month-old infant, which of the following findings should the nurse report IMMEDIATELY?

A) Abdominal respirations

B) Irregular breathing rate

C) Inspiratory grunt

D) Increased heart rate with crying

Review Information: The correct answer is:

C) Inspiratory grunt.

Inspiratory grunting is abnormal and may be a sign of respiratory distress in this infant.

Question 14

A client is admitted to the hospital because of heart failure and digoxin toxicity. At home, the client was taking digoxin (Lanoxin) and furosemide (Lasix). Which of the following symptoms would the nurse anticipate finding on the initial assessment?

A) Muscle weakness and cramping

B) Confusion

C) Blood in the urine

D) Tinnitis

Review Information: The correct answer is:

A) Muscle weakness and cramping.

A client taking a non-potassium sparing diuretic such as furosemide will likely need a potassium supplement to prevent hypokalemia. This client did not take supplemental potassium. Signs and symptoms of hypokalemia include weakness and muscle cramps. Hypokalemic clients are more sensitive to digoxin toxicity.

Question 15

The nurse is performing a gestational age assessment on a newborn delivered 2 hours ago. Findings compared to the Ballard scale may be affected by

A) Birth weight

B) Racial differences

C) Fetal distress in labor

D) Birth trauma

Review Information: The correct answer is:

C) Fetal distress in labor.

The effects of earlier distress may alter the findings of reflex responses as measured on the Ballard tool. Other physical characteristics that estimate gestational age, such as amount of lanugo, sole creases and ear cartilage, are unaffected.

Question 16

Which of the following clients is at HIGHEST risk for developing a pressure ulcer?

A) 23 year-old client in traction for fractured femur

B) 72 year-old client with peripheral vascular disease, who is unable to walk without assistance

C) 75 year-old client with left sided paresthesia and is incontinent of urine and stool

D) 30 year-old who is comatose following a ruptured aneurysm

Review Information: The correct answer is:

C) 75 year-old client with left sided paresthesia and is incontinent of urine and stool.

Risk factors for pressure ulcers include: immobility, absence of sensation, decreased LOC, poor nutrition and hydration, skin moisture, incontinence, increased age, decreased immune response. This client has the greatest number of risk factors.

Question 17

When suctioning a client's tracheostomy, the nurse should instill saline in order to

A) Decrease the client's discomfort

B) Promote oxygenation during suctioning

C) Prevent client aspiration

D) Reduce viscosity of secretions

Review Information: The correct answer is:

D) Reduce viscosity of secretions.

Saline will thin and loosen secretions, making it easier to suction.

Question 18

When teaching a client with coronary artery disease about nutrition, the nurse should emphasize

A) Eating 3 balanced meals a day

B) Adding complex carbohydrates

C) Avoiding very heavy meals

D) Limiting sodium to 7 gms per day

Review Information: The correct answer is:

C) Avoiding very heavy meals.

Eating large, heavy meals can pull blood away from the heart for digestion and is dangerous for the client with coronary artery disease.

Question 19

The nurse is teaching a parent about side effects of routine immunizations. Which of the following MUST be reported immediately?

A) Irritability

B) Slight edema at site

C) Local tenderness

D) Temperature of 102.5 F

Review Information: The correct answer is:

D) Temperature of 102.5 F.

An adverse reaction of a fever should be reported immediately.

Question 20

Prior to giving an immunization, the nurse should FIRST assess the child for possible contraindications, including

A) Mild cold symptoms

B) Chronic asthma

C) Depressed immune system

D) Allergy to eggs

Review Information: The correct answer is:

C) Depressed immune system.

Children who have a depressed immune system related to HIV or chemotherapy should not be given routine immunizations.

Question 21

Nurses can teach parents of pre-schoolers that the best way they can begin teaching their child about injury prevention is to

A) Set good examples themselves

B) Protect their child from outside influences

C) Make sure their child understands all the safety rules

D) Discuss the consequences of not wearing protective devices

Review Information: The correct answer is:

A) Set good examples themselves.

Preschool years is the time for parents to begin emphasizing safety education as well as providing protection. Setting a good example themselves is crucial because of the imitative behaviors of pre-schoolers; they are quick to notice discrepancies between what they see and what they are told.

Question 22

Which of the following oxygen delivery systems would the nurse apply that would provide the HIGHEST concentrations of oxygen to the client?

A) Venturi mask

B) Partial rebreather mask

C) Non-rebreather mask

D) Simple face mask

Review Information: The correct answer is:

C) Non-rebreather mask.

The non-rebreather mask has a one-way valve that prevents exhales air from entering the reservoir bag and one or more valves covering the air holes on the face mask itself to prevent inhalationof room air but to allow exhalation of air. When a tight seal is achieved around the mask up to 100% of oxygen is available. Some believe the actual oxygen content delivered to most client's to be close to 60-80%, however it is still the highest concentration of oxygen available to the client.

Question 23

The parents of a toddler ask the nurse how long their child will have to sit in a car seat while in the automobile. The BEST response is "The child needs to use a car seat until the child...

A) weighs at least 40 pounds."

B) is at least 5 years-old."

C) is 50 inches tall."

D) is content to use a regular seat belt."

Review Information: The correct answer is:

A) weighs at least 40 pounds.".

A child should use a car seat until they weigh 40 pounds.

Question 24

The nurse is caring for a client who had a total hip replacement four days ago. Which of the following symptoms requires the nurse's IMMEDIATE attention?

A) Spasm in the affected hip leg

B) Chest pain with palpitations

C) Urinary output of 500 cc in eight hours

D) Increased pain at operative site

Review Information: The correct answer is:

B) Chest pain with palpitations.

Clients who have had hip or knee surgery are at greatest risk for development of post operative pulmonary embolism. This is life threatening and requires immediate attention.

Question 25

The nurse is caring for a client with extracellular fluid volume deficit. Which of the following assessments would the nurse anticipate finding?

A) Bounding pulse

B) Rapid respirations

C) Oliguria

D) Neck veins are distended

Review Information: The correct answer is:

C) Oliguria.

Kidneys maintain fluid volume through adjustments in urine volume.

Question 26

The nurse practicing in a maternity setting recognizes that neonatal sepsis is MOST often related to

A) Maternal diabetes

B) Prolonged rupture of membranes

C) Cesarean delivery

D) Precipitous vaginal birth

Review Information: The correct answer is:

B) Prolonged rupture of membranes.

PROM is a leading cause of newborn sepsis. After 12-24 hours of leaking fluid, measures are taken to reduce the risk to mother and the fetus/newborn.

Question 27

The nurse is caring for a one year-old child who has six teeth. What is the BEST way for the nurse to give mouth care to this child?

A) Using a moist soft brush or cloth to clean teeth and gums

B) Swabbing teeth and gums with flavored mouthwash

C) Offering a bottle of water for the child to drink

D) Brushing with toothpaste and flossing each tooth

Review Information: The correct answer is:

A) Using a moist soft brush or cloth to clean teeth and gums.

The nurse should use a soft cloth or soft brush to do mouth care so that the child can adjust to the routine of cleaning the mouth and teeth.

Question 28

A client who is 12 hour post-op becomes confused and complains of giant sharks swimming across the ceiling. Which assessment is necessary to adequately identify the source of this client's behavior?

A) Rhythm strip from cardiac monitor

B) Pupil response to light and accommodation

C) Pulse oximetry

D) Blood Glucose

Review Information: The correct answer is:

C) Pulse oximetry.

A sudden change in mental status in any post-op client should trigger a nursing intervention directed toward correcting respiratory status. Arterial blood gasses (or pulse oximetry) would be the initial test necessary to an adequate assessment. Acute respiratory failure is the sudden inability of the respiratory system to maintain adequate gas exchange resulting in hypercapnia and/or hypoxemia. Clinical manifestations of hypoxemia include restlessness, agitation, dyspnea, disorientation, confusion, delirium, hallucinations, and loss of consciousness. While there may be other factors influencing the client''s symptoms, nevertheless, the first nursing action should be directed toward correcting ventilatory status and alleviation of symptoms.

Question 29

A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial temperature is 35 C axillary. The nurse recognizes that cold stress may lead to

A) Lowered BMR

B) Reduced PaO2

C) Lethargy

D) Metabolic alkalosis

Review Information: The correct answer is:

B) Reduced PaO2.

Cold stress causes increased risk for respiratory distress. The baby delivered in such circumstances needs careful monitoring. In this situation, the newborn must be warmed immediately to increase its temperature to at least 36 degrees C (97 degrees F).

Question 30

When providing discharge instructions for a client with open-angle glaucoma, the nurse should advise the client to avoid

A) Driving

B) Sedatives

C) Swimming

D) Constipation

Review Information: The correct answer is:

D) Constipation.

Lifting heavy objects, crying and constipation (which would involve straining) would increase intraocular pressure and should be avoided.

Question 31

The nurse is caring for an 81 year-old client with colorectal cancer. The client's pain has been managed until now with acetaminophen with codeine. Because of increased pain, the order is changed to morphine. The nurse recognizes that this order is

A) Inappropriate because of potential respiratory depression

B) Appropriate despite the expected effect of mental confusion

C) Inappropriate and demonstrates poor knowledge of pain control

D) Appropriate pain management around-the-clock

Review Information: The correct answer is:

D) Appropriate pain management around-the-clock.

Elderly clients with cancer pain are frequently under medicated. This management is appropriate, and should be offered throughout the day and night.

Question 32

A 70 year-old woman is evaluated in the emergency room for a wrist fracture with no known precipitating cause. In assessing the client, the nurse identifies which of the following as related to risk factors for osteoporosis?

A) Reports late menarche and menopause

B) Takes steroids for arthritis

C) Maintains an active lifestyle

D) Continues on estrogen replacement

Review Information: The correct answer is:

B) Takes steroids for arthritis.

The use of steroids over time increases the risk for osteoporosis. Other risk factors include low bone mass, poor calcium absorption and moderate to high alcohol ingestion.

Question 33

The nurse is caring for a client with a myocardial infarction. Which of the following assessment findings requires the nurse's IMMEDIATE action?

A) Periorbital edema

B) Dizziness spells

C) Lethargy

D) Shortness of breath

Review Information: The correct answer is:

B) Dizziness spells.

Cardiac dysrhythmias may cause a transient drop in cardiac output and decreased blood flow to the brain. Near syncope refers to lightheartedness, dizziness, temporary confusion. Such "spells" may indicate runs of ventricular tachycardia or periods of asystole and should be reported immediately.

Question 34

A client is receiving digitalis. The nurse should instruct the client to report which of the following side effects

A) Nausea, vomiting, fatigue

B) Rash, shortness of breath and edema in ankles

C) Polyuria, thirst, dry skin

D) Hunger, dizziness, diaphoresis

Review Information: The correct answer is:

A) Nausea, vomiting, fatigue.

Side effects of digitalis include fatigue, nausea, vomiting, anorexia, and bradycardia. Digitalis inhibits the sodium potassium ATPase, which makes more calcium available for contractile proteins, resulting in increased cardiac output.

Question 35

The nurse is performing a neurological assessment on a client post right CVA. Which of the following findings, if observed by the nurse, would warrant IMMEDIATE attention?

A) Decrease in level of consciousness

B) Loss of bladder control

C) Altered sensation to stimuli

D) Emotional lability

Review Information: The correct answer is:

A) Decrease in level of consciousness.

A further decrease in the level of consciousness would be indicative of a further progression of the CVA.

Question 36

A client is admitted with the diagnosis of pulmonary embolism. While taking a history, the client tells the nurse he was admitted for the same thing twice before, the last time just three months ago. The nurse would anticipate the physician ordering

A) Pulmonary embolectomy

B) Vena caval interruption

C) Increasing the coumadin therapy to an INR of 3-4

D) Thrombolytic therapy

Review Information: The correct answer is:

B) Vena caval interruption.

Clients with contraindications to heparin, recurrent PE or those with complications related to the medical therapy may require vena caval interruption by the placement of a filter device in the inferior vena cava. A filter can be placed transvenously to trap clots before they travel to the pulmonary circulation.

Question 37

The nurse is teaching home care to the parents of a child with acute spasmodic croup. The MOST important aspect of this care is

A) Sedation as needed to prevent exhaustion

B) Antibiotic therapy for 10-14 days

C) Humidified air and increased oral fluids

D) Antihistamines to decrease allergic response

Review Information: The correct answer is:

C) Humidified air and increased oral fluids.

The most important aspect of home care for a child with acutespasmodic croup is to provide humidified air and increased oral fluids. Moisture soothes inflamed membranes. Adequate systemic hydration aids is mucocillary clearance and keeps secretions thin, white, watery, and easily removed with minimal coughing.

Question 38

A couple trying to conceive asks the nurse when ovulation occurs. The woman reports a regular 32 day cycle. The BEST response by the nurse is

A) Days 7-10

B) Days 10-13

C) Days 14-16

D) Days 17-19

Review Information: The correct answer is:

D) Days 17-19.

Ovulation occurs 14 days prior to menses. Considering that the woman''s cycle is 32 days, subtracting 14 from 32 suggests ovulation is at about the 18th day.

Question 39

A nurse prepares to care for a 4 year-old newly admitted for rhabdomyosarcoma. The nurse should be aware that this type of tumor affects

A) All striated muscles

B) The cerebellum

C) Kidneys and bladder

D) Leg bones

Review Information: The correct answer is:

A) All striated muscles.

Rhabdomyosarcoma is the most common children''s soft tissue sarcoma. It originates in striated (skeletal) muscles and can be found anywhere in the body.

Question 40

A client returns from surgery after an open reduction of a femur fracture. There is a small bloodstain on the cast. Four hours later, the nurse observes that the stain has doubled in size. What is the BEST action for the nurse to take?

A) Call the physician

B) Access the site by cutting a window in the cast

C) Record the findings in the nurse's notes only

D) Outline the spot with a pencil and note the time and date on the cast

Review Information: The correct answer is:

D) Outline the spot with a pencil and note the time and date on the cast.

This is a good way to assess the amount of bleeding over a period of time. The bleeding does not appear to be excessive and some bleeding is expected with this type of surgery. Thebleeding should also be documented in the nurse's notes.

Question 1

A client with an aplastic sickle cell crisis is receiving a blood transfusion and begins to complain of "feeling hot". Almost immediately, the client begins to wheeze. The nurse's first ACTION is to

A) Stop the blood infusion

B) Notify the physician

C) Take/record vital signs

D) Send blood samples to lab

Review Information: The correct answer is:

A) Stop the blood infusion.

If a reaction of any type is suspected during administration of blood products, stop the infusion immediately, keep the line open with saline, notify the physician, monitor vital signs and other changes, and then send a blood sample to the lab.

Question 2

As a nurse manager, it is important to give positive and negative feedback to staff as appropriate. Which of the following BEST describes the characteristic of an effective reward-feedback system?

A) Specific feedback is given as close to the event as possible

B) All staff are given feedback equally

C) Positive statements always precede a negative statement

D) Performance goals should be higher than what is attainable

Review Information: The correct answer is:

A) Specific feedback is given as close to the event as possible.

Feedback is most useful when given immediately. Positive behavior is strengthened through immediate feedback, and it is easier to modify problem behaviors if the standards are clearly understood.

Question 3

The nurse is assessing a young child at a clinic visit for a mild respiratory infection. Koplik spots are noted on the oral mucous membranes. The nurse recognizes that the presence of these spots suggests

A) Rubeola

B) Pertussis

C) Varicella

D) Rubella

Review Information: The correct answer is:

A) Rubeola.

A characteristic sign of rubeola is Koplik spots (small red spots with a bluish white center). These are found on the buccal mucosa about two days before and after the onset of the measles rash.

Question 4

The nurse has been teaching an apprehensive primipara who has difficulty in initial nursing of the newborn. What observation at the time of discharge suggests that initial breast feeding is effective?

A) The mother feels calmer and talks to the baby while nursing

B) The mother awakens the newborn to feed whenever it falls asleep

C) The newborn falls asleep after three minutes at the breast

D) The newborn refuses the supplemental bottle of glucose water

Review Information: The correct answer is:

A) The mother feels calmer and talks to the baby while nursing.

Early evaluation of successful breastfeeding can be measured by the client''s voiced confidence and satisfaction with the infant.

Question 5

The recent increase in the reported cases of active tuberculosis in the United States is attributed to

A) The increasing homeless population

B) The rise in reported cases of HIV infection

C) The migration patterns from foreign countries

D) The aging of the population

Review Information: The correct answer is:

B) The rise in reported cases of HIV infection.

Since 1985 there has been a 20% increase in the reported cases of TB. The increase was most evident in cities with a high incidence of HIV infection. HIV infection currently is the greatest known risk factor for reactivating latent TB infections as well.

Question 6

The nurse is caring for an 87 year-old client with urinary retention. Which of the following should be reported immediately?

A) Fecal impaction

B) Infrequent voiding

C) Stress incontinence

D) Burning with urination

Review Information: The correct answer is:

A) Fecal impaction.

The nurse should report fecal impaction or constipation which can cause obstruction of the bladder outlet. Bladder outlet obstruction is a common cause of urine retention in the elderly.

Question 7

The nurse is assessing a child with suspected lead poisoning. Which of the following assessments is the nurse MOST likely to find?

A) Complaints of numbness and tingling in feet

B) Wheezing noted when lung sound auscultated

C) Excessive perspiration

D) Difficulty sleeping

Review Information: The correct answer is:

A) Complaints of numbness and tingling in feet.

A child who has unusual neurologic signs or symptoms, neuropathy, footdrop, or anemia that cannot be attributed to other causes may be suffering from lead poisoning. This most often occurs when a child ingests or inhales paint chips from lead-based paint or dust from remodeling in older buildings.

Question 8

A client with multiple sclerosis plans to begin an exercise program. In addition to discussing the benefits of regular exercise, the nurse should caution the client to avoid activities which

A) Increase the heart rate

B) Lead to dehydration

C) Are considered aerobic

D) May be competitive

Review Information: The correct answer is:

B) Lead to dehydration.

The client must take in adequate fluids before and during exercise periods.

Question 9

The nurse is assessing a client who is on long term glucocorticoid therapy. Which of the following findings would the nurse expect?

A) Buffalo hump

B) Increased muscle mass

C) Peripheral edema

D) Jaundice

Review Information: The correct answer is:

A) Buffalo hump.

With high doses of glucocorticoid, iatrogenic Cushing''s syndrome develops. The exaggerated physiological action causes abnormal fat distribution which results in a moon-shaped face, a dorsocervical pad on the neck (buffalo hump) and truncal obesity with slender limbs.

Question 10

Which of the following people would be at greatest risk for developing hypertension?

A) 45 year-old African American attorney

B) 60 year-old Asian American shop owner

C) 40 year-old Caucasian nurse

D) 55 year-old Hispanic teacher

Review Information: The correct answer is:

A) 45 year-old African American attorney.

The incidence of hypertension is greater among African Americans than other groups in the US.

Question 11

Today's prothrombin time for a client receiving Coumadin is 20 (normal range listed by the lab is 10-14). What is the APPROPRIATE nursing action?

A) Notify the physician immediately

B) Recognize that this is a therapeutic level

C) Observe the client for hematoma development

D) Assess for bleeding at gums or IV sites

Review Information: The correct answer is:

B) Recognize that this is a therapeutic level.

For the client on Coumadin therapy, this prothrombin level is within the therapeutic range.

Question 12

A client is admitted to the emergency room with renal calculi and is complaining of moderate to severe flank pain and nausea. The client's temperature is 100.8 F. The PRIORITY nursing goal for this client is

A) Maintain fluid and electrolyte balance

B) Control nausea

C) Manage pain

D) Prevent urinary tract infection

Review Information: The correct answer is:

C) Manage pain.

The immediate goal of therapy is to alleviate the client's pain.

Question 13

A client comes to the clinic for treatment of recurrent pelvic inflammatory disease. The nurse recognizes that this condition MOST frequently follows which type of infection?

A) Trichomoniasis

B) Chlamydia

C) Staphylococcus

D) Streptococcus

Review Information: The correct answer is:

B) Chlamydia.

Chlamydial infections are one of the most frequent causes of salpingitis or pelvic inflammatory disease.

Question 14

The nurse is providing education for a newly diagnosed tuberculosis client. The MOST important information to include is to instruct the client to

A) "Isolate yourself from your family members until you are finished taking your medication."

B) "Follow up with your primary care physician in 3 months."

C) "Continue to take your medications even when you are feeling fine."

D) "Continue to get yearly tuberculin skin tests."

Review Information: The correct answer is:

C) "Continue to take your medications even when you are feeling fine.".

The most important piece of information the tuberculosis client needs is to understand the importance ofmedication compliance even if he is no longer experiencing symptoms. Clients are most infective early in the course of therapy. The numbers of acid-fast bacilli are greatly reduced as early as 2 weeks after therapy begins.

Question 15

The nurse is caring for a client with a serum potassium level of 3.5 mEq/L. The client is placed on a cardiac monitor and receives 40 mEq KCL in 1000 ml of 5% dextrose in water IV. Which of the following EKG patterns indicates to the nurse that the infusions should be discontinued?

A) Narrowed QRS complex

B) Shortened "PR" interval

C) Tall peaked T waves

D) Prominent "U" waves

Review Information: The correct answer is:

C) Tall peaked T waves.

A tall peaked T wave is a sign of hyperkalemia. The physician should be notified regarding discontinuing the medication.

Question 16

The nurse is giving discharge teaching to a client 7 days post myocardial infarction. He asks the nurse why he must wait 6 weeks before having sexual intercourse. The nurse's BEST response to this question is

A) "You need to regain your strength before attempting such exertion."

B) "When you can climb two flights of stairs without problems, it is generally safe."

C) "Have a glass of wine to relax you, then you can try to have sex."

D) "If you can maintain an active walking program, you will have less risk."

Review Information: The correct answer is:

B) "When you can climb two flights of stairs without problems, it is generally safe.".

There is a risk of cardiac rupture at the point of the myocardial infarction for about 6 weeks. Scar tissue should form about that time. Waiting until the client can tolerate climbing stairs is the usual advice given by physicians.

Question 17

Which of the following should the nurse implement to prepare a client for a KUB (Kidney, Ureter, Bladder) radiograph test?

A) Client must be NPO before the examination

B) Enema to be administered prior to the examination

C) Medicate client with Demerol 25 mgm IM 30 minutes prior to the examination

D) No special orders are necessary for this examination

Review Information: The correct answer is:

D) No special orders are necessary for this examination.

No special preparation is necessary for this examination.

Question 18

A client is receiving erythromycin 500mg IV every 6 hours to treat a pneumonia. Which of the following is the MOST common side effect of the medication?

A) Blurred vision

B) Nausea and vomiting

C) Severe headache

D) Insomnia

Review Information: The correct answer is:

B) Nausea and vomiting.

Nausea is a common side-effect of erythromycin in both oral and intravenous forms.

Question 19

The nurse is performing an assessment on a child who has been recently diagnosed with Cystic Fibrosis. Which of the following findings would the nurse anticipate?

A) Poor appetite

B) Ribbon stools

C) Dry, non-productive cough

D) Frequent urinary infections

Review Information: The correct answer is:

C) Dry, non-productive cough.

Noisy respirations and a dry non-productive cough are usually the first respiratory symptoms to appear in a newly diagnosed Cystic Fibrosis client.

Question 20

When caring for a child who ingested 15 maximum strength acetaminophen tablets 45 minutes ago, which of the following actions should the nurse take FIRST?

A) Induce vomiting with syrup of ipecac

B) Administer the antidote mucomist

C) Start an IV of glucose in saline

D) Prepare for emergency dialysis

Review Information: The correct answer is:

A) Induce vomiting with syrup of ipecac.

Removing as much of the drug as possible is the first step in treatment for this drug overdose. Ipecac should be given within one hour of ingesting this poison unless the child is comatose.

Question 21

The home health nurse visits a male client to provide wound care and finds the client lethargic and confused. His wife states he fell down the stairs two hours ago. The nurse should

A) Place a call to the client's physician for instructions

B) Send him to the emergency room for evaluation

C) Reassure the client's wife that the symptoms are transient

D) Instruct the client's wife to call the doctor if his symptoms become worse

Review Information: The correct answer is:

B) Send him to the emergency room for evaluation.

This client requires immediate evaluation. A delay in treatment could result in further deterioration and harm. Home care nurses must prioritize interventions based on assessment findings that are in the client''s best interest.

Question 22

During an assessment of a client with cardiomyopathy, the nurse finds that the systolic blood pressure has decreased from 145 to 125 mm Hg and the heart rate has risen from 72 to 88 beats per minute and the client complains of periodic dizzy spells. The nurse instructs the client to

A) Increase fluids and eat Jell-O and ice-pops

B) Restrict fluids and eat non-saltine crackers

C) Force fluids and eat potato chips

D) Limit fluids to non-caffeine beverages

Review Information: The correct answer is:

C) Force fluids and eat potato chips.

Postural hypotension, a decrease in systolic blood pressure of more than 15 mm Hg and an increase in heart rate of more than 15 percent usually accompanied by dizziness indicates volume depletion, inadequate vasoconstrictor mechanisms, and autonomic insufficiency. Oral replacement may be accomplished by giving fluids that contain sodium (such as salty broth), by providing salty foods along with liquid or by using commercial rehydration fluids.

Question 23

The family of a client tells the admitting nurse that they value the practice of Chinese medicine. The nurse must understand that for this family the PRIORITY goal is to

A) Achieve harmony

B) Maintain energy balance

C) Respect life

D) Restore yin and yang

Review Information: The correct answer is:

D) Restore yin and yang.

For followers of Chinese medicine, health is maintained through balance between the forces of yin and yang.

Question 24

The nurse is speaking at a community meeting about personal responsibility for health promotion. A participant asks about chiropractic treatment for illnesses. The BEST response focuses on

A) Electrical energy fields

B) Spinal column manipulation

C) Mind - body balance

D) Exercise of joints

Review Information: The correct answer is:

B) Spinal column manipulation.

The theory underlying chiropractic is that interference with transmission of mental impulses between the brain and body organs produces diseases. Such interference is caused by misalignment of the vertebrae. Manipulation reduces the subluxation.

Question 25

The nurse is caring for a client with a venous stasis ulcer. Which nursing intervention would be MOST effective in promoting healing?

A) Apply dressing using sterile technique

B) Improve the client's nutrition status

C) Initiate limb compression therapy

D) Begin proteolytic debridement

Review Information: The correct answer is:

B) Improve the client''s nutrition status.

The goal of clinical management in a client with venous stasis ulcers is to promote healing. This only can be accomplished with proper nutrition. The other answers are correct, but without proper nutrition, the other interventions would be of little help.

Question 26

While assessing the growth of children during their school age years, the nurse would expect to see

A) Decreasing amounts of body fat and muscle mass

B) Little change in body appearance from year to year

C) Progressive height increase of 4 inches each year

D) Yearly weight gain of about 5.5 pounds per year

Review Information: The correct answer is:

D) Yearly weight gain of about 5.5 pounds per year.

School age children gain about 5.5 pounds each year and increase about 2 inches in height.

Question 27

In order to be effective in administering cardiopulmonary resuscitation to a 5 year-old, the nurse MUST remember to

A) Assess the brachial pulses

B) Breathe once every 5 compressions

C) Use both hands to apply chest pressure

D) Compress 80-90 times per minute

Review Information: The correct answer is:

B) Breathe once every 5 compressions.

For a 5 year-old, the nurse should give one breath for every 5 compressions.

Question 28

The parents of a child who has recently been diagnosed with asthma ask the nurse to explain the condition to them. The BEST response is "Asthma causes

A) the airway to become narrow and obstructs airflow."

B) air to be trapped in the lungs because the airways are dilated."

C) the nerves that control respiration to become hyperactive."

D) a decrease in the stress hormones which prevents the airways from opening."

Review Information: The correct answer is:

A) the airway to become narrow and obstructs airflow.".

Asthma is defined as airway obstruction or a narrowing that is characterized by bronchial irritability after exposure to various stimuli.

Question 29

In children suspected to have a diagnosis of diabetes, which one of the following complaints would be MOST likely to prompt parents to take their school age child for evaluation?

A) Polyphagia

B) Dehydration

C) Bed wetting

D) Weight loss

Review Information: The correct answer is:

C) Bed wetting.

In children, fatigue and bed wetting are the chief complaints that prompt parents to take their child for evaluation. Bed wetting in a school age child is readily detected by the parents.

Question 30

The nurse practicing in a maternity setting recognizes that the post mature infant is at risk due to

A) Excessive fetal weight

B) Low blood sugar levels

C) Depletion of subcutaneous fat

D) Progressive placental insufficiency

Review Information: The correct answer is:

D) Progressive placental insufficiency.

The placenta functions less efficiently as pregnancy continues beyond 42 weeks. Immediate and long term effects may be related to hypoxia.

Question 31

The nurse is preparing to administer an enteral feeding to a client via an nasogastric feeding tube. The MOST important action of the nurse is

A) Verify correct placement of the tube

B) Check that the feeding solution matches the dietary order

C) Aspirate abdominal contents to determine the amount of last feeding remaining in stomach

D) Ensure that feeding solution is at room temperature

Review Information: The correct answer is:

A) Verify correct placement of the tube.

Proper placement of the tube prevents aspiration.

Question 32

The major purpose of community health research is to

A) Describe the health conditions of populations

B) Evaluate illness in the community

C) Explain the health conditions of families

D) Identify the health conditions of the environment

Review Information: The correct answer is:

A) Describe the health conditions of populations.

Community health focuses upon aggregate population care.

Question 33

While assessing the quality of home care for a client with Alzheimer's disease, the PRIORITY for the nurse is to emphasize

A) Good nutrition

B) Family counseling

C) Client safety

D) Medication compliance

Review Information: The correct answer is:

C) Client safety.

Ensuring safety of the client with increasing memory loss is a priority of home care.

Question 34

A postpartum woman admits to alcohol use throughout the pregnancy. Which of the following newborn assessments suggests to the nurse that the infant has fetal alcohol syndrome?

A) Growth retardation is evident

B) Multiple anomalies are identified

C) Cranial facial abnormalities are noted

D) Prune belly syndrome is suspected

Review Information: The correct answer is:

C) Cranial facial abnormalities are noted.

Characteristic facial abnormalities are seen in the newborn with fetal alcohol syndrome.

Question 35

A pregnant client comes to the clinic for a first visit. The nurse gathers data about her obstetric history, which includes: she has 3 year-old twins at home and had a miscarriage at 12 weeks gestation ten years ago. The nurse would accurately document

A) Gravida 4 para 2

B) Gravida 2 para 1

C) Gravida 3 para 1

D) Gravida 3 para 2

Review Information: The correct answer is:

C) Gravida 3 para 1.

Gravida is the number of pregnancies and Parity is the number of pregnancies that reach viability (not the number of fetuses). Thus, for this woman, she is now pregnant, had two prior pregnancies, and one viable birth (twins).

Question 36

A nursing student is concerned about future practice opportunities in a changing health care system. Which of the following BEST defines re-engineering in health care?

A) Downsizing or elimination of staffing positions to cut health care costs

B) Redesign of processes and service (care) delivery to improve quality

C) Cross-training staff for multiple tasks to reduce number of employees

D) The use of management consultants to increase staff efficiency

Review Information: The correct answer is:

B) Redesign of processes and service (care) delivery to improve quality.

Although staffing cuts and cross-training may accompany re-engineering plans, the goal is to redesign the delivery of care system for higher efficiency and quality of care.

Question 37

Which of the following is MOST hazardous to an 8 month-old child?

A) Riding in a car

B) Falling off a bed

C) Electrical outlets

D) Eating peanuts

Review Information: The correct answer is:

D) Eating peanuts.

Asphyxiation by foreign materials in the respiratory tract is the leading cause of death in children < 6 years of age.

Question 38

The nurse is caring for a ten year-old client who will be placed on heparin therapy. Which of the following assessments is critical for the nurse to make before initiating therapy

A) Vital signs

B) Weight

C) Lung sounds

D) Skin turgor

Review Information: The correct answer is:

B) Weight.

Check the client''s weight because dosage is calculated on the basis of weight.

Question 39

A depressed client is experiencing severe insomnia. The physician orders trazadone (Desyrel). The nurse tells the client to expect

A) Improvement of acne

B) Relief of insomnia

C) Reduced arthritic pain

D) Less nasal stuffiness

Review Information: The correct answer is:

B) Relief of insomnia.

The sedative effects of the antidepressant are expected to relieve insomnia.

Question 40

While planning care for a toddler, the nurse teaches the parents about the expected developmental changesfor this age. Which statement by the mother shows that she understands the child's developmental needs?

A) "I want to protect my child from any falls."

B) "I will set limits on exploring the house."

C) "I understand the need to use those new skills."

D) "I intend to keep control over our child."

Review Information: The correct answer is:

C) "I understand the need to use those new skills.".

Erikson describes the stage of the toddler as being the time when there is normally an increase in autonomy. The child needs to use motor skills to explore the environment.

Question 1

The nurse is taking a health history from a Native American client. In order to be culturally sensitive when speaking to the client and family, the nurse MUST remember that eye contact is considered

A) Critical

B) Rude

C) Professional

D) Valued

Review Information: The correct answer is:

B) Rude.

Native Americans consider direct eye contact to be impolite or aggressive among strangers.

Question 2

Which of the following is MOST likely to ensure the safety of the nurse while making a home visit?

A) Seeing no evidence of weapons in the home

B) Reading no entries about previous violence in the client's record

C) Staying alert at all times and leaving if cues suggest the home is not safe

D) Carrying a cell phone, pager, and/or hand held alarm

Review Information: The correct answer is:

C) Staying alert at all times and leaving if cues suggest the home is not safe.

No person or equipment can guarantee nurses'' safety, although the risk of violence can be minimized. Before making initial visits, review referral information carefully and have a plan to communicate with agency staff. Schedule appointments with clients. When driving into an area for the first time, note potential hazards and sources of assistance. Become acquainted with neighbors. Be alert and confident while parking the car, walking to the client''s door, making the visit, walking to the car, and driving away. LISTEN to clients; if they tell you to leave, do so.

Question 3

An 80 year-old nursing home resident has a temperature of 101.6 rectally. This is a sudden change in an otherwise healthy client. Which should the nurse assess FIRST?

A) Lung sounds

B) Urine output

C) Level of alertness

D) Appetite

Review Information: The correct answer is:

C) Level of alertness.

Assessing level of consciousness (alert vs. lethargic vs. unresponsive) will help the health care provider determine the severity of the acute episode. If the client is alert, responses to questions about complaints can be followed-up quickly.

Question 4

The nurse is providing foot care instructions to a client with arterial insufficiency. The nurse would identify the need for ADDITIONAL teaching if the client stated

A) "I can only wear cotton socks."

B) "I cannot go barefoot around my house."

C) "I will trim corns and calluses regularly."

D) "I should ask a family member to inspect my feet daily."

Review Information: The correct answer is:

C) "I will trim corns and calluses regularly.".

Clients who are elderly, have diabetes, and/or have vascular disease often have decreased circulation and sensation in one or bothfeet. Their vision may also be impaired. Therefore, they need to be taught to examine their feet daily or have someone else do so. They should wear cotton socks which have not been

mended, and always wear shoes when out of bed. They should not cut their nails, corns, and calluses, but should have them trimmed by their physician, nurse, or other provider who specializes in foot care.

Question 5

The mother of a burned child asks the nurse to clarify what is meant by a third degree burn. The BEST response by the nurse is

A) "The top layer of the skin is destroyed."

B) "The skin layers are swollen and reddened."

C) "All layers of the skin were destroyed in the burn."

D) "Muscle, tissue and bone have been injured."

Review Information: The correct answer is:

C) "All layers of the skin were destroyed in the burn.".

A third degree burn is a full thickness injury to dermis, epidermis and subcutaneous tissue.

Question 6

As a client is being discharged following resolution of a spontaneous pneumothorax, he tells the nurse that he is now going to Hawaii for a vacation. The nurse would warn him to avoid

A) Surfing

B) Scuba diving

C) Parasailing

D) Swimming

Review Information: The correct answer is:

B) Scuba diving.

The nurse would strongly emphasize the need for clients with history of spontaneous pneumothorax problems to avoid high altitudes, flying in unpressurized aircraft and scuba diving. The negative pressures could cause the lung to collapse again.

Question 7

Parents are concerned that their 11 year-old child is a very picky eater. The nurse suggests which of the following as the BEST initial approach?

A) Consider a liquid supplement to increase calories

B) Discuss consequences of an unbalanced diet with the child

C) Provide fruit, vegetable and protein snacks

D) Encourage the child to keep a daily log of foods eaten

Review Information: The correct answer is:

B) Discuss consequences of an unbalanced diet with the child.

It is important to educate the preadolescent as to appropriate diet, and the problems that might arise if diet is not adequate.

Question 8

The nurse is providing home care for a client with heart failure and pulmonary edema. Which of the following nursing diagnoses should have PRIORITY in planning care?

A) Impaired Skin Integrity related to dependent edema

B) Activity Intolerance related to oxygen supply and demand imbalance

C) Constipation related to immobility

D) Risk for infection related to ineffective mobilization of secretions

Review Information: The correct answer is:

B) Activity Intolerance related to oxygen supply and demand imbalance.

This is the primary problem due to decreased cardiac output related to heart failure. There is a reduction of oxygen and complaints of dyspnea and fatigue.

Question 9

The incidence of a Hepatitis B refers to

A) The number of persons in a population who develop Hepatitis B during a specific period of time

B) The total number of persons in a population who have Hepatitis B at a particular time

C) The death rate resulting from Hepatitis B

D) The occurrence of Hepatitis B in the population

Review Information: The correct answer is:

A) The number of persons in a population who develop Hepatitis B during a specific period of time.

This is the correct definition of incidence of the disease.

Question 10

The client is experiencing symptoms of tardive dyskinesia. The nurse would expect to see

A) Rapid tongue movements

B) Uncontrolled hand tremors during meals

C) Behavioral changes

D) Repetitive slapping movements

Review Information: The correct answer is:

A) Rapid tongue movements.

This symptom is identified with tardive dyskinesia.

Question 11

A fifteen month-old child comes to the clinic for a follow-up visit after hospitalization for treatment of Kawasaki Disease. The nurse recognizes that which of the following scheduled immunizations will be delayed?

A) MMR

B) Hib

C) IPV

D) DtaP

Review Information: The correct answer is:

A) MMR.

Medical management of Kawasaki involves administration of immunoglobulins. Measles, mumps, rubella (MMR) is a live virus vaccine. Following administration of immunoglobulins, live vaccines should be held due to possible interference with the body''s ability to form antibodies.

Question 12

The nurse discovers that the parents of a 2 year-old child continue to use an apnea monitor each night. The parents state that they remain concerned about the possible occurrence of sudden infant death syndrome (SIDS). In order to take appropriate action, the nurse must understand that

A) The child is within the age group most susceptible to SIDS

B) The peak age for occurrence of SIDS is 8-12 months of age

C) The apnea monitor is not effective on a child in this age group

D) Ninety-five percent of all SIDS cases occur before 6 months

Review Information: The correct answer is:

D) Ninety-five percent of all SIDS cases occur before 6 months.

Peak age of SIDS occurrence is 2-4 months and 95% of cases occur by 6 months of age. It is the leading cause of death in infants 1 month to 1 year of age.

Question 13

In assessing a post partum client, the nurse palpates a firm fundus. Also observed is a constant trickle of bright red blood from the vagina. The nurse suspects

A) Uterine atony

B) Genital lacerations

C) Retained placenta

D) Clotting disorder

Review Information: The correct answer is:

B) Genital lacerations.

Continuous bleeding in the absence of a boggy fundus indicates undetected genital tract lacerations.

Question 14

The nurse is assessing a newborn delivered at home by an admitted heroin addict. Which of the following would the nurse expect to observe?

A) Hypertonic neuro reflex

B) Immediate CNS depression

C) Lethargy and sleepiness

D) Jitteriness at 24-48 hours

Review Information: The correct answer is:

D) Jitteriness at 24-48 hours.

Withdrawal signs may not be evident for 1-2 days after birth. Irritability and poor feeding also are evident.

Question 15

The nurse is taking a health history from parents of a child admitted with possible Reye's Syndrome. Which of the following recent illnesses would the nurse recognize as increasing the risk to develop Reye's Syndrome?

A) Rubeola

B) Meningitis

C) Varicella

D) Hepatitis

Review Information: The correct answer is:

C) Varicella.

Varicella (chicken pox) and influenza are viral illnesses that have been identified as increasing the risk for Reye''s Syndrome. Use of aspirin is contraindicated for children with these infections.

Question 16

The nurse is teaching a mother who will breast feed for the first time. Which of the following is a PRIORITY?

A) Show her films on the physiology of lactation

B) Give the client several illustrated pamphlets

C) Assist her to position the newborn at the breast

D) Give her privacy for the initial feeding

Review Information: The correct answer is:

C) Assist her to position the newborn at the breast.

While all of the responses are helpful in teaching, the priority is placing the infant to breast as soon after birth as possible to establish contact and allow the newborn to begin to suck.

Question 17

The nurse is teaching a 27 year-old client with asthma about management of their therapeutic regime. Which of the following statements would indicate the need for ADDITIONAL instruction?

A) "I should monitor my peak flow every day."

B) "I should contact the clinic if I am using my medication more often."

C) "I need to limit my exercise, especially activities such as walking and running."

D) "I should learn stress reduction and relaxation techniques."

Review Information: The correct answer is:

C) "I need to limit my exercise, especially activities such as walking and running.".

Limiting physical activity in an otherwise healthy, young client should not be necessary. If exercise intolerance exists, the asthma management plan should include specific medications to treat the problem such as using an inhaled beta-agonist 5 minutes before exercise. The goal is always to return to a normal lifestyle.

Question 18

An adolescent client is admitted in respiratory alkalosis following aspirin overdose. The nurse recognizes that this condition was caused by

A) Tachypnea

B) Acidic byproducts

C) Vomiting and dehydration

D) Hyperpyrexia

Review Information: The correct answer is:

A) Tachypnea.

Stimulation of respiratory center leads to hyperventilation, thus decreasing CO_2 levels which causes respiratory alkalosis.

Question 19

The physician has ordered daily high doses of aspirin for a client with rheumatoid arthritis. The nurse instructs the client to discontinue the medication and contact the physician if which of the following symptoms occurs?

A) Infection of the gums

B) Diarrhea for more than one day

C) Numbness in the lower extremities

D) Ringing in the ears

Review Information: The correct answer is:

D) Ringing in the ears.

Aspirin stimulates the central nervous system which may result in ringing in the ears.

Question 20

When teaching parents about sickle cell disease, the nurse should tell them that their child's anemia is caused by

A) Reduced oxygen capacity of cells due to lack of iron

B) An imbalance between red cell destruction and production

C) Depression of red and white cells and platelets

D) Inability of sickle shaped cells to regenerate

Review Information: The correct answer is:

B) An imbalance between red cell destruction and production.

Anemia results when the rate of red cell destruction exceeds the rate of production through stimulated erythropoiesis in bone marrow (life span shortened from 120 days to 12-20 days).

Question 21

While giving care to a two year-old client, the nurse should remember that the toddler's tendency to say "no" to almost everything is an indication of

A) Stubborn behavior

B) Rejection of parents

C) Frustration with adults

D) Assertion of control

Review Information: The correct answer is:

D) Assertion of control.

Negativism is a normal behavior in toddlers. The nurse must be aware that this behavior is an important sign of the child''s progress from dependency to autonomy and independence.

Question 22

For which of the following mother-baby pairs should the nurse review the Coomb's test in preparation for administering Rh0 (D) immune globulin within 72 hours of birth?

A) Rh negative mother with Rh positive baby

B) Rh negative mother with Rh negative baby

C) Rh positive mother with Rh positive baby

D) Rh positive mother with Rh negative baby

Review Information: The correct answer is:

A) Rh negative mother with Rh positive baby.

An Rh - mother who delivers an Rh + baby may develop antibodies to the fetal red cells to which she may be exposed during pregnancy or at placental separation. If the Coombs test is negative, no sensitization has occurred. The Rh0(D) immune globulin is given to block antibody formation in the mother.

Question 23

An adolescent client is hospitalized with menarthrosis from a Hemophilia A bleeding episode. Which of the following orders should be questioned by the nurse?

A) Passive range of motion

B) Replacement of factor VIII

C) Aspirin for pain management

D) Immobilization splint

Review Information: The correct answer is:

C) Aspirin for pain management.

Aspirin is contraindicated in any client who is actively bleeding. Ibuprofen is a more common pain medication.

Question 24

A client with a fracture of the radius had a plaster cast applied two days ago. The client complains of constant pain and swelling of the fingers. The FIRST action of the nurse should be

A) Elevate the arm no higher than heart level

B) Remove the cast

C) Assess capillary refill of the exposed hand and fingers

D) Apply a warm soak to the hand

Review Information: The correct answer is:

C) Assess capillary refill of the exposed hand and fingers.

A deterioration in neurovascular status indicates the development of compartment syndrome (elevated tissue pressure within a confined area) which requires immediate pressure reducing interventions.

Question 25

The nurse is caring for a client with congestive heart failure. Which of the following assessments requires the nurse's IMMEDIATE attention?

A) Pulse oximetry of 85%

B) Nocturia

C) Crackles in lungs

D) Diaphoresis

Review Information: The correct answer is:

A) Pulse oximetry of 85%.

An oxygen saturation of 88% or less indicates hypoxemia and requires the nurse''s immediate attention.

Question 26

The nurse is planning care for a client who is taking cyclosporin (Neoral). What would be an appropriate nursing diagnsosis for this client?

A) Alteration in body image

B) High risk for infection

C) Altered growth and development

D) Impaired physical mobility

Review Information: The correct answer is:

B) High risk for infection.

Cyclosporin (Neoral) inhibits normal immune responses. Clients receiving cyclosporin are at risk for infection.

Question 27

When caring for a client who is receiving a thrombolytic agent to open a clot occluded coronary artery after a myocardial infarction, which of the following findings would be of GREATEST concern to the nurse?

A) Sero sanginous drainage from gums

B) Hematemesis

C) Pink frothy sputum

D) Slight red color at urine

Review Information: The correct answer is:

B) Hematemesis.

Frank bleeding should be of the greatest concern to the nurse.

Question 28

The nasogastric tube of a post-op gastrectomy client has stopped draining greenish liquid. The nurse should

A) Irrigate it as ordered with distilled water

B) Irrigate it as ordered with normal saline

C) Place the end of the tube in water to see if the water bubbles

D) Withdraw the tube several inches and reposition it

Review Information: The correct answer is:

B) Irrigate it as ordered with normal saline.

Nasogastric tubes are only irrigated with normal saline to maintain patency.

Question 29

When providing discharge teaching to a client with asthma, the nurse will warn against the use of which of the following over-the-counter medications?

A) Cortisone ointments for skin rashes

B) Aspirin products for pain relief

C) Cough medications containing guaifenesin

D) Histamine blockers for gastric distress

Review Information: The correct answer is:

B) Aspirin products for pain relief.

Aspirin is known to induce asthma attacks. Aspirin can also cause nasal polyps and rhinitis. Warn individuals with asthma about signs and symptoms resulting from complications due to aspiriningestion.

Question 30

An infant has just returned from surgery for placement of a gastrostomy tube as an initial treatment for tracheoesophageal fistula. The mother asks the nurse when the tube can be used for feeding. The nurse's BEST response is that

A) Feedings can begin in 5-7 days

B) Use of feeding tube can begin immediately

C) Stomach contents and air must be drained first

D) Incision healing must be complete before feeding

Review Information: The correct answer is:

C) Stomach contents and air must be drained first.

After surgery for gastrostomy tube placement, the catheter is left open and attached to gravity drainage for 24 hours or more.

Question 31

A nursing assistant asks the nurse manager to explain the beliefs of a Christian Scientist who refuses admission to the hospital following a motor vehicle accident. The BEST response emphasizes the importance to the believer of

A) Spiritual healing

B) Dietary practices

C) Fasting and prayer

D) Meditation

Review Information: The correct answer is:

A) Spiritual healing.

For the Christian Scientist, a mind cure uses spiritual healing methods. For the believer, medical treatments interfere with drawing closer to God.

Question 32

The nurse is caring for a client with end-stage heart failure. The family members are distressed about the client's impending death. What should the nurse do FIRST?

A) Explain the stages of death and dying to the family

B) Recommend an easy-to-read book on grief

C) Assess the family's patterns for dealing with death

D) Ask about their religious affiliations

Review Information: The correct answer is:

C) Assess the family''s patterns for dealing with death.

When a new problem is identified, it is important for the nurse to collect accurate assessment data. This is crucial to ensure that the client and their family''s needs are adequately identified in order to select the best nursing care approaches.

Question 33

In providing care for a client with pain from a sickle cell crisis, which one of the following medication orders for pain control should be questioned by the nurse?

A) Demerol

B) Morphine

C) Methadone

D) Codeine

Review Information: The correct answer is:

A) Demerol.

Meperidine is not recommended in clients with sickle cell disease. Normeperidine, a metabolite of meperidine, is a central nervous system stimulant that produces anxiety, tremors, myoclonus, and

generalized seizures when it accumulates with repetitive dosing. Clients with sickle cell disease are particularly at risk for normeperidine-induced seizures.

Question 34

The nurse is providing diet instruction to the parents of a child with Cystic Fibrosis. The nurse would emphasize that the diet should be

A) High calorie, low fat, low sodium

B) High protein, low fat, low carbohydrate

C) High protein, high calorie, unrestricted fat

D) High carbohydrate, low protein, moderate fat

Review Information: The correct answer is:

C) High protein, high calorie, unrestricted fat.

The child with Cystic Fibrosis needs a well balanced diet that is high in protein and calories. Fat does not need to be restricted.

Question 35

The nurse is caring for a client suspected to have Tuberculosis (TB). Which of the following diagnostic tests is essential for determining the presence of active TB?

A) Tuberculin skin testing

B) Sputum culture

C) White blood cell count

D) Chest x-ray

Review Information: The correct answer is:

B) Sputum culture.

The sputum culture is the most accurate method for determining the presence of active TB.

Question 36

The nurse is teaching a group of adults about modifiable cardiac risk factors. Which of the following should the nurse focus on FIRST?

A) Weight reduction

B) Stress management

C) Physical exercise

D) Smoking cessation

Review Information: The correct answer is:

D) Smoking cessation.

Stopping smoking is the priority for clients at risk for cardiac disease, because of the effect to reduce oxygenation and constrict blood vessels.

Question 37

The nurse is assessing a pregnant client in her third trimester. The parents are informed that the ultrasound suggests that the baby is small for gestational age (SGA). An earlier ultrasound indicated normal growth. The nurse understands that this change is MOST likely due to

A) Sexually transmitted infection

B) Exposure to teratogens

C) Maternal hypertension

D) Chromosomal abnormalities

Review Information: The correct answer is:

C) Maternal hypertension.

Pregnancy induced hypertension is a common cause of late pregnancy fetal growth retardation. Vasoconstriction reduces placental exchange of oxygen and nutrients.

Question 38

A client has been taking alprazolam (Xanax) for 3 days. Nursing assessment should reveal which of the following expected effects of the drug?

A) Tranquilization, numbing of emotions

B) Sedation, analgesia

C) Relief of insomnia and phobias

D) Diminished tachycardia and tremors associated with anxiety

Review Information: The correct answer is:

A) Tranquilization, numbing of emotions.

The anti-anxiety drugs produce tranquilizing effects and may numb the emotions.

Question 39

Which of the following assessments by the nurse would indicate that the client is having a possible adverse response to the INH?

A) Severe headache

B) Appearance of jaundice

C) Tachycardia

D) Decreased hearing

Review Information: The correct answer is:

B) Appearance of jaundice.

Clients receiving INH therapy are at risk for developing drug induced hepatitis. The appearance of jaundice may indicate that the client has liver damage.

Question 40

The nurse is caring for a client with Meniere's disease. When teaching the client about the disease, the nurse should explain that the client should avoid foods high in

A) Calcium

B) Fiber

C) Sodium

D) Carbohydrate

Review Information: The correct answer is:

C) Sodium.

The client with Meniere''s disease has an excess accumulation of fluid in the inner ear. A low sodium diet will aid in reducing the fluid. Sodium restriction is also ordered as adjunct to diuretic therapy.

Question 1

The nurse is caring for a 4 year-old who will have surgery for Tetralogy of Fallot tomorrow. Which laboratory report must receive PRIORITY attention by the nurse?

A) Erythrocyte sedimentation rate

B) White blood cell count

C) Hemoglobin and hematocrit

D) Arterial blood gases

Review Information: The correct answer is:

C) Hemoglobin and hematocrit.

Tetralogy of Fallot is a cyanotic heart defect, which can manifest in polycythemia due to release of erythropoietin. Hemoglobin valuesof up to 20 and hematocrit''s of 60 or higher may be seen. These must be noted and reported to the physician.

Question 2

The nurse is assessing a client with portal hypertension. Which of the following findings would the nurse expect?

A) Expiratory wheezes

B) Blurred vision

C) Acites

D) Dilated pupils

Review Information: The correct answer is:

C) Acites.

Portal hypertension can occur in a client with right-sided heart failure or cirrhosis of the liver. Portal hypertension can lead to acites due to the increased protal pressure as well as a lowered osmotic pressure.

Question 3

A 67 year-old client with non-insulin dependent diabetes should be instructed to contact the out-patient clinic IMMEDIATELY if the following symptoms are present

A) Temperature of 37.5 degrees C with painful urination

B) An open wound on their heel

C) Insomnia and daytime fatigue

D) Nausea with two episodes of vomiting

Review Information: The correct answer is:

B) An open wound on their heel.

When signs of infection occur in their feet, elderly clients who have diabetes and/or vascular disease should seek health care quickly and continue treatment until the infection is resolved. Without treatment, serious infection, gangrene, limb loss, and death may result.

Question 4

The nurse is assessing a newborn the day after birth. The following are noted: high pitched cry, irritability and lack of interest in feeding. The mother signed her own discharge against medical advice. Which of the following is APPROPRIATE nursing care?

A) Reduce the environmental stimuli

B) Offer formula every 2 hours

C) Talk to the newborn while feeding

D) Rock the baby frequently

Review Information: The correct answer is:

A) Reduce the environmental stimuli.

This newborn appears to be withdrawing from substances taken by the mother before its birth. Reducing noise and light will reduce the central nervous system responses to stimuli.

Question 5

The nurse is caring for a child receiving albuterol (Proventil) for asthma. The parents ask the nurse why their child is receiving this medication. The nurse should explain that "Albuterol is prescribed to

A) decrease the swelling in the airways."

B) relax the smooth muscles in the airways."

C) reduce the secretions blocking the airways."

D) stimulate the respiratory center in the brain that control respirations."

Review Information: The correct answer is:

B) relax the smooth muscles in the airways.".

Albuterol (beta-adrenergic agonist) is the drug of choice in treating asthma because it allows the smooth muscle in the airway to relax. The airway can then dilate to increase airflow.

Question 6

The nurse is caring for a client with asthma who has developed gastroesophageal reflux disease (GERD). Which of the following medications prescribed for the client may aggravate GERD?

A) Anticholinergics

B) Corticosteroids

C) Histamine blocker

D) Antibiotics

Review Information: The correct answer is:

A) Anticholinergics.

An anticholinergic medication will decrease gastric emptying and the pressure on the lower esophageal sphincter.

Question 7

The nurse assesses several post partum women in the clinic. Which of the following women is at HIGHEST risk for puerperal infection?

A) 12 hours post partum, temperature of 100.4 F since delivery

B) 2 days post partum, temperature of 101.2 F this morning

C) 3 days post partum, temperature of 100.8 F the past 2 days

D) 4 days post partum, temperature of 100 F since delivery

Review Information: The correct answer is:

C) 3 days post partum, temperature of 100.8 degrees F the past 2 days.

A temperature of 100.4 F or higher on 2 successive days, not counting the first 24 hours after birth, constitutes a post partum infection.

Question 8

A child is diagnosed with poison ivy. The mother tells the nurse that she does not knowhow her child contracted the rash since he had not been playing in wooded areas. As the nurse asks questions about possible contact, which of the following would the nurse recognize as highest risk for exposure?

A) Playing with toys in a back yard flower garden

B) Eating small amounts of grass while playing "farm"

C) Playing with cars on the pavement near burning leaves

D) Throwing a ball to a neighborhood child who has poison ivy

Review Information: The correct answer is:

C) Playing with cars on the pavement near burning leaves.

Smoke from burning leaves or stems of the poison ivy plant can produce a reaction. Direct contact with the toxic oil, urushiol, is the most common cause for this dermatitis.

Question 9

A parent tells the nurse that their six year-old child who normally enjoys school, has not been doing well since his grandmother died two months ago. Which statement MOST accurately describes thoughts on death and dying at this age?

A) Death is personified as the bogeyman or devil

B) Death is perceived as being irreversible

C) The child feels guilty for the grandmother's death

D) The child is worried that he, too, might die

Review Information: The correct answer is:

A) Death is personified as the bogeyman or devil.

Personification of death is typical of this developmental level.

Question 10

A client is admitted for COPD. Which of the following symptoms would require the nurse's IMMEDIATE attention?

A) Nausea and vomiting

B) Restlessness and confusion

C) Low-grade fever and cough

D) Irritating cough and liquefied sputum

Review Information: The correct answer is:

B) Restlessness and confusion.

Respiratory failure may be signaled by excessive somnolence, restless, aggressiveness, confusion, central cyanosis and shortness of breath. When these symptoms occur, ABGs should be obtained.

Question 11

While caring for a client with infective endocarditis, the nurse must be alert for signs of pulmonary embolism. Which of the following assessment findings suggests this complication?

A) Positive Homan's sign

B) Fever and chills

C) Dyspnea and cough

D) Sensory impairment

Review Information: The correct answer is:

C) Dyspnea and cough.

Vegetation from the infected heart valves often leads to pulmonary embolism in the client with infective endocarditis. Cough, pleuritic chest pain and dyspnea are early symptoms.

Question 12

The nurse admits an elderly Mexican-American migrant worker following an accident in the fields. To facilitate communication, it is a PRIORITY for the nurse to

A) Request an interpreter

B) Speak through the family

C) Assume English is the second language

D) Assess the client's ability to speak English

Review Information: The correct answer is:

D) Assess the client''s ability to speak English.

Despite the cultural heritage, the nurse cannot make assumptions. Stereotyping is to be avoided. The nurse should assess the client''s comfort in speaking English.

Question 13

The nurse is teaching a child and the family about the medication phenytoin (Dilantin) prescribed for seizure control. Which of the following side effects is MOST likely to occur?

A) Vertigo

B) Drowsiness

C) Gum hyperplasia

D) Vomiting

Review Information: The correct answer is:

C) Gum hyperplasia.

Swollen and tender gums occur often with use of phenytoin. Oral hygiene and regular visits to the dentist should be emphasized.

Question 14

The nurse is caring for a client with Hepatitis A. Which of the following would be APPROPRIATE in planning care for this client?

A) Wear masks and/or goggles during procedures

B) Observe stool and needle precautions

C) Wear gown and gloves during client contact

D) Report this case of Hepatitis A to the local health department

Review Information: The correct answer is:

C) Wear gown and gloves during client contact.

The Hepatitis A virus is spread by contact with oral and respiratory secretions, feces, andserum from infected persons. The nurse should recognize the importance of isolation precautions from the initial contact with the client on admission until the noncontagious convalescence period.

Question 15

To prevent keratitis in an unconscious client, the nurse should apply moisturizing ointment to the

A) Finger and toenail quicks

B) Eyes

C) Perianal area

D) External ear canals

Review Information: The correct answer is:

B) Eyes.

Keratitis is a corneal ulcer or abrasion. Keratitis is caused by exposure and requires application of moisturizing ointment to the exposed cornea and a plastic bubble shield or eye patch.

Question 16

The nurse is caring for a client with active tuberculosis who has a history of noncompliance. Which of the following actions by the nurse would represent appropriate care for this client?

A) Instruct the client to wear a high efficiency particulate air mask in public places.

B) Ask a family member to supervise daily compliance

C) Schedule weekly clinic visits for the client

D) Ask the physician to change the regimen to fewer medications

Review Information: The correct answer is:

B) Ask a family member to supervise daily compliance.

Direct-observed therapy (DOT) is a recognized method for ensuring client compliance to the drug regimen. The program can be set up to directly observe the client taking the medication in the clinic, home, workplace or other convenient location.

Question 17

A pre-term baby develops nasal flaring, cyanosis and diminished breath sounds on one side. The physician's diagnosis is spontaneous pneumothorax. Which of the following should the nurse prepare for FIRST?

A) Cardiopulmonary resuscitation

B) Insertion of a chest tube

C) Oxygen therapy

D) Assisted ventilation

Review Information: The correct answer is:

B) Insertion of a chest tube.

Because a portion of the lung has collapsed, a chest tube will be inserted to restore negative pressure in the chest cavity.

Question 18

A child is treated with edetate calcium disodium (Calcium EDTA) for lead poisoning. Which of the following must the nurse assess FIRST?

A) Serum potassium level

B) Blood calcium level

C) Urinary output

D) Deep tendon reflexes

Review Information: The correct answer is:

C) Urinary output.

Calcium EDTA is toxic to the kidneys. Urine output must be measured to monitor renal function.

Question 19

At a routine health assessment, a client tells the nurse that she is planning a pregnancy in the near future. She asks about pre-conception diet changes. Which of the statements made by the nurse is BEST?

A) "Include fibers in your daily diet."

B) "Increase green leafy vegetable intake."

C) "Drink a glass of milk with each meal."

D) "Eat at least one serving of fish weekly."

Review Information: The correct answer is:

B) "Increase green leafy vegetable intake.".

Folic acid sources should be included in the diet and are critical in the pre-conceptual and early gestational periods to foster neural tube development and prevent birth defects such as spina bifida.

Question 20

The nurse observes a staff member caring for a client with a left unilateral mastectomy. The nurse would intervene if she notices the staff member is

A) Advising client to restrict sodium intake

B) Taking the blood pressure in the left arm

C) Elevating her left arm above heart level

D) Compressing the drainage device

Review Information: The correct answer is:

B) Taking the blood pressure in the left arm.

For those clients who have had a unilateral mastectomy, blood pressure should not be measured on the affected side to avoid the possibility of lymphedema.

Question 21

A nurse manager is using the technique of brainstorming to help staff solve a problem. One nurse criticizes a contribution and begins to find objections to the suggestion. The nurse manager's BEST response is

A) Ignore the comment to allow the discussion to flow creatively

B) Ask the nurse to reserve judgment until after all suggestions are offered

C) Compliment the nurse on her analytic skills and interest

D) Explore the nurse's criticism for spin off ideas

Review Information: The correct answer is:

D) Explore the nurse''s criticism for spin off ideas.

The goal of brainstorming is to gather as many ideas as possible without judgment that slows the creative process and may discourage innovative ideas. Exploring the nurses comments would encourage the generation of new ideas.

Question 22

The nurse is caring for an acutely ill 10 year-old client. Which of the following assessments would require the nurses IMMEDIATE attention?

A) A rapid bounding pulse

B) A temperature of 38.5 degrees C

C) Profuse Diaphoresis

D) Slow, irregular respirations

Review Information: The correct answer is:

D) Slow, irregular respirations.

A slow and irregular respiratory rate is a sign of fatigue in an acutely ill child. Fatigue can rapidly lead to respiratory arrest.

Question 23

The primary teaching for a client following an extracorporeal shock-wave lithotripsy (ESWL) procedure is

A) Drink 3000 to 4000 cc of fluid each day for one month

B) Limit fluid intake to 1000 cc each day for one month

C) Increase intake of citrus fruits to 3 servings per day

D) Restrict milk and dairy products for one month

Review Information: The correct answer is:

A) Drink 3000 to 4000 cc of fluid each day for one month.

Drinking 3 to 4 quarts (3000 to 4000 cc) of fluid each day will aid passage of fragments and help prevent formation of new calculi.

Springhouse. (1998).

Question 24

The nurse is caring for a client with Rheumatoid Arthritis. Which nursing diagnosis should receive PRIORITY in the plan of care?

A) Risk for injury

B) Self care deficit

C) Alteration in comfort

D) Alteration in mobility

Review Information: The correct answer is:

C) Alteration in comfort.

Relieving pain is the number one objective of this client''s plan of care.

Question 25

A 52 year-old client is being transfused with one unit of packed cells. A half hour after the transfusion was initiated, the client complains of chills and a headache. The FIRST action of the nurse should be

A) Notify the physician

B) Check the client's temperature

C) Stop the transfusion

D) Obtain a urine specimen

Review Information: The correct answer is:

C) Stop the transfusion.

The first action when a client exhibits signs of a potential transfusion reaction is to discontinue the transfusion immediately.

Question 26

A client is scheduled to have a blood test for cholesterol and triglycerides the next day. The nurse would tell the client

A) "Be sure and eat a fat-free diet until the test."

B) "Do not eat or drink anything but water for 12 hours before the blood test."

C) "Have the blood drawn within two hours of eating breakfast."

D) "Stay at the laboratory so two blood samples can be drawn an hour apart."

Review Information: The correct answer is:

B) "Do not eat or drink anything but water for 12 hours before the blood test.".

Blood lipid levels should be measured on a fasting sample.

Question 27

The nurse is caring for a five year-old child who has the left leg in skeletal traction. Which of the following activities would be an APPROPRIATE diversional activity?

A) Kicking balloons with right leg

B) Playing "Simon Says"

C) Playing hand held games

D) Throw bean bags

Review Information: The correct answer is:

C) Playing hand held games.

Immobilization with traction must be maintained until bone ends are in satisfactory alignment. Activities that increase mobility interfere with the goals of treatment.

Question 28

A six month-old infant who is being treated for developmental dysplasia of the hip has been placed in a hip spica cast. The nurse should teach the parents

A) That gently rubbing the skin with a cotton swab will relieve itching

B) To place his favorite books and push-pull toys in his crib

C) To check frequently for swelling in the baby's feet

D) To turn the baby every 2 hours utilizing the abduction stabilizer bar

Review Information: The correct answer is:

C) To check frequently for swelling in the baby''s feet.

A child in a hip spica cast must be checked for circulatory impairment. Observe extremities for swelling, discoloration, movement and sensation. For children beyond the neonatal period, traction and/or surgery followed by hip spica casting is usually needed.

Question 29

A nursing student asks the nurse manager to explain the forces that drive health care reform. The BEST response by the nurse manager should emphasize

A) Escalating fees and decreasing reimbursement

B) High costs of end-of-life treatment procedures

C) Increasing numbers of elderly, chronically ill

D) Rising physician-specialist salaries

Review Information: The correct answer is:

A) Escalating fees and decreasing reimbursement.

The percentage of the gross national product representing health care costs rose dramatically with reimbursement based on fee for service. Reimbursement for Medicare and Medicaid recipients based on fee for service escalates health care costs.

Question 30

A nurse caring for premature newborns in an intensive care setting carefully monitors oxygen concentration. The MOST important reason for this assessment is to prevent

A) Intraventricular hemorrhage

B) Retinopathy of prematurity

C) Bronchial pulmonary dysplasia

D) Necrotizing enterocolitis

Review Information: The correct answer is:

B) Retinopathy of prematurity.

While there are other causes for retinal damage in the premature infant, maintaining the oxygen concentration below 40% reduces one risk factor.

Question 31

The nurse is caring for a client who is receiving procainnamide (Pronestyl) intravenously. It is important for the nurse to monitor

A) Hourly urinary output

B) Serum potassium levels

C) Continuous EKG readings

D) Neurological signs

Review Information: The correct answer is:

C) Continuous EKG readings.

Procainnamide (Pronestyl) is used to suppress cardiac arrythmias. When administered intravenously, it must be accompanied by continuous cardiac monitoring by ECG.

Question 32

The nurse is working with parents to plan home care for a 2 year-old with a heart problem. A PRIORITY nursing intervention would be to

A) Encourage the parents to enroll in cardiopulmonary resuscitation class

B) Assist the parents to plan quiet play activities at home

C) Stress to the parents that they will need relief care givers

D) Instruct the parents to avoid contact with persons with infection

Review Information: The correct answer is:

A) Encourage the parents to enroll in cardiopulmonary resuscitation class.

While all suggestions are appropriate, the education of the parents/caregivers should include techniques of cardiopulmonary resuscitation in order to provide for emergency care of their child.

Question 33

The nurse manager identifies that time spent by staff in charting is excessive, requiring overtime for completion. The nurse manager requests that staff form a task force to investigate and develop potential solutions to the problem, and report on this at the next staff meeting. The nurse manager's leadership style is BEST described as

A) Laissez-faire

B) Autocratic

C) Participative

D) Group

Review Information: The correct answer is:

C) Participative.

Participative style of management involves staff in decision-making processes. Staff/manager interactions are open and trusting. Most work efforts are joint.

Question 34

A one year-old child is receiving temporary total parental nutrition (TPN) through a central venous line. This is the first day of TPN therapy. Although all of the following nursing actions must be included in the plan of care of this child, which one would be a PRIORITY at this time?

A) Use aseptic technique during dressing changes

B) Maintain central line catheter integrity

C) Monitor serum glucose levels

D) Check results of liver function tests

Review Information: The correct answer is:

C) Monitor serum glucose levels.

Hyperglycemia may occur during the first day or two as the child adapts to the high-glucose load of the TPN solution. Thus, a chief nursing responsibility is blood glucose testing.

Question 35

The nurse is caring for a child with Cystic Fibrosis. The nurse would anticipate that the child would be deficient in which of the following vitamins?

A) B, D, and K

B) A, D, and K

C) A, C, and D

D) A, B, and C

Review Information: The correct answer is:

B) A, D, and K.

The uptake of fat soluble vitamins is decreased in children with Cystic Fibrosis. Vitamins A, D, and K are fat soluble and are likely to be deficient in clients with Cystic Fibrosis.

Question 36

Before administering digoxin (Lanoxin) to a client, which of the following nursing assessments is a PRIORITY?

A) Auscultate breath sounds

B) Check for bowel sounds

C) Monitor the heart rate

D) Measure the blood pressure

Review Information: The correct answer is:

C) Monitor the heart rate.

Because digoxin slows the heart rate, the medication should be held if the heart rate is below 60.

Question 37

While caring for a child with Reye's Syndrome, the nurse should give which of the following the HIGHEST priority?

A) Monitoring intake and output

B) Providing good skin care

C) Assessing level of consciousness

D) Assisting with range of motion

Review Information: The correct answer is:

C) Assessing level of consciousness.

Altered level of consciousness suggests increasing intercranial pressure related to cerebral edema.

Question 38

The nurse has identified what appears to be ventricular tachycardia on the cardiac monitor of a client being evaluated for possible myocardial infarction. The FIRST action the nurse would perform is to

A) Begin cardiopulmonary resuscitation

B) Prepare for immediate defibrillation

C) Notify the "Code" team and physician

D) Assess airway breathing and circulation

Review Information: The correct answer is:

D) Assess airway breathing and circulation.

The nurse must first assess the client to determine the appropriate next step. In this case the first step the nurse must take is to evaluate the A, B, C''s.

Question 39

A client has had his entire stomach removed surgically. Which of the following assessment would the nurse anticipate finding?

A) Complaints of fatigue

B) Poor wound healing

C) Decreased night vision

D) Tendency to bruise easily

Review Information: The correct answer is:

A) Complaints of fatigue.

Clients with all of their stomach removed lose the intrinsic factor responsible for production of Vitamin B12. This results in pernicious anemia with causes symptoms of chronic fatigue.

Question 40

A newborn presents with a pronounced cephalhematoma following a birth in the posterior position. The nursing diagnosis which should guide the plan for care is

A) Pain related to periosteal injury

B) Impaired mobility related to bleeding

C) Parental anxiety related to knowledge deficit

D) Injury related to intercranial hemorrhage

Review Information: The correct answer is:

C) Parental anxiety related to knowledge deficit.

This hematoma is related to pressure at the time of labor and birth. The condition resolves within a few days. Parental anxiety must be addressed by listening to their fears and explaining the nature of this common alteration.

Question 1

A client with acute asthma has been admitted to the hospital. The client's pulse oximeter reading is 89%. Which of the following nursing diagnoses would be MOST appropriate for this client based on this assessment data?

A) Anxiety related to hospitalization

B) Ineffective airway clearance related to thick secretions

C) Altered health maintenance related to asthma

D) Impaired gas exchange related to bronchoconstriction and mucosal edema

Review Information: The correct answer is:

D) Impaired gas exchange related to bronchoconstriction and mucosal edema.

Pulse oximetry reflects oxygenation of arterial blood. While the other diagnoses may be appropriate for a client hospitalized with asthma, impaired gas exchange is the only diagnosis supported by the given assessment data.

Question 2

A 6 year-old female is diagnosed with recurrent urinary tract infections (UTI). Which one of the following instructions would be BEST for the nurse to tell the caregiver?

A) Increase bladder tone by delaying voiding

B) When laundering clothing, rinse several times

C) Use plain water for the bath, shampooing hair last

D) Have the child use antibacterial soaps while bathing

Review Information: The correct answer is:

C) Use plain water for the bath, shampooing hair last.

Hair should be shampooed last with a rinsing of plain water over the genital area. The oils in soaps and bubble bath can cause irritation, which may lead to UTI''s in young girls.

Question 3

A female client diagnosed with genital herpes simplex virus 2 complains of dysuria, dyspareunia and leukorrhea and lesions on the labia and perianal skin. A PRIMARY nursing action should be to

A) Encourage 3-4 warm sitz baths per day

B) Encourage frequent hand washing

C) Spray water over genitalia while urinating

D) Apply heat or cold to lesions

Review Information: The correct answer is:

A) Encourage 3-4 warm sitz baths per day.

Frequent sitz baths may sooth the area and reduce inflammation.

Question 4

A client with chronic congestive heart failure should be instructed to contact the home health nurse if which of the following occurs?

A) Weight gain of 2 pounds or more in a 48 hour period

B) Urinating 4-5 times each day

C) A decrease in appetite

D) Appearance of non-pitting ankle edema

Review Information: The correct answer is:

A) Weight gain of 2 pounds or more in a 48 hour period.

It is critical for clients to report and be treated for rapid weight gain, decreased urinary output, worsening nocturnal orthopnea, pitting ankle edema, and other symptoms of chronic heart failure to decrease their risk of hospitalization.

Question 5

The nurse is caring for a client with status epilepticus. The MOST important nursing assessment of this client is

A) Intravenous drip rate

B) Level of consciousness

C) Pulse and respiration

D) Injuries to the extremities

Review Information: The correct answer is:

B) Level of consciousness.

Cerebral blood flow undergoes a 250% increase during seizure activity depleting oxygen at the neuronal level. Cerebral anoxia may result in progressive brain tissue injury and destruction. The nurse should monitor the client's level of consciousness continuously. Even when seizures are controlled, the client may be unconscious for a while.

Question 6

A client returned from surgery for a perforated appendix with localized peritonitis. In view of this diagnosis, how would the nurse position the client?

A) Prone

B) Dorsal recumbent

C) Semi-Fowler

D) Supine

Review Information: The correct answer is:

C) Semi-Fowler.

The semi-Fowler position assists drainage and prevents spread of infection throughout the abdominal cavity.

Question 7

The nurse is administering albuterol (Proventil) to a child with asthma. Which of the following assessments by the nurse indicate the need for an adjustment of the medication?

A) Lethargy and fatigue

B) Edema is the lower extremities

C) Apical Pulse of 112

D) Temperature of 101 F

Review Information: The correct answer is:

C) Apical Pulse of 112.

One of the most common adverse effects of beta adrenergic medications is an increase in heart rate.

Question 8

The nurse is providing instructions for a client with asthma who is sensitive to house dust mites. Which of the following would be the MOST helpful in controlling asthma symptoms?

A) Wash bed linens in warm water with a cold rinse

B) Change the bed linens every week

C) Wash the bed linens in hot water

D) Use air filters

Review Information: The correct answer is:

C) Wash the bed linens in hot water.

For asthma clients who are sensitive to house-dust mites it is essential the mattresses and pillows are encased in and allergen-impermeable cover OR are the pillows are washed weekly. All bed linen (sheets and blankets) are washed in hot water weekly at temperatures above 130 degrees Fahrenheit which is necessary to kill the mites.

Question 9

A newly appointed nurse manager is concerned about time management. Which of the following is the MOST effective in developing a plan?

A) Set daily goals and establish priorities

B) Ask for additional assistance when necessary

C) Keep a time log

D) Complete each task before beginning another activity

Review Information: The correct answer is:

C) Keep a time log.

The first step in planning for time management is to establish a baseline for activities and time use.

Question 10

The nurse is teaching childbirth preparation classes. One woman asks about her rights to develop a birthing plan. Which response made by the nurse would be BEST?

A) "What is your reason for wanting such a plan?"

B) "Have you talked with your physician about this?"

C) "Let us discuss your rights as a couple."

D) "Write your ideal plan for the next class."

Review Information: The correct answer is:

C) "Let us discuss your rights as a couple.".

Discussion of the physician''s role and the couple''s rights and limitations in selecting birth options must precede development of a plan.

Question 11

The nurse is caring for a client with Legionnaire's disease. Which of the following physical findings would require the nurse's IMMEDIATE attention?

A) Cramping abdominal pain

B) Urinary output of 200 cc in eight hours

C) Presence of pitting edema in the lower extremities

D) Decrease in chest wall expansion

Review Information: The correct answer is:

D) Decrease in chest wall expansion.

The respiratory status for a client experiencing this acute bacterial pneumonia known as Legionnaires'' disease is critical. Evaluate chest wall expansion, depth and pattern of respirations, cough, and chest pain. Watch the client for restlessness, which may indicate hypoxemia. He may need suctioning, repositioning, postural drainage, chest physiotherapy, or aggressive oxygen therapy. Mechanical ventilation may be needed.

Question 12

In reviewing the assessment data of a client suspected of having diabetes insipidus, the nurse expects which of the following after a water deprivation test?

A) Increased edema and weight gain

B) Unchanged urine specific gravity

C) Rapid protein excretion

D) Decreased blood potassium

Review Information: The correct answer is:

B) Unchanged urine specific gravity.

When fluids are restricted, the client continues to excrete large amounts of dilute urine. This finding supports the diagnosis. Normally, urine is more concentrated with reduced fluid intake.

Question 13

The nurse manager has a nurse employee who is suspected of a problem with chemical dependency. Which intervention is the BEST action by the nurse manager?

A) Confront the nurse about the suspicions in a private meeting

B) Schedule a staff conference, without the nurse present, to collect information

C) Refer to human resources in light of the Americans with Disabilities Act

D) Counsel the employee to resign to avoid a time consuming investigation

Review Information: The correct answer is:

C) Refer to human resources in light of the Americans with Disabilities Act.

To avoid legal repercussions, the nurse needs to consult with the human resources department for proper procedure for documentation and counseling. The employee may be protected under the Americans with Disabilities Act.

Question 14

At a nursing staff meeting, there is discussion of perceived inequities in weekend staff assignments. As a follow-up, the nurse manager should INITIALLY

A) Allow the staff to change assignments

B) Clarify reasons for current assignments

C) Help staff see the complexity of issues

D) Facilitate creative thinking on staffing

Review Information: The correct answer is:

D) Facilitate creative thinking on staffing.

The "moving phase" of change involves viewing the problem from a new perspective, incorporating new and different approaches to the problem. The manager can facilitate staff''s solving the problem.

Question 15

The nurse is explaining the effects of cocaine abuse to a pregnant client. Which of the following MUST the nurse understand as a basis for teaching?

A) Cocaine use can cause fetal growth retardation

B) The drug has been linked to neural tube defects

C) Newborn withdrawal generally occurs immediately after birth

D) Breast feeding promotes positive parenting behaviors

Review Information: The correct answer is:

A) Cocaine use can cause fetal growth retardation.

Cocaine is vasoconstrictive, and this effect in the placental vessels causes fetal hypoxia and diminished growth. Other risks of continued cocaine use during pregnancy include preterm labor, congenital abnormalities, altered brain development and subsequent behavioral problems in the infant.

Question 16

The nurse is assessing a client with a deep vein thrombosis. Which of the following signs and/or symptoms would the nurse anticipate finding?

A) Rapid respirations

B) Diaphoresis

C) Swelling of lower extremity

D) Positive Babinski's sign

Review Information: The correct answer is:

C) Swelling of lower extremity.

The most common signs of deep vein thrombosis are pain in the region of the thrombus and unilateral swelling distal to the site.

Question 17

You are teaching a client about the client Controlled Analgesia (PCA) planned for post-operative care. Which indicates FURTHER teaching may be needed by the client?

A) "I will be receiving continuous doses of medication."

B) "I should call the nurse before I take additional doses."

C) "I will call for assistance if my pain is not relieved."

D) "The machine will prevent an overdose."

Review Information: The correct answer is:

B) "I should call the nurse before I take additional doses.".

Continuous dosing of pain medication is more effective than prn. Client controlled analgesia offers the client more control. The client should be instructed to initiate additional doses as needed without asking for assistance unless there is insufficient control of the pain.

Question 18

The school nurse is called to the playground for an episode of mouth trauma. The nurse finds that the front tooth of a 9 year-old child has been avulsed ("knocked out"). After recovering the tooth, the INITIAL response should be to

A) Rinse the tooth in water before placing it in the socket

B) Place the tooth in a clean plastic bag for transport to the dentist

C) Hold the tooth by the roots until reaching the emergency room

D) Ask the child to replace the tooth even if the bleeding continues

Review Information: The correct answer is:

A) Rinse the tooth in water before placing it in the socket.

Following avulsion of a permanent tooth, it is important to rinse the dirty tooth in water, saline solution or milk before re-implantation. If possible, replace the tooth in its socket within 30 minutes, avoiding contact with the root. The child should be taken to the dentist as soon as possible.

Question 19

A client has been admitted for meningitis. In reviewing the laboratory analysis of cerebrospinal fluid (CSF), the nurse would expect to note

A) High protein

B) Clear color

C) Elevated sed rate

D) Increased glucose

Review Information: The correct answer is:

A) High protein.

A positive CSF for meningitis would include presence of protein, a positive blood culture, decreased glucose, cloudy color with an increased opening pressure, and an elevated white blood cell count.

Philadelphia: W. B. Saunders.

Question 20

A 4 month-old childtaking digoxin (Lanoxin) has a blood pressure of 92/78; resting pulse of 78; respirations 28 and a potassium level of 4.8 mEq/L. The client is irritable and has vomited twice since the morning dose of digoxin. The nurse recognizes that the most common sign of digoxin toxicity is

A) Bradycardia

B) Lethargy

C) Irritability

D) Vomiting

Review Information: The correct answer is:

A) Bradycardia.

The most common sign of digoxin toxicity in children is bradycardia (heart rate below 100 in an infant).

Question 21

A child with Tetralogy of Fallot visits the clinic several weeks before planned surgery. The nurse should give PRIORITY attention to

A) Assessment of oxygenation

B) Observation for developmental delays

C) Prevention of infection

D) Maintenance of adequate nutrition

Review Information: The correct answer is:

A) Assessment of oxygenation.

All of the above would be important in a child diagnosed with Tetralogy of Fallot. However, persistent hypoxemia causes acidosis which further decreases pulmonary bloodflow. Additionally, low oxygenation leads to development of polycythemia and resultant neurologic complications.

Question 22

The hospital is planning to downsize and eliminate a number of staff positions as a cost-saving measure. To assist staff in this change process, the nurse manager is preparing for the "unfreezing" phase of change. The nurse manager should INITIALLY

A) Plan how to deal with defensive staff behavior

B) Explain to staff why the change is necessary

C) Help staff accept the new change

D) Work with staff to internalize the changes

Review Information: The correct answer is:

B) Explain to staff why the change is necessary.

The first phase of change, unfreezing, begins with awareness of the need for change. This can be facilitated by the manager who clearly understands the need and stands behind it. The phase is completed when staff comprehend the need for change.

Question 23

A client was admitted with a diagnosis of pneumonia. When auscultating the client's breath sounds, the nurse hears inspiratory crackles in the right base. Temperature is 102.3 orally. The nurse would expect to find which of the following?

A) Flushed skin

B) Bradycardia

C) Mental confusion

D) Hypotension

Review Information: The correct answer is:

C) Mental confusion.

Crackles suggest pneumonia, which is likely to be accompanied by mental confusion related to hypoxia.

Question 24

Discharge planning for the hospitalized client begins

A) With the admission assessment

B) Following development of the treatment plan

C) When the client's symptoms are in remission

D) When the treatment outcomes are being evaluated

Review Information: The correct answer is:

A) With the admission assessment.

Assessment establishes the framework for diagnosis, outcomes identification, treatment, and discharge planning. Relationships are time limited and terminate when outcomes are achieved. Termination parallels evaluation. Preparation for termination begin with the first encounter.

Question 25

A hospitalized child suddenly has a seizure while his family is visiting. The nurse notes whole body rigidity followed by general jerking movements. The child vomits immediately after the seizure. A PRIORITY nursing diagnosis for the child is

A) High risk for infection

B) Altered family processes related to chronic illness

C) Fluid volume deficit related to vomiting

D) Risk for aspiration related to loss of consciousness

Review Information: The correct answer is:

D) Risk for aspiration related to loss of consciousness.

The tonic-clonic seizure appears suddenly and often leads to brief loss of consciousness. The greatest risk for the child is from airway blockage, as might follow aspiration.

Question 26

A Hispanic client confides in the nurse that she is concerned that staff may give her newborn the "evil eye." The nurse should communicate to other personnel it is MOST important to

A) Touch the baby after looking at him

B) Bless the newborn while speaking to him

C) Avoid touching the child

D) Look only at the parents

Review Information: The correct answer is:

A) Touch the baby after looking at him.

In many cultures, an "evil eye" is cast when looking at a person without touching him. Thus, the spell is broken by touching while looking or assessing.

Question 27

The nurse is caring for a client on mechanical ventilation. When performing endotrachial suctioning, the nurse will avoid hypoxia by

A) Inserting a fenestrated catheter with a whistle tip without suction

B) Completing suction pass in 30 seconds with pressure of 150 mm Hg

C) Hyperoxygenating with 100% O2 for 1-2 minutes before and after each suction pass

D) Minimizing suction pass to 60 seconds while slowly rotating the lubricated catheter

Review Information: The correct answer is:

C) Hyperoxygenating with 100% O2 for 1-2 minutes before and after each suction pass.

Administer supplemental 100% oxygen through the mechanical ventilator or manual resuscitation bag for 1 to 2 minutes before, after and between suctioning passes to prevent hypoxemia.

Question 28

The nurse would teach a client with Raynaud's phenomenon that it is MOST important to

A) Stop smoking

B) Keep feet dry

C) Reduce stress

D) Avoid caffeine

Review Information: The correct answer is:

A) Stop smoking.

The most important teaching for this client is to stop smoking. The question is asking what is the most important teaching. Thus, the approach to the options is to prioritize them from most to least IMPORTANT and not to think of 3 wrong and 1 right. Of the given options, the test strategy that might help is to ask yourself which ones are commonly more frequent or less frequent. Persons who smoke usually do so on a daily basis and sometimes hourly. The others tend to be done less frequently and are less ofa threat. This is stated as a specific action statement. "Reduce stress" is too general and vague in contrast to the "stop smoking" and general vague options are not usually the best answer with questions that ask about priorities.

Black, J., Hawks, J. & Keene, A. (2001). Medical Surgical Nursing. Philadelphia:Saunders.

Question 29

The nurse is caring for a 4 year-old child with a greenstick fracture. In explaining this type of fracture to the parents, the BEST response by the nurse should be that

A) A child's bone is more flexible and can be bent 45 degrees before breaking

B) Bones of children are more porous than adults and often have incomplete breaks

C) Compression of porous bones produces a buckle or torus type break

D) Bone fragments often remain attached by a periosteal hinge

Review Information: The correct answer is:

B) Bones of children are more porous than adults and often have incomplete breaks.

The pliable bones of growing children are more porous than those of the adult, which allows them to bend, buckle, and break in a "greenstick" manner. A greenstick fracture occurs when a bone is angulated beyond the limits of bending. The compressed side bends and the tension side fails, causing an incomplete fracture.

Question 30

While assessing an Rh positive newborn whose mother is Rh negative, the nurse recognizes the risk for hyperbilirubinemia. Which of the following should be reported IMMEDIATELY?

A) Jaundice evident at 26 hours

B) Hematocrit of 55%

C) Serum bilirubin of 12mg

D) Positive Coomb's test

Review Information: The correct answer is:

C) Serum bilirubin of 12mg.

The elevated bilirubin is in the range that requires immediate intervention, such as phototherapy. The physician determines the therapy appropriate after reviewing all laboratory findings.

Question 31

The nurse administered intravenous gamma globulin to an 18 month-old child with AIDS. The parent asks why this medication is being given. The BEST response is

A) "It will slow down the replication of the virus."

B) "This medication will improve your child's overall health status."

C) "This medication is used to prevent bacterial infections."

D) "It will increase the effectiveness of the other medications your child receives."

Review Information: The correct answer is:

C) "This medication is used to prevent bacterial infections.".

Intravenous gamma globulin is given to help prevent as well as to fight bacterial infections in young children with AIDS.

Question 32

The nurse uses the DRG (Diagnosis Related Group) manual to

A) Classify nursing diagnoses from the client's health history

B) Identify symptoms related to a medical diagnosis

C) Determine reimbursement for a medical diagnosis

D) Implement nursing care based on case management protocol

Review Information: The correct answer is:

C) Determine reimbursement for a medical diagnosis.

DRG''s are the basis of prospective payment plan for reimbursement for Medicare clients.

Question 33

A client with COPD is receiving Oxygen per nasal cannula at 2 liters per minute. Which of the following assessments should receive the nurse's IMMEDIATE attention?

A) Pulse oximetry of 92%

B) Crackles in lungs on auscultation

C) Rapid shallow respirations

D) Excessive thirst

Review Information: The correct answer is:

C) Rapid shallow respirations.

Clients with COPD are at risk for developing respiratory acidosis with the administration of oxygen which may remove hypoxic drive and lead to respiratory acidosis. Rapid shallow respirations are an indication of respiratory acidosis.

Question 34

A two month-old infant has both a cleft lip and palate which will be repaired in stages. In the immediate postoperative period for a cleft lip repair, which one of the following nursing measures should be PRIORITY?

A) Utilize elbow restraints at all times

B) Initiate formula/breast feedings when alert

C) Teach parents to cleanse the suture line with alcohol

D) Position the infant on the back after feedings

Review Information: The correct answer is:

A) Utilize elbow restraints at all times.

The major efforts in the post operative period are directed toward protecting the operative site. Elbow restraints should be used and only one arm released at a time with close supervision by the nurse and/or parents.

Question 35

The nurse is administering the initial total parenteral nutrition solution to a client. Which of the following assessments require the nurse's IMMEDIATE attention?

A) Temperature of 37.5 C

B) Urine output of 300 cc in four hours

C) Poor skin turgor

D) Blood glucose of 350 mg/dl

Review Information: The correct answer is:

D) Blood glucose of 350 mg/dl.

Total parenteral nutrition formulas contain dextrose in concentrations of 10% or greater to supply 20% to 50% of the total calories. Blood glucose levels should be checked every 4 to 6 hours. A sliding scale dose of insulin may be ordered to maintain the blood glucose level below 200mg/dl.

Question 36

The nurse is caring for a child who is having an acute episode of reactive airway disease. Which of the following findings would the nurse anticipate finding?

A) Periods of apnea

B) Inspiratory stridor

C) Wheezing on expiration

D) A productive cough

Review Information: The correct answer is:

C) Wheezing on expiration.

In an acute episode of reactive airway disease, breathing is likely to be characterized by wheezing on expiration. This sound is made as air is forced through the narrowed passages.

Question 37

An 82 year-old client is prescribed eye drops for treatment of glaucoma. What assessment is needed before the nurse begins teaching proper administration of the medication?

A) Determine third party payment plan for this treatment

B) The client's manual dexterity

C) Proximity to health care services

D) Ability to use visual assistive devices

Review Information: The correct answer is:

B) The client's manual dexterity.

Inability to self administer eye drops is a common problem among the elderly due to decreased finger dexterity.

Question 38

The nurse is admitting a client with the diagnosis of Parkinson's disease. When assessing mobility, the nurse would anticipate finding

A) Weakness in the lower extremities

B) A shuffling gait

C) Muscle spasm in the legs and arms

D) Intention tremor

Review Information: The correct answer is:

B) A shuffling gait.

Clients with Parkinson''s disease have a very distinctive gait with quick short steps (shuffling) which may increase in speed so that they are unable to stop.

Question 39

A child and his family were exposed to Mycobacterium tuberculosis about two months ago, to confirm the presence or absence of an infection, it is MOST important for all family members to have a

A) Chest x-ray

B) Blood culture

C) Sputum culture

D) PPD intradermal test

Review Information: The correct answer is:

D) PPD intradermal test.

The administration of the PPD intradermal test determines the presence of the infection with the Mycobacterium tuberculosis organism. It is effective at 3-6 week after the initial infection.

Question 40

A hospitalized 8 month-old is receiving gentamicin (Cidomycin). In monitoring the infant for drug toxicity, the nurse should review which laboratory results FIRST?

A) Blood urea nitrogen

B) Thyroxin levels

C) Growth hormone levels

D) Platelet counts

Review Information: The correct answer is:

A) Blood urea nitrogen.

Toxicity to the aminoglycoside antibiotic, gentamicin, is seen in increased BUN and serum creatinine levels. Kidney damage may be reversible if the drug is stopped at the first sign of toxicity.

Question 1

A young child is admitted for treatment of lead poisoning. The nurse recognizes that the MOST serious effect of chronic lead poisoning is

A) Central nervous system damage

B) Moderate anemia

C) Renal tubule damage

D) Growth impairment

Review Information: The correct answer is:

A) Central nervous system damage.

The most serious consequences of chronic lead poisoning occur in the central nervous system. Neural cells are destroyed by the toxic effects of the lead resulting in many problems with the intellect ranging from mild deficits to mental retardation and even death.

Question 2

A Hispanic client refuses emergency room treatment until a curandero is called. The nurse should understand that this person brings

A) Holistic healing

B) Spiritual advising

C) Herbal preparations

D) Witchcraft potions

Review Information: The correct answer is:

A) Holistic healing.

This traditional folk practitioner uses holistic methods for illnesses not related to witchcraft. Many times, the curandero works with traditional health care providers to restore health.

Spector, R. (1999).

Cultural Diversity in Health and Illness.

Stamford, CT: Appleton & Lange.

Purnell, L. & Paulanka, B. (1998).

Transcultural Health Care.

Philadelphia: F.A. Davis.

Question 3

A client asks the nurse about including her 2 and 12 year-old sons in the care of their newborn sister. Which of the following is an appropriate initial statement by the nurse?

A) "Focus on your sons' needs during the first days at home."

B) "Tell each child what he can do to help with the baby."

C) "Suggest that your husband spend more time with the boys."

D) "Ask the children what they would like to do for the newborn."

Review Information: The correct answer is:

A) "Focus on your sons'' needs during the first days at home.".

In an expanded family, it is important for parents to reassure older children that they are loved and as important as the newborn.

Question 4

The nurse is assessing a 15 month-old child with otitis media. Which of the following symptoms would the nurse anticipate finding?

A) Periorbital edema, absent light reflex and translucent tympanic membrane

B) Irritability, rinorrhea, and bulging tympanic membrane

C) Diarrhea, retracted tympanic membrane and enlarged parotid gland

D) Vomiting, pulling at ears and pearly white tympanic membrane

Review Information: The correct answer is:

B) Irritability, rinorrhea, and bulging tympanic membrane.

Clinical manifestations of otitis media include irritability, rinorrhea and bulging tympanic membrane.

Question 5

The new graduate nurse interviews for a position in a large health care agency which has shared governance. Which of the following BEST demonstrates shared governance in the nursing department?

A) A board is appointed to oversee administrative decisions

B) Departments share responsibility for quality client care

C) Staff groups are appointed to discuss practice and education

D) Non-nurse managers supervise nursing staff in all units

Review Information: The correct answer is:

B) Departments share responsibility for quality client care.

Shared governance or self-governance is a method of organizational design that promotes empowerment of nurses, giving them responsibility for client care issues.

Question 6

The nurse is performing a physical assessment on a client with insulin dependent diabetes mellitus. Which of the following client complaints calls for IMMEDIATE nursing action?

A) Diaphoresis and shakiness

B) Reduced lower leg sensation

C) Intense thirst and hunger

D) Painful hematoma on thigh

Review Information: The correct answer is:

A) Diaphoresis and shakiness.

Diaphoresis is a sign of hypoglycemia which warrants immediate attention.

Question 7

A client is receiving oxygen therapy via a nasal cannula. When providing nursing care, which of the following interventions would be appropriate?

A) Determine that adequate mist is supplied

B) Inspect the nares and ears for skin breakdown

C) Lubricate the tips of the cannula before insertion

D) Maintain sterile technique when handling cannula

Review Information: The correct answer is:

B) Inspect the nares and ears for skin breakdown.

Oxygen therapy can cause drying of the nasal mucosa. Pressure from the tubing can cause skin irritation.

Dettenmeier, P.A. (1992).

Pulmonary Nursing Care.

St. Louis: Mosby

Question 8

The nurse is planning care for a client with increased intracranial pressure. The BEST position for this client is

A) Trendelenberg

B) Prone

C) Semi-Fowlers

D) Side-lying with head flat

Review Information: The correct answer is:

C) Semi-Fowlers.

Maintaining the head of the bed at 15-30 degrees reduces cerebral venous congestion.

Question 9

The nurse admits a hypertensive client who complains of dizziness after taking diltiazem (Cardizem). Which of the following is the MOST important information for the nurse to assess?

A) Schedule for taking medicine

B) Daily intake of potassium

C) Activity and rest patterns

D) Baseline heart rate

Review Information: The correct answer is:

A) Schedule for taking medicine.

A critical assessment is compliance with the prescribed medication schedule and dose.

Question 10

When caring for a client with Total Parenteral Nutrition, the MOST important action on the part of the nurse is to

A) Record the number of stools per day

B) Maintain strict intake and output records

C) Sterile technique for dressing change at IV site

D) Monitor for cardiac arrhythmias

Review Information: The correct answer is:

C) Sterile technique for dressing change at IV site.

Clients receiving TPN are very susceptible to infection. The concentrated glucose solutions are a good medium for bacterial growth. Strict sterile technique is crucial in preventing infection at IV infusion site.

Question 11

The nurse is caring for a client with Parkinson's disease. The client spends over one hour to dress for scheduled therapies. The MOST appropriate action for the nurse is to

A) Ask family members to dress the client

B) Encourage the client to dress more quickly

C) Allow the client the time needed to dress

D) Demonstrate methods on how to dress more quickly

Review Information: The correct answer is:

C) Allow the client the time needed to dress.

Clients with Parkinson''s disease often wish to take care of themselves but become very upset when hurried and then are unable to manage at all. Any form of hurrying the client will result in a very upset and nonfunctioning client.

Question 12

A client with spinal cord injury at the C-6 level complains of a pounding headache and his blood pressure is 180/120. The nurse should

A) Place the client in a supine position

B) Administer antispasmodic medication

C) Check the urinary catheter tubing for kinking

D) Assist client to use relaxation techniques

Review Information: The correct answer is:

C) Check the urinary catheter tubing for kinking.

These are symptoms of autonomic dysreflexia. This response occurs in clients with a spinal cord injury at the T-7 level or above as a result of a noxious stimulus commonly from a full bladder or fecal impaction. The stimulus creates an exaggerated response of the sympathetic nervous system and can be a life-threatening event.

Question 13

A woman comes to the antepartum clinic for a routine prenatal examination. She is 12 weeks pregnant with her second child. The nurse would document

A) Para 2, Gravida 1

B) Nulligravida 2, Para 1

C) Primagravida 1, Para 1

D) Gravida 2, Para 1

Review Information: The correct answer is:

D) Gravida 2, Para 1.

Gravida describes a woman who is or has been pregnant, regardless of pregnancy outcome. Para describes the number of babies born past a point of viability. Therefore a woman pregnant with her second child would be described as Gravida 2, Para 1. Primipara refers to a woman who has completed one pregnancy to the period of viability. Multipara refers to a woman who has completed two or more pregnancies to the stage of viability. Therefore a woman pregnant with her second child will be described as Gravida 2, Para 1.

Question 14

A client was re-admitted to the hospital following a recent skull fracture. Which of the following symptoms requires the nurse's IMMEDIATE attention?

A) Lethargy

B) Agitation

C) Ataxia

D) Hearing loss

Review Information: The correct answer is:

A) Lethargy.

The level of consciousness or responsiveness is the most important measure of the client''s rising intracranial pressure. Look for lethargy, delay in response to verbal suggestions and slowing of speech. Assess for rising blood pressure or widening pulse pressure and for respiratory irregularities. There may be vomiting but it is usually projectile without the presence of nausea.

Question 15

In addition to disturbances in mental awareness and orientation, a client with cognitive impairment is also likely to show loss of ability in

A) Hearing speech and sight

B) Endurance, strength and mobility

C) Learning, creativity and judgment

D) Balance, flexibility and coordination

Review Information: The correct answer is:

C) Learning, creativity and judgment.

Cognitive impairments are due to physiological processes that affect memory & other cognitive processes.

Question 16

A hospitalized eight month-old infant is receiving digoxin for the treatment of Tetralogy of Fallot. Prior to administering the next dose of medication, the infant's parent reports that the baby has vomited one time, just after breakfast. The heart rate is 72. The INITIAL response of the nurse should be to

A) Give the dose after lunch

B) Reduce the next dose by half

C) Double the next dose

D) Hold the medication

Review Information: The correct answer is:

D) Hold the medication.

Toxic side effects of digoxin include bradycardia, dysrhythmia, nausea, vomiting, anorexia, dizziness, headache, weakness and fatigue. In infants and young children, only one episode of vomiting, associated with mealtime, does not usually warrant withholding the medication. However, bradycardia (normal rate in this age child is 80-100 in the awake stage) is sufficient reason to hold the medication and notify the appropriate practitioner.

Question 17

The nurse is performing an admission assessment on a client with chronic glaucoma. Which of the following statements by the client would the nurse anticipate?

A) "I have constant blurred vision."

B) "I can't see on my left side."

C) "I have to turn my head to see my room."

D) "I have specks floating in my eyes."

Review Information: The correct answer is:

C) "I have to turn my head to see my room.".

Intraocular pressure becomes elevated which slowly produces a progressive loss of the visual field with rainbow halos around lights. Intraocular pressure becomes elevated due to microscopic obstruction of the trabeculae meshwork. If medical treatment fails, surgery is necessary.

Question 18

The nurse is caring for a 20 lbs (9 kg) six month-old with a 3 day history of diarrhea, occasional vomiting and fever. Peripheral intravenous therapy has been initiated, with 5% dextrose in 0.33% normal saline with 20 mEq of potassium per liter infusing at 35 ml/hr. Which of the following should be reported to the physician IMMEDIATELY?

A) Three episodes of vomiting in 1 hour

B) Periodic crying and irritability

C) Vigorous sucking on a pacifier

D) No measurable voiding in 4 hours

Review Information: The correct answer is:

D) No measurable voiding in 4 hours.

The concern is possible hyperkalemia, which could occur with continued potassium administration and a decrease in urinary output since potassium is excreted via the kidneys.

Question 19

A nurse is caring for a2 year-old child after corrective surgery for Tetralogy of Fallot. The mother reports that the child has suddenly begun seizing. The nurse recognizes this problem is probably due to

A) A cerebral vascular accident

B) Postoperative meningitis

C) Medication reaction

D) Metabolic alkalosis

Review Information: The correct answer is:

A) A cerebral vascular accident.

Polycythemia occurs as a physiological reaction to chronic hypoxemia which commonly occurs in clients with Tetralogy of Fallot. Polycythemia and the resultant increased viscosity of the blood increase the risk of thromboembolic events. Cerebrovascular accidents may occur. Signs and symptoms include sudden paralysis, altered speech, extreme irritability or fatigue, and seizures.

Question 20

An adolescent client comes to the clinic three weeks after the birth of her first baby. She tells the nurse she is concerned because she has not returned to her pre-pregnant weight. Which of the following should be a FIRST intervention?

A) Review the client's weight pattern over the year

B) Ask the mother to record her diet for the last 24 hours

C) Encourage her to talk about her view of herself

D) Give her several pamphlets on postpartum nutrition

Review Information: The correct answer is:

C) Encourage her to talk about her view of herself.

To an adolescent, body image is very important. The nurse must acknowledge this before assessment and teaching.

Question 21

A nurse is assigned to perform well child assessments at a day care center. A staff member interrupts the examinations to ask for assistance. They find a crying 3year-old child on the floor with her mouth wide open and gums bleeding. Two unlabeled open bottles lie next to her. The nurse's FIRST action should be

A) Call the poison control center, then 911

B) Administer syrup of Ipecac to induce vomiting

C) Give the child milk to coat her stomach

D) Ask the staff about the contents of the bottles

Review Information: The correct answer is:

D) Ask the staff about the contents of the bottles.

The nurse needs to assess what the child ingested before determining the next action. Once the substance is identified, the poison control center and emergency response team should be called.

Question 22

The nurse is caring for a client admitted to the hospital with right lower lobe (RLL) pneumonia. On assessment, the nurse notes crackles over the RLL. The client has significant pleuritic pain and is unable to take in a deep breath in order to cough effectively. Which of the following nursing diagnoses would be MOST appropriate for this client based on this assessment data?

A) Impaired gas exchange related to acute infection and sputum production

B) Ineffective airway clearance related to sputum production and ineffective cough

C) Ineffective breathing pattern related to acute infection

D) Anxiety related to hospitalization and role conflict

Review Information: The correct answer is:

B) Ineffective airway clearance related to sputum production and ineffective cough.

Ineffective airway clearance is defined as the inability to cough effectively. While the other diagnoses may be appropriate for this client, this is the only one supported directly by the assessment data given.

Question 23

The nurse is caring for a woman two hours after a vaginal delivery. Documentation indicates that the membranes were ruptured for 36 hours prior to delivery. A PRIORITY nursing diagnoses at this time is

A) Altered tissue perfusion

B) Risk for fluid volume deficit

C) High risk for hemorrhage

D) Risk for infection

Review Information: The correct answer is:

D) Risk for infection.

Membranes ruptured over 24 hours prior to birth greatly increases the risk of infection to both mother and the newborn.

Question 24

The nurse is assessing a 12 year-old who has Hemophilia A. Which of the following assessment findings would the nurse anticipate finding?

A) An excess of red blood cells

B) An excess of white blood cells

C) A deficiency of clotting factor VIII

D) A deficiency of clotting factors VIII and IX

Review Information: The correct answer is:

C) A deficiency of clotting factor VIII.

Hemophilia A is characterized by an absence or deficiency of Factor VIII.

Question 25

The nurse is caring for a client on complete bed rest. Which action by the nurse is MOST important in preventing the formation of deep vein thrombosis?

A) Elevate the foot of the bed

B) Apply knee high support stockings

C) Encourage passive exercises

D) Prevent pressure at back of knees

Review Information: The correct answer is:

D) Prevent pressure at back of knees.

Preventing popliteal pressure will prevent venous stasis and possibly deep vein thrombosis.

Question 26

While performing an initial assessment on a newborn following a breech delivery, the nurse suspects hip dislocation. Which of the following is MOST suggestive of the abnormality?

A) Flexion of lower extremities

B) Negative Ortlani response

C) Lengthened leg of affected side

D) Irregular hip symmetry

Review Information: The correct answer is:

D) Irregular hip symmetry.

Early assessment of irregular hip symmetry alerts the nurse and physician to a correctable congenital hip dislocation.

Question 27

The nurse is assessing a newborn infant and observes low set ears, short palpebral fissures, flat nasal bridge and indistinct philtrum. A PRIORITY maternal assessment by the nurse should be to ask about

A) Alcohol use during pregnancy

B) Usual nutritional intake

C) Family genetic disorders

D) Maternal and paternal ages

Review Information: The correct answer is:

A) Alcohol use during pregnancy.

The identification of this cluster of facial characteristics is often linked to fetal alcohol syndrome.

Question 28

When caring for a client with advanced cirrhosis of the liver, which of the following nursing diagnosis should take PRIORITY?

A) Risk for injury: hemorrhage

B) Risk for injury related to peripheral neuropathy

C) Altered nutrition: less than body requirements

D) Fluid volume excess

Review Information: The correct answer is:

A) Risk for injury: hemorrhage.

Liver disease interferes with the production of prothrombin and other factors essential for blood clotting. Hemorrhage, especially from esophageal varices can be life threatening. This takes priority over the other nursing diagnosis.

Question 29

While caring for the client during the first hour after delivery, the nurse determines that the uterus is boggy and there is vaginal bleeding. The nurse's FIRST action should be to

A) Check vital signs

B) Massage the fundus

C) Offer a bedpan

D) Check for perineal lacerations

Review Information: The correct answer is:

B) Massage the fundus.

The nurse's first action should be to massage the fundus until it is firm as uterine atony is the primary cause of bleeding in the first hour after delivery.

Question 30

Before administering a feeding through a gastrostomy tube, what is the PRIORITY nursing assessment?

A) Measure the vital signs

B) Palpate the abdomen

C) Assess for breath sounds

D) Verify tube patency

Review Information: The correct answer is:

D) Verify tube patency.

Tube patency should be checked prior to all feedings. The feeding should not be attempted if the tube is not patent.

Question 31

When teaching new parents the MOST important practice to prevent Sudden Infant Death Syndrome (SIDS) the nurse should instruct them to

A) Place the infant in a supine or side lying position for sleep

B) Do not allow anyone to smoke in the home

C) Follow recommended immunization schedule

D) Be sure to check infant every one hour

Review Information: The correct answer is:

A) Place the infant in a supine or side lying position for sleep.

Before 1992, almost 70% of infants were placed on their stomachs to sleep. Because of research findings and the "Back to Sleep" campaign, that number and the number of SIDS deaths dropped dramatically.

Cowan, M. (1996).

Children''s Health. In Stanhope, M. and Lancaster, J., Community Health Nursing: Promoting Health of Aggregates, Families, and Individuals. (4th ed.).

St. Louis: Mosby.

Nielsen, P. (1998).

SIDS: Reducing Risk Factors.

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Question 32

The nurse is caring for a client with left ventricular heart failure. Which one of the following assessments is an early indication of inadequate oxygen transport?

A) Crackles in the lungs

B) Confusion and restlessness

C) Distended neck veins

D) Use of accessory muscles

Review Information: The correct answer is:

B) Confusion and restlessness.

Neurological changes are early signs of inadequate oxygenation.

Question 33

A 14 month-old had cleft palate surgical repair several days ago. The parents ask the nurse about feedings after discharge. Which of the following lunches is the BEST example of an appropriate meal?

A) Hot dog, carrot sticks, gelatin, milk

B) Soup, blenderized soft foods, ice cream, milk

C) Peanut butter and jelly sandwich, chips, pudding, milk

D) Baked chicken, applesauce, cookie, milk

Review Information: The correct answer is:

B) Soup, blenderized soft foods, ice cream, milk.

In a child with cleft palate repair, parents should prepare soft foods and avoid those foods with particles that might traumatize the surgical site.

Question 34

The nurse is planning care for a 2 month-old child in bilateral leg casts for congenital clubfoot. Which of the following should be a PRIORITY nursing goal following cast application?

A) Infant will experience no pain

B) Muscle spasms will be relieved

C) Mobility will be enhanced

D) Tissue perfusion will be maintained

Review Information: The correct answer is:

D) Tissue perfusion will be maintained.

Immediately following cast application, the chief goal is to maintain circulation and tissue perfusion around the cast. Permanent tissue damage can occur within a few hours if perfusion is not maintained.

Question 35

The nurse is assessing the growth and development of a toddler with AIDS. The nurse would anticipate finding that the child is

A) Achieving developmental milestones at normal rate

B) Delayed in musculoskeletal development

C) Displaying difficulty with speech development

D) Delayed in achieving all developmental milestones

Review Information: The correct answer is:

D) Delayed in achieving all developmental milestones.

The majority of children with AIDS have neurological involvement. There is decreased brain growth as evidenced by microcephaly and abnormal neurologic findings. Developmental delays are common, or after achieving normal development, there may be loss of milestones.

Question 36

If a very active 2 year-old client pulls his tunneled central venous catheter out, what INITIAL nursing action is appropriate?

A) Obtain emergency equipment

B) Assess heart rate, rhythm and all pulses

C) Apply pressure to the vessel insertion site

D) Use cold packs at the exit incision site

Review Information: The correct answer is:

C) Apply pressure to the vessel insertion site.

If a central venous catheter is accidentally removed, pressure should be applied to the vein entry site.

Question 37

The nurse reviews an order to administer Rh (D) immune globulin to an Rh negative woman following the birth of an Rh positive baby. Whichassessment is a PRIORITY before the nurse gives the injection?

A) Newborn's blood type

B) Coomb's test results

C) Previous RhoGAM history

D) Gravida and parity

Review Information: The correct answer is:

B) Coomb''s test results.

Rh (D) immune globulin (RhoGAM) is given only if antibody formation has not occurred. The negative Coomb''s test confirms this.

Question 38

A 57 year-old male client has a hemoglobin of 10 mg/dl and a hematocrit of 32%. What would be the MOST appropriate follow-up by the home care nurse?

A) Ask the client if he has noticed any bleeding or dark stools

B) Tell the client to call 911 and go to the emergency department immediately

C) Schedule a repeat Hemoglobin and Hematocrit in one month

D) Tell the client to schedule an appointment with a hematologist

Review Information: The correct answer is:

A) Ask the client if he has noticed any bleeding or dark stools.

Normal hemoglobin for males is 13.0 - 18 g/100 ml. Normal hemotocrit for males is 42 - 52%. These values are below normal and indicate mild anemia. The first thing the nurse should do is ask the client if he''s noticed any bleeding or change in stools that could indicate bleeding from the GI tract.

Question 39

The nurse is caring for a trauma victim with a significant blood loss. Immediately following multiple transfusions, what is the MOST accurate indicator of oxygenation?

A) Pulse oximetry

B) Hemoglobin

C) Hematocrit

D) Blood gases

Review Information: The correct answer is:

D) Blood gases.

Arterial blood gases are the most accurate measure of oxygenation at this time.

Question 40

A client tells the nurse he is fearful of planned surgery because of evil thoughts about a family member. The BEST initial response by the nurse is to

A) Call a chaplain

B) Deny the feelings

C) Cite recovery statistics

D) Listen to the client

Review Information: The correct answer is:

D) Listen to the client.

Therapeutic communications are based on attentive listening to expressed feelings. If the nurse is not familiar with the cultural beliefs of a client, acceptance of feelings is followed by questions about the beliefs.

Question 1

A 16 year-old client is admitted to a psychiatric unit with a diagnosis of attempted suicide. The nurse is aware that the most frequent cause for suicide in adolescents is

A) Progressive failure to adapt

B) Feelings of anger or hostility

C) Reunion wish or fantasy

D) Feelings of alienation or isolation

Review Information: The correct answer is:

D) Feelings of alienation or isolation.

The isolation may occur gradually resulting in a loss of all meaningful social contacts. Isolation can be self imposed or can occur as a result of the inability to express feelings.

Question 2

The nursing care plan for a client with decreased adrenal function should include

A) Encouraging activity

B) Placing client in reverse isolation

C) Limiting visitors

D) Measures to prevent constipation

Review Information: The correct answer is:

C) Limiting visitors.

Any exertion, either physical or emotional, places additional stress on the adrenal glands which could precipitate an addisonian crisis. The plan of care should protect this client from the physical and emotional exertion of visitors.

Question 3

The nurse is caring for a 2 month-old child who has had a cleft lip repair. The BEST restraint to use for this child is the

A) Elbow restraint

B) Mummy restraint

C) Jacket restraint

D) Clove hitch restraint

Review Information: The correct answer is:

A) Elbow restraint.

The elbow restraint will prevent the child from touching the surgical site without hindering movement of other parts of his body.

Question 4

The nurse is caring for a newly delivered woman with HIV/AIDS. The client asks about the infant's risk of developing AIDS. Which of the following responses by the nurse is based on an understanding of perinatally acquired AIDS?

A) "Your baby is at high risk immediately after birth."

B) "Most newborns are immune to the HIV virus."

C) "The first 18 months are the time of greatest risk."

D) "Breast feeding will reduce your baby's risk."

Review Information: The correct answer is:

C) "The first 18 months are the time of greatest risk.".

The majority of infants with perinatally acquired AIDS develop symptoms within the first 18 months of life.

Question 5

The nurse is teaching a client with chronic obstructive pulmonary disease to use occasional pursed-lip breathing. What is the MAJOR reason for this?

A) Maintain an open airway

B) Expel carbon dioxide

C) Avoid dry mucous membranes

D) Prevent alveolar collapse

Review Information: The correct answer is:

D) Prevent alveolar collapse.

Clients with chronic obstructive pulmonary disease have difficulty exhaling fully as a result of their disease process. Alveolar collapse can be avoided by using pursed-lip breathing.

Question 6

The nurse is assessing a client who has taken haldol (Haloperidol) for several months. Which of the following is a side effect of this medication and must be reported IMMEDIATELY to the physician?

A) Muscle flaccidity

B) Dystonic reaction

C) Mood swings

D) Dry, harsh cough

Review Information: The correct answer is:

B) Dystonic reaction.

Haldol is a neuroleptic antipsychotic drug that may cause distonic reaction. Dosage may have to be adjusted.

Question 7

A client with schizophrenia is receiving Haloperidol (Haldol) 5 mg t.i.d. The client's family is alarmed and calls the clinic when "his eyes rolled upward." The nurse recognizes this as

A) Oculogyric crisis

B) Tardive dyskinesia

C) Nystagmus

D) Dysphagia

Review Information: The correct answer is:

A) Oculogyric crisis.

This refers to involuntary muscles spasm of the eye.

Question 8

A client with asthma has low pitched wheezes present on the final half of exhalation. One hour later the client has high pitched wheezes extending throughout exhalation. What does this change in assessment indicate to the nurse?

A) The client's airway obstruction is worsening

B) The client's airway obstruction is improving

C) The client needs to be suctioned

D) The client is hyperventilating

Review Information: The correct answer is:

A) The client''s airway obstruction is worsening.

The higher pitched a sound is, the more narrow the airway; therefore, the obstruction has worsened. There is no evidence to support a need for suctioning; inhaled corticosteroids are not used during an acute attack.

Question 9

A nurse is using an interpreter to teach a client about home care. It is IMPORTANT for the nurse to

A) Speak directly to the interpreter while presenting content

B) Talk to the interpreter in advance and leave the client and interpreter alone

C) Include family member and direct comments to that person

D) Face the client while presenting content

Review Information: The correct answer is:

D) Face the client while presenting content.

Communication is the cornerstone of an effective teaching plan, especially when the nurse and client do not share the same cultural heritage. Even if the nurse uses an interpreter, it is critical that the nurse use conversational style and spacing, personal space, eye contact, touch, and orientation to time strategies that are acceptable to the client. Therefore, face the client and present the content to the client, allow the interpreter to translate the content. Facing the client allows non-verbal communication to take place between the client and nurse.

Question 10

The nurse is caring for a client with a long leg cast. During discharge teaching about appropriate exercises for the affected extremity, the nurse should recommend

A) Isometric

B) Range of motion

C) Aerobic

D) Isotonic

Review Information: The correct answer is:

A) Isometric.

The nurse should instruct the client on isometric exercises for the muscles of the casted extremity, i.e.., instruct the client to alternately contract and relax muscles without moving the affected part. The client should also be instructed to do active range of motion exercises for every joint that is not immobilized at regular and frequent intervals.

Question 11

Following a diagnosis of acute glomerulonephritis (AGN) in their 6 year-old child, the parents remark that they are unclear as to how he caught the disease. The nurse's response is based on the understanding that

A) AGN is a streptococcal infection involving the kidney tubules

B) The disease is easily transmissible in schools and camps

C) The illness is usually associated with chronic respiratory infections

D) It is not "caught" but is a response to a previous B-hemolytic strep infection

Review Information: The correct answer is:

D) It is not "caught" but is a response to a previous B-hemolytic strep infection.

AGN is generally accepted as an immune-complex disease in relation to an antecedent streptococcal infection, and is considered as a noninfectious renal disease.

Question 12

A client is two days post operative. The vital signs are: BP - 120/70, HR - 110, RR - 26, and Temperature - 100.4 degrees F (38 degrees C). The client suddenly becomes profoundly short of breath, skin color is gray. Which assessment would have alerted the nurse FIRST to the client's change in condition?

A) Heart rate

B) Respiratory rate

C) Blood pressure

D) Temperature

Review Information: The correct answer is:

B) Respiratory rate.

Tachypnea is one of the first clues that the client is not oxygenating appropriately. The compensatory mechanism for decreased oxygenation is increased respiratory rate.

Question 13

A newborn has been diagnosed with hypothyroidism. In discussing the condition and treatment with the family, the nurse should emphasize

A) They can expect the child will be mentally retarded

B) Administration of thyroid hormone will prevent problems

C) This rare problem is always hereditary

D) Physical growth/development will be delayed

Review Information: The correct answer is:

B) Administration of thyroid hormone will prevent problems.

Early identification and continued treatment with hormone replacement corrects this condition.

Question 14

A nurse who is evaluating a mentally retarded two year-old in a clinic should stress the following goal when talking to the child's mother

A) Teaching the child self care skills

B) Preparing for independent toileting

C) Promoting the child's optimal development

D) Helping the family decide on long term care

Review Information: The correct answer is:

C) Promoting the child''s optimal development.

The primary goal of nursing care for a mentally retarded child is to promote the child''s optimum development.

Question 15

A client complained of nausea, a metallic taste in her mouth, and fine hand tremors 2 hours after her first dose of lithium carbonate (Lithane). The nurse's BEST explanation would be

A) These side effects are common and should subside in a few days

B) She is probably having an allergic reaction and should discontinue the drug

C) Taking the lithium on an empty stomach should decrease these symptoms

D) Decreasing dietary intake of sodium and fluids should minimize the side effects

Review Information: The correct answer is:

A) These side effects are common and should subside in a few days.

Nausea, metallic taste and fine hand tremors are common side effects that usually subside within days.

Question 16

A 3 year-old had a hip spica cast applied two hours ago. In order to facilitate drying, the nurse should

A) Expose the cast to air and turn the child frequently

B) Use a heat lamp to reduce the drying time

C) Handle the cast with the abductor bar

D) Turn the child as little as possible

Review Information: The correct answer is:

A) Expose the cast to air and turn the child frequently.

The child should be turned every two hours, with surface exposed to the air.

Question 17

The physician has ordered transdermal nitroglycerin patches for a client. The nurse should instruct the client to

A) Remove the patch when swimming or bathing

B) Apply the patch to any non-hairy area of the body

C) Apply a second patch with chest pain

D) Remove the patch if ankle edema occurs

Review Information: The correct answer is:

B) Apply the patch to any non-hairy area of the body.

The patch may be applied to any non-hairy area on the body.

Question 18

A home health nurse is caring for a client with diabetes and arthritis who has difficulty drawing up insulin. It would be MOST appropriate for the nurse to refer the client to

A) A social worker

B) An occupational therapist

C) A physical therapist

D) A home health aid

Review Information: The correct answer is:

B) An occupational therapist.

An occupational therapist can assist a client to improve the fine motor skills needed to prepare an insulin injection.

Question 19

A PRIORITY goal of involuntary hospitalization of the severely mentally ill client is

A) Re-orientation to reality

B) Elimination of symptoms

C) Protection from self-harm and harm to others

D) Return to independent functioning

Review Information: The correct answer is:

C) Protection from self-harm and harm to others.

Involuntary hospitalization may be required for persons considered dangerous to self or others or for individuals who are considered gravely disabled.

Question 20

The nurse prepares to administer eye drops to a six year-old child. The CORRECT way to give the eye drops is to instill them

A) Directly on the anterior surface of the eyeball

B) In the corner where the lids meet

C) Under the upper lid as it is pulled upward

D) In the conjunctival sac as the lower lid is pulled down

Review Information: The correct answer is:

D) In the conjunctival sac as the lower lid is pulled down.

Eye drops should be placed in the sac between the eye and the lower lid. This sac is formed by pulling the lower lid down.

Question 21

A client is scheduled for an Intravenous Pyelogram (IVP). In order to prepare the client for this test, the nurse would

A) Instruct the client to maintain a regular diet the day prior to the examination

B) Restrict the client's fluid intake 4 hours prior to the examination

C) Administer a laxative to the client the evening before the examination

D) Inform the client that only one x-ray of his abdomen is necessary

Review Information: The correct answer is:

C) Administer a laxative to the client the evening before the examination.

Bowel prep is important because it will allow greater visualization of the bladder and ureters.

Question 22

The nurse is assisting at a Poison Control Center telephone hotline. In which of the following cases of childhood poisoning would the nurse suggest that parents induce vomiting?

A) A 14 month-old chewed two leaves of a philodendron plant

B) An 18 month-old ate an undetermined amount of crystal drain cleaner

C) A 20 month-old is found comatose on the bathroom floor beside an empty bottle of diazepam (Valium)

D) A 30 month-old has swallowed a mouthful of charcoal lighter fluid

Review Information: The correct answer is:

A) A 14 month-old chewed two leaves of a philodendron plant.

With ingestion of a plant, there is no danger of aspiration or further tissue damage from emesis. Therefore, vomiting is a safe way to stop the poisoning process.

Question 23

For a 6 year-old child hospitalized with moderate edema and mild hypertension associated with acute glomerulonephritis (AGN), which one of the following nursing interventions would be appropriate?

A) Institute seizure precautions

B) Weigh the child twice per shift

C) Encourage the child to eat protein-rich foods

D) Relieve boredom through physical activity

Review Information: The correct answer is:

A) Institute seizure precautions.

The severity of the acute phase of AGN is variable and unpredictable; therefore, a child with edema, hypertension, and gross hematuria may be subject to complications, and anticipatory preparation such as seizure precautions are needed.

Question 24

The nurse is caring for a post-surgical client at risk for developing deep vein thrombosis. Which of the following is an effective preventive measure?

A) Place pillows under the knees

B) Use elastic stockings continuously

C) Encourage range of motion and ambulation

D) Massage the legs twice daily

Review Information: The correct answer is:

C) Encourage range of motion and ambulation.

Mobility reduces the risk of deep vein thrombosis in the post-surgical client and the adult at risk.

Question 25

The nurse is caring for a 13 year-old following spinal fusion for scoliosis. Which of the following interventions is appropriate in the immediate post-operative period?

A) Raise the head of the bed at least 30 degrees

B) Encourage ambulation within 24 hours

C) Maintain in a flat position, logrolling as needed

D) Encourage leg contraction and relaxation after 48 hours

Review Information: The correct answer is:

C) Maintain in a flat position, logrolling as needed.

The bed should remain flat for at least the first 24 hours to prevent injury. Logrolling is the best way to turn for the client while on bed rest.

Question 26

An infant weighed 7 pounds 8 ounces at birth. If growth occurs at a normal rate, the nurse would expect the six month-old to

A) Double the birth weight

B) Triple the birth weight

C) Gain 6 ounces each week

D) Add 2 pounds each month

Review Information: The correct answer is:

A) Double the birth weight.

Although growth rates vary, infants normally double their birth weight by 6 months.

Question 27

A client was admitted to the psychiatric unit after complaining to her friends and family that neighbors have bugged her home in order to hear all of her business. She remains aloof from other clients, paces the floor and believes that the hospital is a house of torture. Nursing interventions for the client should appropriately be directed toward

A) Convincing the client that the hospital staff is trying to help

B) Helping the client to enter into client group recreational activities

C) Helping the client learn to trust staff

D) Arranging the environment to limit the client's contact with other clients

Review Information: The correct answer is:

C) Helping the client learn to trust staff.

This establishes trust, facilitates a therapeutic alliance between staff and client.

Question 28

Which response by the nurse would BEST assist the chemically impaired client to deal with issues of guilt?

A) "Addiction usually causes people to feel guilty. Don't worry, it is a typical response due to your drinking behavior."

B) "What have you done that you feel most guilty about and what steps can you begin to take to help you lessen this guilt?"

C) "Don't focus on your guilty feelings. These feelings will only lead you to drinking and drugging."

D) "You've caused a great deal of pain to your family and close friends, so it will take time to undo all the things you've done."

Review Information: The correct answer is:

B) "What have you done that you feel most guilty about and what steps can you begin to take to help you lessen this guilt?".

This response encourages the client to get in touch with their feelings and utilize problem solving steps to reduce guilt feelings.

Question 29

A client treated for depression tells the nurse at the mental health clinic that he recently purchased a handgun because he is thinking about suicide. The FIRST nursing action should be to

A) Notify the physician immediately

B) Suggest in-client psychiatric care

C) Respect the client's confidential disclosure

D) Phone the family to warn them of the risk

Review Information: The correct answer is:

A) Notify the physician immediately.

The physician must be contacted immediately as the client is a danger to self and others. Hospitalization is indicated.

Question 30

On admission to the psychiatric unit, the client is trembling and appears fearful. The nurse's INITIAL response should be to

A) Give the client orientation materials and review the unit rules and regulations

B) Introduce him/herself and accompany the client to the client's room

C) Take the client to the day room and introduce her to the other clients

D) Ask the nursing assistant to get the client's vital signs and complete the admission search

Review Information: The correct answer is:

B) Introduce him/herself and accompany the client to the client's room.

Anxiety is triggered by change that threatens the individual's sense of security. In response to anxiety in clients, the nurse should remain calm, minimize stimuli, and move the client to a calmer, more secure/safe setting.

Question 31

The nurse enters the room as a three year-old is having a generalized seizure. Which of the following should the nurse do FIRST?

A) Clear the area of any hazards

B) Place the child on the side

C) Restrain the child

D) Give the prescribed anticonvulsant

Review Information: The correct answer is:

B) Place the child on the side.

Protecting the airway is the top priority in a seizure. From the Pediatric reference below, it is stated (pg.1055) 'if a child is actively convulsing, a patent airway and oxygenation must be assured....If the event occurs when the child is in a chair or standing, the child should be gently be helped to the ground and placed on one side and any nearby objects moved out of the way.' Thus, first note that the test question topic is about a generalized seizure. Given the options, most test takers narrow it to options a or b, which are both correct. Based on the data above and what you know to deal with airway first, ask yourself, 'Which action supports airway maintenance?' Of course, option b is the best answer. Protection from the environment, option a, is the second action.

Question 32

A mother brings her 26 month-old to the well-child clinic. She expresses frustration and anger due to her child's constantly saying "no" and his refusal to follow her directions. The nurse explains this is normal for his age, as negativism is attempting to meet which developmental need?

A) Trust

B) Initiative

C) Independence

D) Self-esteem

Review Information: The correct answer is:

C) Independence.

Independence and autonomy versus shame and doubt are the developmental tasks of toddler hood.

Question 33

To prevent a valsalva maneuver in a client recovering from an acute myocardial infarction, the nurse would

A) Assist the client to use the bedside commode

B) Administer stool softeners every day as ordered

C) Administer antidysrhythmics prn as ordered

D) Maintain the client on strict bed rest

Review Information: The correct answer is:

B) Administer stool softeners every day as ordered.

Administering stool softeners every day will prevent straining on defecation which causes the Valsalva maneuver. If constipation occurs then laxatives would be necessary to prevent straining. If straining on defecation produced the valsalva maneuver and rhythm disturbances resulted then antidysrhythmics would be appropriate.

Question 34

While planning care for a two year-old hospitalized child, the nurse expects that behavior would be MOST affected by

A) Strange bed and surroundings

B) Separation from parents

C) Presence of other toddlers

D) Unfamiliar toys and games

Review Information: The correct answer is:

B) Separation from parents.

Separation anxiety if most evident from 6 months to 30 months of age. It is the greatest stress imposed on a toddler by hospitalization. If separation is avoided, young children have a tremendous capacity to withstand other stress.

Question 35

The nurse is assessing an infant with developmental dysplasia of the hip. Which of the following findings would the nurse anticipate?

A) Unequal leg length

B) Limited adduction

C) Diminished femoral pulses

D) Symmetrical gluteal folds

Review Information: The correct answer is:

A) Unequal leg length.

Shortening of a leg is a sign of developmental dysplasia of the hip.

Question 36

Which of the following measures would be appropriate for the nurse to teach the parent of a nine month-old infant about diaper dermatitis?

A) Use only cloth diapers that are rinsed in bleach

B) Do not use occlusive ointments on the rash

C) Use commercial baby wipes with each diaper change

D) Discontinue a new food that was added to the infant's diet just prior to the rash

Review Information: The correct answer is:

D) Discontinue a new food that was added to the infant''s diet just prior to the rash.

The addition of new foods to the infant''s diet may be a cause of diaper dermatitis.

Question 37

The nurse is caring for a client in the late stages of Amyotrophic Lateral Sclerosis (A.L.S.). Which of the following assessments would the nurse expect to find?

A) Confusion

B) Loss of half of visual field

C) Shallow respirations

D) Tonic-clonic seizures

Review Information: The correct answer is:

C) Shallow respirations.

A.L.S. is a chronic progressive disease that involves degeneration of the anterior horn of the spinal cord as well as the corticospinal tracts. When the intercostal muscles and diaphragm become involved, the respirations become shallow and coughing is ineffective.

Question 38

Which of the following behavioral characteristics describes the domestic abuser?

A) Alcoholic

B) Over confident

C) High tolerance for frustrations

D) Low self-esteem

Review Information: The correct answer is:

D) Low self-esteem.

Batterers are usually physically or psychologically abused as children or have had experiences of parental violence. Batterers are also manipulative, have a low self-esteem, and have a great need to exercise control or power-over partner.

Question 39

The parents of a newborn male with hypospadias want their child circumcised. The BEST response by the nurse is to inform them that

A) Circumcision is delayed so the foreskin can be used for the surgical repair

B) This procedure is contraindicated because of the permanent defect

C) There is no medical indication for performing a circumcision on any child

D) The procedure should be performed as soon as the infant is stable

Review Information: The correct answer is:

A) Circumcision is delayed so the foreskin can be used for the surgical repair.

Even if mild hypospadias is suspected, circumcision is not done in order to save the foreskin for surgical repair, if needed.

Question 40

The nurse is teaching parents about the treatment plan for a 2 week-old infant with Tetralogy of Fallot. While awaiting future surgery, the nurse instructs the parents to IMMEDIATELY report

A) Loss of consciousness

B) Feeding problems

C) Poor weight gain

D) Fatigue with crying

Review Information: The correct answer is:

A) Loss of consciousness.

While parents should report any of the observations, they need to call the physician immediately if the level of alertness changes. This indicates anoxia, which may lead to death. The structural defects associated with Tetralogy of Fallot include pulmonic stenosis, ventricular septal defect, right ventricular hypertrophy and overriding of the aorta. Surgery is often delayed, or may be performed in stages.

Question 1

The nurse is caring for a client in the coronary care unit. The display on the cardiac monitor indicates ventricular fibrillation. What should the nurse do FIRST?

A) Perform defibrillation

B) Administer epinephrine as ordered

C) Assess for presence of pulse

D) Institute CPR

Review Information: The correct answer is:

C) Assess for presence of pulse.

Artifact can mimic ventricular fibrillation on a cardiac monitor. If the client is truly in ventricular fibrillation, no pulse will be present. The standard of care is to verify the monitor display with an assessment of the client's pulse.

Question 2

Which of the following conditions assessed by the nurse would contraindicate the use of benztropine (Cogentin)?

A) Neuromalignant syndrome

B) Acute extrapyramidal syndrome

C) Glaucoma, myasthenia gravis, prostatic hypertrophy

D) Parkinson's disease, atypical tremors

Review Information: The correct answer is:

C) Glaucoma, myasthenia gravis, prostatic hypertrophy.

Glaucoma, myasthenia gravis, and prostatic hypertrophy are contra indications to the use of benztropine (Cogentin) as the drug is an anticholinergic agent.

Question 3

The INITIAL nursing intervention for a delusional client who refuses to eat because of a belief that the food is poisoned is

A) "You think that someone wants to poison you?"

B) "Why do you think the food is poisoned?"

C) "These feelings are a symptom of your illness."

D) "You're safe here. I won't let anyone poison you."

Review Information: The correct answer is:

A) "You think that someone wants to poison you?".

This response acknowledges perception through a reflective question which presents opportunity for discussion, clarification of meaning, and expressing doubt.

Question 4

A client has been receiving dexamethasone (Decadron) for control of cerebral edema. Which of the following assessments would indicate that the treatment is effective?

A) A positive Babinski's reflex

B) Increased response to motor stimuli

C) A widening pulse pressure

D) Temperature of 37 C

Review Information: The correct answer is:

B) Increased response to motor stimuli.

Decadron is a corticosteroid that acts on the cell membrane to decrease inflammatory responses as well as stabilize the blood-brain barrier. Once Decadron reaches a therapeutic level, there should be a decrease in symptomology with improvement in motor,

Question 5

A parent has numerous questions regarding normal growth and development of a 10 month-old infant. Which of the following parameters is of MOST concern to the nurse?

A) 50% increase in birth weight

B) Head circumference greater than chest

C) Crying when the parents leave

D) Able to stand up briefly in play pen

Review Information: The correct answer is:

A) 50% increase in birth weight.

Birth weight should be doubled at 6 months of age, tripled at one year, and quadrupled by 18 months.

Question 6

A client is discharged following hospitalization for congestive heart failure. The nurse teaching the family suggests they encourage the client to rest frequently in which of the following positions?

A) Sitting in a chair

B) Supine

C) Left lateral position

D) Low Fowler's

Review Information: The correct answer is:

A) Sitting in a chair.

Sitting in a chair or resting in a bed in high Fowler''s position decreases the cardiac workload and facilitates breathing.

Question 7

The nurse is planning care for a client with pneumococcal pneumonia. Which of the following would be MOST effective in removing respiratory secretions?

A) Administration of cough suppressants

B) Increasing oral fluid intake to 3000 cc per day

C) Maintaining bed rest with bathroom privileges

D) Performing chest physiotherapy twice a day

Review Information: The correct answer is:

B) Increasing oral fluid intake to 3000 cc per day.

Secretion removal is enhanced with adequate hydration which thins and liquefies secretions.

Question 8

The nurse in a well-child clinic examines many children on a daily basis. Which of the following toddlers requires further follow up?

A) A 13 month-old unable to walk

B) A 20 month-old only using 2 and 3 word sentences

C) A 24 month-old who cries during examination

D) A 30 month-old only drinking from a sippy cup

Review Information: The correct answer is:

D) A 30 month-old only drinking from a sippy cup.

A 30 month-old should be able to drink from a cup without a cover.

Question 9

The nurse is discussing dietary intake with an adolescent who has acne. The MOST appropriate statement for the nurse is

A) "Eat a balanced diet for your age."

B) "Increase your intake of protein and Vitamin A."

C) "Decrease fatty foods from your diet."

D) "Do not use caffeine in any form, including chocolate."

Review Information: The correct answer is:

A) "Eat a balanced diet for your age.".

A diet for a teenager with acne should be a well balanced diet for their age. There are no recommended additions and subtractions from the diet.

Question 10

The nurse is performing physical assessments on adolescents. The nurse would anticipate that females experience growth spurts

A) About two years earlier than males

B) About the same time as males

C) Just prior to the onset of puberty

D) That increase height by four inches each year

Review Information: The correct answer is:

A) About two years earlier than males.

Normally, females in their teen age years experience a growth spurt about two years earlier than their male peers.

Question 11

A client has just returned to the medical-surgical unit following a segmental lung resection. After assessing the client, the FIRST nursing action would be to

A) Administer pain medication

B) Suction excessive tracheobronchial secretions

C) Assist client to turn, cough and deep breathe

D) Monitor oxygen saturation

Review Information: The correct answer is:

B) Suction excessive tracheobronchial secretions.

Suctioning the copious tracheobronchial secretions present in post-thoracic surgery clients maintains an open airway which is always the priority nursing intervention.

Question 12

The nurse is caring for a client with benign prostatic hypertrophy. Which of the following assessments would the nurse anticipate finding?

A) Large volume of urinary output with each voiding

B) Involuntary voiding with coughing and sneezing

C) Frequent urination

D) Urine is dark and concentrated

Review Information: The correct answer is:

C) Frequent urination.

Clients with Benign Prostatic Hypertrophy have overflow incontinence with frequent urination in small amounts day and night.

Question 13

A 23 year-old single client is in the 33rd week of her first pregnancy. She tells the nurse that she has everything ready for the baby and has made plans for the first weeks together at home. Which normal emotional reaction does the nurse recognize?

A) Acceptance of the pregnancy

B) Focus on fetal development

C) Anticipation of the birth

D) Ambivalence about pregnancy

Review Information: The correct answer is:

C) Anticipation of the birth.

Directing activities toward preparation for the newborn''s needs and personal adjustment are indicators of appropriate emotional response in the third trimester.

Question 14

Which of the following nursing assessments indicate immediate discontinuance of an antipsychotic medication?

A) Involuntary rhythmic stereotypic movements and tongue protrusion

B) Cheek puffing, involuntary movements of extremities and trunk

C) Agitation, constant state of motion

D) Hyperpyrexia, severe muscle rigidity, malignant hypertension

Review Information: The correct answer is:

D) Hyperpyrexia, severe muscle rigidity, malignant hypertension.

Hyperpyrexia, sever muscle rigidity, and malignant hypertension are assessment signs indicative of NMS (neuroleptic malignant syndrome).

Question 15

A client continually repeats phrases that others have just said. The nurse recognizes this behavior as

A) Autistic

B) Ecopraxic

C) Echolalic

D) Catatonic

Review Information: The correct answer is:

C) Echolalic.

Echolalic - repeating words heard.

Question 16

The nurse is caring for a client with acute pancreatitis. Which of the following, after pain management, should be included in the plan of care

A) Cough and deep breathe every two hours

B) Place the client in contact isolation

C) Provide a diet high in protein

D) Institute seizure precautions

Review Information: The correct answer is:

A) Cough and deep breathe every two hours.

Respiratory infections are common because of fluid in the retro peritoneum pushing up against the diaphragm causing shallow respirations. Encouraging the client to cough and deep breathe every two hours will diminish the occurrence of this complication.

Question 17

The nurse is caring for a 10 year-old on admission to the burn unit. One assessment parameter that will indicate that the child has adequate fluid replacement is

A) Urinary output of 30 ml per hour

B) No complaints of thirst

C) Increased hematocrit

D) Good skin turgor around burn

Review Information: The correct answer is:

A) Urinary output of 30 ml per hour.

For a child of this age, this is adequate output, yet does not suggest overload.

Question 18

In providing care to acutely ill pediatric clients, the nurse should recognize that the child at HIGHEST risk for cardiac arrest is the individual experiencing

A) Congenital cardiac defects

B) An acute febrile illness

C) Prolonged hypoxemia

D) Severe multiple trauma

Review Information: The correct answer is:

C) Prolonged hypoxemia.

Most often, the cause of cardiac arrest in the pediatric population is prolonged hypoxemia.

Question 19

A client is in her third month of her first pregnancy. During the interview, she tells the nurse that she has several sex partners and is unsure of the identity of the baby's father. Which of the following nursing interventions is a PRIORITY?

A) Counsel the woman to consent to HIV screening

B) Perform tests for sexually transmitted diseases

C) Discuss her high risk for cervical cancer

D) Refer the client to a family planning clinic

Review Information: The correct answer is:

A) Counsel the woman to consent to HIV screening.

The client''s behavior places her at high risk for HIV. Testing is the first step. If the woman is HIV positive, the earlier treatment begins, the better the outcome.

Question 20

The nurse is caring for a client with trigeminal neuralgia (tic douloureaux). To assist the client with nutrition needs, the nurse should

A) Offer small meals of high calorie soft food

B) Assist the client to sit in a chair for meals

C) Provide additional servings of fruits and raw vegetables

D) Encourage the client to eat fish, liver and chicken

Review Information: The correct answer is:

A) Offer small meals of high calorie soft food.

If the client is losing weight because of poor appetite due to the pain, assist in selecting foods that are high in calories and nutrients, to provide more nourishment with less chewing. Suggest that frequent, small meals be eaten instead of three large ones. To minimize jaw movements when eating, suggest that foods be pureed.

Question 21

Which of the following should be included when the nurse is teaching a client about chlorpromazine HCL (Thorazine)?

A) Avoid direct sunlight

B) Avoid foods containing tyramine

C) Avoid foods fermented with yeast

D) Avoid canned citrus fruit drinks

Review Information: The correct answer is:

A) Avoid direct sunlight.

Phenothiazine increases sensitivity to the sun, making clients especially susceptible to sunburn.

Question 22

When teaching a client with chronic obstructive pulmonary disease about oxygen by cannula, the nurse should also instruct the client's family to

A) Avoid smoking near the client

B) Turn off oxygen during meals

C) Adjust the liter flow to 10 as needed

D) Remind the client to keep mouth closed

Review Information: The correct answer is:

A) Avoid smoking near the client.

Since oxygen supports combustion, there is a risk of fire if anyone smokes near the oxygen equipment.

Question 23

The nurse is teaching a client who has a hip prostheses following total hip replacement. Which of the following should be included in the instructions for home care?

A) Avoid climbing stairs for three months

B) Ambulate using crutches only

C) Sleep only on your back

D) Do not cross legs

Review Information: The correct answer is:

D) Do not cross legs.

Hip flexion should not exceed 60 degrees.

Question 24

While assessing an out-patient with a panic disorder, the nurse completes a thorough health history and physical exam. Which of the following is MOST significant for this client?

A) Compulsive behavior

B) Sense of impending doom

C) Fear of flying

D) Predictable episodes

Review Information: The correct answer is:

B) Sense of impending doom.

The feeling of overwhelming and uncontrollable doom is characteristic of a panic attack.

Question 25

Which of the following are examples of variations in the newborn resulting from the presence of maternal hormones?

A) Engorgement of the breasts

B) Mongolian spots

C) Edema of the scrotum

D) Lanugo

Review Information: The correct answer is:

A) Engorgement of the breasts.

Breast engorgement occurs in both sexes as a result of the withdrawal of maternal hormones.

Question 26

A 16 month-old child has just been admitted to the hospital. As the nurse assigned to this child enters the hospital room for the first time, the toddler runs to the mother, clings to her and begins to cry. What would be the initial action by the nurse?

A) Arrange to change client care assignments

B) Explain that this behavior is expected

C) Discuss the appropriate use of "time-out"

D) Explain that the child needs extra attention

Review Information: The correct answer is:

B) Explain that this behavior is expected.

During normal development, fear of strangers becomes prominent beginning around age 6-8 months. Such behaviors include clinging to parent, crying, and turning away from the stranger. These fears/behaviors extend into the toddler period and may persist into preschool.

Question 27

The nurse is reviewing a depressed client's history from an earlier admission. Documentation of anhedonia is noted. The nurse understands that this symptom refers to

A) Reports of difficulty falling and staying asleep

B) Expression of persistent suicidal thoughts

C) Lack of enjoyment in usual pleasures

D) Reduced senses of taste and smell

Review Information: The correct answer is:

C) Lack of enjoyment in usual pleasures.

Lack of enjoyment in usual pleasures defines this term.

Question 28

While explaining an illness to a ten year-old, the nurse should keep in mind that at this developmental stage a child will

A) Make simple association of ideas

B) Think logically in organizing facts

C) Interpret events from own perspective

D) Base conclusions on abstract thinking

Review Information: The correct answer is:

B) Think logically in organizing facts.

The child in the concrete operations stage, according to Piaget, is capable of mature thought when allowed to manipulate and organize objects.

Question 29

A client has just been admitted with portal hypertension. Which one of the following nursing diagnosis would be a PRIORITY in planning care?

A) Altered nutrition: less than body requirements

B) Potential complication hemorrhage

C) Ineffective individual coping

D) Fluid volume excess

Review Information: The correct answer is:

B) Potential complication hemorrhage.

Esophageal varices are dilated and tortuous vessels of the esophagus that are at high risk for rupture if portal circulation pressures rise.

Question 30

A fifteen year-old client with a lengthy confining illness is at risk for altered growth and development related to

A) Loss of control

B) Insecurity

C) Dependence

D) Lack of trust

Review Information: The correct answer is:

C) Dependence.

The client role fosters dependency. Adolescents may react to dependency with rejection, uncooperativeness, or withdrawal.

Question 31

The nurse is assessing a 2 year-old client with a possible diagnosis of congenital heart disease. Which of the following is MOST likely related to this diagnosis?

A) Several otitis media episodes in the last year

B) Weight and height in 10th percentile since birth

C) Takes frequent rest periods while playing

D) Changing food preferences and dislikes

Review Information: The correct answer is:

C) Takes frequent rest periods while playing.

Children with heart disease tend to have exercise intolerance. The child self-limits activity, which is consistent with manifestations of congenital heart disease in children.

Question 32

The nurse is caring for a child who has just returned from surgery following a tonsillectomy and adenoidectomy. Which of the following actions by the nurse is appropriate?

A) Offer ice cream

B) Place the child in a supine position

C) Allow the child to drink through a straw

D) Observe swallowing patterns

Review Information: The correct answer is:

D) Observe swallowing patterns.

The nurse should observe for increased swallowing frequency to check for hemorrhage.

Question 33

Which playroom activities should the nurse organize for a small group of seven year-old hospitalized children?

A) Sports and games with rules

B) Finger paints and water play

C) "Dress-up" clothes and props

D) Chess and television programs

Review Information: The correct answer is:

A) Sports and games with rules.

The purpose of play for the seven year-old is cooperation. Rules are very important. Logical reasoning and social skills are developed through play.

Question 34

The nurse is responsible for decisions regarding client room assignments. Which one of the following possible roommates would be MOST appropriate for a three year-old child with minimal change nephrotic syndrome?

A) Two year-old with respiratory infection

B) Three year-old fracture whose sibling has chickenpox

C) Four year-old with bilateral inguinal hernia repair

D) Six year-old with a sickle cell anemia crisis

Review Information: The correct answer is:

C) Four year-old with bilateral inguinal hernia repair.

The nurse must know that children with nephrotic syndrome are at high risk for development of infections as a result of the standard use of immunosuppressant therapy as well as from the accumulation of fluid (edema). Therefore, these children must be protected from sources of possible infection.

Question 35

The charge nurse on the eating disorder unit instructs a new staff member to weigh each client in his or her hospital gown only. What is the rationale for this nursing intervention?

A) To reduce the risk of the client feeling cold due to decreased fat and subcutaneous tissue

B) To cover the bony prominence and areas where there is skin breakdown

C) So the client knows what type of clothing to wear when weighed

D) To reduce the tendency of the client to hide objects under his or her clothing

Review Information: The correct answer is:

D) To reduce the tendency of the client to hide objects under his or her clothing.

The client may conceal weights on their body to increase weight gain.

Question 36

The nurse is caring for a client with cirrhosis of the liver with ascites. When instructing nursing assistants in the care of the client, the nurse should emphasize that

A) The client should remain on bed rest in a semi-Fowler's position

B) The client should alternate ambulation with bed rest with legs elevated

C) The client may ambulate and sit in chair as tolerated

D) The client may ambulate as tolerated and remain in semi-Fowlers position in bed

Review Information: The correct answer is:B) The client should alternate ambulation with bed rest with legs elevated.

Encourage alternating periods ambulation and bed rest with legs elevated to mobilize edema and ascites. Encourage and

Question 37

The nurse is caring for a client with a sigmoid colostomy who requests assistance in removing theflatus from a one piece drainable ostomy pouch. Which of the following is the correct intervention?

A) Piercing the plastic of the ostomy pouch with a pin to vent the flatus

B) Opening the bottom of the pouch, allowing the flatus to be expelled

C) Pulling the adhesive seal around the ostomy pouch to allow the flatus to escape

D) Assisting the client to ambulate to reduce the flatus in the pouch

Review Information: The correct answer is:B) Opening the bottom of the pouch, allowing the flatus to be expelled.

The only correct way to vent the flatus from a one piece drainable ostomy pouch is to instruct the client to obtain privacy (the release of the flatus will cause odor), and to open the bottom of the pouch, release the flatus and dose the bottom of the pouch.

Question 38

A client has developed thrombophlebitis of the left leg. Which of the following nursing interventions should be given the HIGHEST priority?

A) Elevate leg on two pillows

B) Apply support stockings

C) Apply warm compresses

D) Maintain complete bed rest

Review Information: The correct answer is:A) Elevate leg on two pillows.

The first goal of nonpharmacologic interventions is to minimize edema of the affected extremity by leg elevation.

Question 39

Upon examining the mouth of a 3 year-old child, the nurse discovers that the teeth have chalky white-to-yellowish staining with pitting of the enamel. Which of the following conditions would most likely explain these findings?

A) Ingestion of tetracycline

B) Excessive fluoride intake

C) Oral iron therapy

D) Poor dental hygiene

Review Information: The correct answer is:B) Excessive fluoride intake.

The described signs/symptoms are indicative of fluorosis, a condition characterized by an increase in the extent and degree of the enamel''s porosity. This problem can be associated with repeated swallowing of toothpaste with fluoride or drinking water with high levels of fluoride.

Question 40

The physician has ordered an iodine solution for a client scheduled to undergo a thyroidectomy. When administering this medication the nurse should

A) Provide the client with a straw for drinking the liquid

B) Dilute it in milk and give on an empty stomach

C) Dilute it in fruit juice and give with meals

D) Administer at bedtime followed by an antacid

Review Information: The correct answer is:C) Dilute it in fruit juice and give with meals.

Mix the iodine solution with fruit juice or other liquids to disguise the unpleasant taste and give with meals or at bedtime.