Funds Proctored Exam Rationales

1. A nurse is conducting an admission interview with a client. Which of the following pieces of assessment information should the nurse collect during the introductory phase of the interview?
A. Clients level of comfort and ability to participate in the interview
-The nurse should assess the client's level of comfort and establish a rapport during the introductory or orientation phase. The nurse should engage in active listening and present a relaxed attitude to place the client at ease and encourage client participation. This will assist the nurse in gaining the necessary data to formulate appropriate nursing diagnoses and outcomes.
B. Previous illnesses and surgeries
-incorrect: The nurse should assess the client's health history, including previous illnesses and surgeries, during the working phase of the interview.
C. Events surrounding the client's recent illness
-incorrect: The nurse should assess the client's health history, including events surrounding the recent or current illness, during the working phase of the interview.
D. Sociocultural history
-incorrect: The nurse should assess the client's sociocultural history during the working phase of the interview.

2. A nurse is performing an abdominal assessment of a client. Which of the following positions should the nurse tell the client to assume for this examination?
A. Lithotomy
-incorrect: The lithotomy position is useful for gynecological examinations.
B. Lateral
-incorrect: The lateral recumbent, or side-lying position, limits access to the abdomen. This position is useful when auscultating the heart to detect murmurs.
C. Supine
-The nurse should tell the client to assume the supine position to promote relaxation of the abdominal muscles. Having the client bend the knees enhances relaxation of the stomach muscles.
D. Sims
-incorrect: The Sims' position limits access to the abdomen. This position is useful for rectal and vaginal examinations.

3. A nurse is caring for a client who is postoperative following an abdominal surgery. Which of the following actions should the nurse perform first after discovering the client's wound has eviscerated?
A. Cover the incision with a moist sterile dressing
- The nurse should apply the safety and risk-reduction priority-setting framework, which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's Hierarchy of Needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client. An open wound

increases the risk of peritonitis, and any exposed organ tissue could dry out. Therefore, covering the wound with a moist sterile dressing is the first action the nurse should take to protect the client.
B. Have the client lie on his back with his knees flexed
-incorrect: The nurse should use this position to reduce pressure on the incision. However, the nurse should take another action first.
C. Call the client's surgeon
-incorrect: The nurse should notify the surgeon or direct a colleague to notify the surgeon while tending to the client's immediate need. However, the nurse should take another action first.
D. Reassure the client
-incorrect: The nurse should respond to the client's emotional needs. However, the nurse should take another action first.

4. A nurse is preparing to insert an NG tube for a client who has a bowel obstruction. Which of the following actions should the nurse take first?
A. Give the client a glass of water
-incorrect: The nurse should provide a glass of water to facilitate swallowing during tube insertion of the NG tube. However, there is another action the nurse should take first.
B. Assist the client into a sitting position
-incorrect: The nurse should assist the client into a sitting position to insert the NG tube more easily and allow gravity to help facilitate the passage of the tube. However, there is another action the nurse should take first.
C. Explain the procedure to the client
-The nurse should apply the least invasive priority-setting framework when caring for this client, which assigns priority to nursing interventions that are least invasive to the client, as long as those interventions do not jeopardize client safety. The nurse should take interventions that are not invasive to the client before interventions that are invasive. This reduces the number of organisms introduced into the body, decreasing the number of facility-acquired infections. Informing the client about the procedure reduces fear and assists in gaining the client's cooperation, which is important for NG tube insertion and is the priority nursing intervention.
D. Measure the length of tubing to be inserted
-incorrect: The nurse should measure the length of the tubing to be inserted to ensure proper tube placement. However, there is another action the nurse should take first.

5. A nurse is providing discharge teaching to a client who is recovering from lung cancer. The provider instructed the client that he could resume lower-intensity activities of daily living. Which of the following activities should the nurse recommend to the client?
A. Sweeping the floor
-incorrect: sweeping the floor is moderate-intensity activity
B. Shoveling snow
-incorrect: Shoveling snow is a high-intensity activity
C. Cleaning windows
-incorrect: Cleaning windows is a moderate-intensity activity
D. Washing dishes

-Washing dishes requires a low level of activity and is appropriate for this client.

6. A nurse is caring for a client who is receiving dextrose 5% in water IV at 150 mL/hr and has ingested 4 oz of water and ½ pint of milk. What is the total 8-hr fluid intake in milliliters that the nurse should document for this client? (round to nearest whole number)

-1560

7. A nurse is performing a physical examination of a client. The nurse should use percussion to evaluate which of the following parts of the client's body?
A. Heart
-incorrect: The nurse uses inspection, palpation, and auscultation to evaluate the heart.
B. Lungs
-Percussion creates a vibration that helps the examiner determine the density of the underlying tissue. The lungs are hollow organs that can produce sounds such as resonance (a hollow sound over alveoli) or dullness (a dull sound over consolidated areas of the lungs or diaphragm). The nurse also uses auscultation and palpation when evaluating the lungs.
C. Thyroid gland
-incorrect: The nurse uses inspection and palpation to evaluate the thyroid gland.
D. Skin
-incorrect: The nurse uses inspection and palpation to evaluate the skin.

8. A nurse is supervising a newly licensed nurse who is administering a controlled substance. Which of the following actions by the newly licensed nurse indicates an understanding of the procedure?
A. Placing an unused portion of the medication in a sharps box
-incorrect: The nurse should not dispose of an unused portion of a controlled substance in the sharps container because this action does not maintain safe control of the narcotic.
B. Asking another nurse to observe the disposal of an unused portion of the medication
-The nurse should ask another nurse to witness the disposal of a controlled substance to maintain safe control of the narcotic.
C. Counting the inventory of the available narcotic after administering the medication
-incorrect: The nurse should count the inventory of the controlled substance before removing a dosage to maintain safe control of the narcotic.
D. Ensuring that another nurse signs the control inventory form after disposal of an unused portion of medication
-incorrect: Two nurses should sign the control inventory form after the disposal of a portion of a narcotic to maintain safe control.

9. A nurse is caring for a client who has acute renal failure. Which of the following assessments provides the most accurate measure of the client's fluid status?
A. Daily weight
-According to the evidence-based priority-setting framework, daily weight provides important information about the client's fluid status. A gain or loss of 1 kg (2.2 lb) indicates a gain or loss of

1 L of fluid; therefore, weighing the client daily will provide the most accurate fluid status measurement.
B. Blood Pressure
-incorrect: While blood pressure can indicate a client's fluid gain or losses, it is not the most accurate method of measuring fluid changes.
C. Specific gravity
-incorrect: Specific gravity reflects the kidney's ability to concentrate urine. While specific gravity reflects client's fluid gains or losses, it is not the most accurate method used to measure fluid changes.
D. Intake and Output
-incorrect: Intake and output reflect a client's fluid status. However, this is not the most accurate method to measure fluid changes.

10. A nurse in a long-term care facility is admitting a client who is incontinent and smells strongly of urine. His partner, who has been caring for him at home, is embarrassed and apologizes for the smell. Which of the following responses should the nurse make?
A. "A lot of clients who are cared for at home have the same problem"
-incorrect: This automatic response implies that caregivers in the home are not able to keep client's odor-free. It is a judgmental statement that is not therapeutic.
B. "Don't worry about it. He will get a bath, and that will take care of the odor."
-incorrect: Telling the partner not to worry blocks communication by devaluing her feelings and her concern about the odor.
C. "It must be difficult to care for someone who is confined to bed."
-This response addresses the feelings of the partner by reflecting her feelings, which facilitates therapeutic communication because it is nonjudgmental and encourages the partner to express her feelings.
D. "When was the last time that he had a bath?"
-incorrect: This response implies that the odor of urine has developed because she has not bathed her husband for some time, which is judgmental and nontherapeutic.

11. A nurse is caring for a client who has bilateral cats on her hands. Which of the following actions should the nurse take when assisting the client with feeding?
A. Sit at the bedside when feeding the client
-The nurse should avoid appearing to be in a hurry. Sitting at the bedside provides the client with the nurse's full attention during the feeding
B. Order pureed foods
-incorrect: Without any mouth or throat injuries that make chewing or swallowing difficult, the client should be served foods of an appropriate variety of textures. Pureed foods are for clients who cannot chew, have difficulty swallowing, or do not have teeth.
C. Make sure feedings are provided at room temperature
-incorrect: The nurse should ask the client if the food is the correct temperature
D. Offer the client a drink of fluid after every bite

-incorrect: If the client is unable to communicate, the nurse should offer the client fluids after every 3 or 4 mouthfuls. However, there is no indication that this client is unable to communicate. Therefore, the client should tell the nurse when she would like a drink.

12. A nurse is administering an IM injection to a 5-month-old infant. Which of the following injection sites should the nurse use?
A. Deltoid
-incorrect: The nurse can use the deltoid muscle for injecting small volumes of medication for children 18 months of age or older, but its proximity to several nerves and arteries make it a riskier choice.
B. Ventrogluteal
-incorrect: This is a safe site for IM injections for clients older than 7 months.
C. Vastus lateralis
-The nurse should use the vastus lateralis site over the anterior thigh for IM injections for infants and children.
D. Dorsogluteal
-incorrect: This site is unsafe to use because of its proximity to the sciatic nerve and the superior gluteal nerve and artery.

13. A nurse is caring for a client who has major fecal incontinence and reports irritation in the perianal area. Which of the following actions should the nurse take first?
A. Apply a fecal collection system
-incorrect: The nurse should apply a fecal collection system to divert the feces away from the area of skin irritation; however, there is another action the nurse should take first.
B. Apply a barrier cream
-incorrect: The nurse should apply a barrier cream to decrease skin breakdown in the perianal area from the feces; however, there is another action the nurse should take first.
C. Cleanse and dry the area
-incorrect: The nurse should cleanse and dry the perianal area to decrease skin irritation; however, there is another action the nurse should take first.
D. Check the client's perineum
-The nurse should apply the nursing process priority-setting framework to plan care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify a provider of a change in the client's status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with knowledge to make an appropriate decision. The priority nursing action is for the nurse to collect more data by assessing the area of irritation.

14. A nurse is caring for a client who is receiving IV therapy via a peripheral catheter. The nurse should identify that which of the following findings is an indication of infiltration?
A. Redness at the infusion site
-incorrect: Redness at the infusion site is an indication of phlebitis or infection.
B. Edema at the infusion site

-Edema due to fluid entering subcutaneous tissue is an indication of infiltration.
C. Warmth at the infusion site
-incorrect: Warmth at the infusion site is an indication of phlebitis or infection.
D. Oozing of blood at the infusion site
-incorrect: Oozing of blood at the infusion site is an indication that the IV system is not intact.

15. A nurse is caring for a client who reports not sleeping at night, which interferes with her ability to function during the day. Which of the following interventions should the nurse suggest to this client?
A. Avoid beverages that contain caffeine
-Caffeine is a stimulant. The nurse should suggest that the client avoid caffeinated beverages.
B. Take a sleep medication regularly at bedtime
-incorrect: Sleep-promoting medication is a last resort. The nurse should not suggest this type of medication for the client before recommending other nonpharmacological interventions.
C. Watch television for 30 minutes in bed to relax prior to falling asleep
-incorrect: Clients should associate going to bed with sleep. Therefore, the client should not get into bed until she is sleepy.
D. Advise the client to take several naps during the day
-incorrect: Napping in the daytime can prevent sound sleep at night

16. A nurse is providing teaching to a client regarding protein intake. Which of the following foods should the nurse include as an example of an incomplete protein?
A. Eggs
-incorrect: this is a complete protein, contains all of the essential amino acids necessary for the synthesis of protein in the body.
B. Soybeans
-incorrect: this is a complete protein, contains all of the essential amino acids necessary for the synthesis of protein in the body.
C. Lentils
-Incomplete proteins are missing 1 or more of the essential amino acids necessary for the synthesis of protein in the body. Examples of incomplete proteins include lentils, vegetables, grains, nuts, and seeds.
D. Yogurt
-incorrect: this is a complete protein, contains all of the essential amino acids necessary for the synthesis of protein in the body.

17. A nurse is planning to collect a stool specimen for ova and parasites from a client who has diarrhea. Which of the following actions should the nurse take when collecting the specimen?
A. Instruct the client to defecate into the toilet bowl
-incorrect: The nurse should have the client defecate into a bedpan or a container for stool collection. The toilet water can dilute and contaminate the liquid specimen.
B. Transfer the specimen to a sterile container
-incorrect: The nurse should place the stool specimen in a clean container using a tongue depressor.

C. Refrigerate the collected specimen
-incorrect: The nurse should send the collected stool specimen immediately to the laboratory after labeling the specimen properly to prevent contamination with microorganisms and keep the specimen from getting cold.
D. Place the stool specimen collection container in a biohazard bag
-The nurse should place the specimen collection container in a biohazard bag with the client label on the container and the bag for easy identification. This will also prevent contamination with microorganisms.

18. A nurse is caring for a client who has a tracheostomy and requires suctioning. Which of the following actions should the nurse take?
A. Hyper oxygenate the client before suctioning
-The nurse should use a manual resuscitation bag to hyper oxygenate the client for several minutes prior to suctioning.
B. Insert the catheter during exhalation
-incorrect: The nurse should insert the catheter during inhalation
C. Apply suction during insertion of the catheter
-incorrect: Applying suction while inserting the catheter increases the risk of damage to the tracheal mucosa and removes oxygen from the airways.
D. Apply suction for no more than 15 secs
-incorrect: The nurse should apply suction for no more than 10 seconds

19. A nurse is caring for a client who was admitted to a long-term care facility for rehabilitation after a total hip arthroplasty. At which of the following times should the nurse begin discharge planning?
A. One week prior to the client's discharge
-incorrect: Beginning to plan for the client's discharge a week prior to the event might not allow sufficient time for planning. The nurse should begin discharge planning at the time of admission.
B. Upon the client's admission to the care facility
-The nurse should begin discharge planning at the time that the client is admitted to the facility.
C. Once the discharge date is identified
-incorrect: Beginning to plan for the client's discharge once the discharge date is identified might not allow sufficient time for planning. The nurse should begin discharge planning at the time of admission.
D. When the client addresses the topic with the nurse
-incorrect: Beginning to plan for the client's discharge once the discharge date is identified might not allow sufficient time for planning. The nurse should begin discharge planning at the time of admission.

20. A nurse is preparing to administer a cleansing enema to a client. Which of the following actions should the nurse plan to take?
A. Insert the rectal tube 15.2 cm (6 in)
-incorrect: The nurse should insert the rectal tube 7 to 10 cm (3 to 4 in)
B. Wear sterile gloves to insert the tubing

-incorrect: The nurse should wear clean (nonsterile) gloves to prevent contamination.
C. Position the client on his left side
-Positioning is an important aspect of administering an enema. Having the client lie on his left side facilitates the flow of the enema solution into the sigmoid and descending colon.
D. Hold the solution bag 91 cm (36 inch) above the client's rectum
-incorrect: The nurse should hold the solution bag 30 cm (12 in) above the client's rectum for a low enema and 45 cm (18 in) for a high enema. If the nurse holds the solution bag too high, the solution might run in too fast, causing discomfort and spasms that make retaining the enema more difficult.

21. A nurse in an emergency department is assessing a client who reports diarrhea and decreased urination for 4 days. Which of the following actions should the nurse take to assess the client's skin turgor?
A. Push on a fingernail bed until it blanches, release it, and observe how long it takes the skin to become pink.
-incorrect: This technique assesses capillary refill.
B. Grasp a skin fold on the chest under the clavicle, release it, and note whether it springs back.
-The nurse should use this technique to assess skin turgor. If the client has good turgor and is properly hydrated, the skin will immediately return to normal; in dehydration, the skin will remain tented. The nurse can also assess turgor by grasping a skinfold on the back of the forearm.
C. Press the skin above the ankle for 5 seconds, release it, and note the depth of the impression.
-incorrect: This technique determines the extent of a client's pitting edema.
D. Measure the skinfold thickness on the upper arm using a pair of calibrated skinfold calipers.
-incorrect: This technique determines a client's body fat percentage.

22. A nurse discovers that a client received the wrong medication. Which of the following actions should the nurse take first?
A. Complete a medication error report
-incorrect: The nurse should follow the facility's protocol for documenting the incident; however, this is not the first action the nurse should take.
B. Notify the prescribing provider
-incorrect: The nurse should follow the facility's protocol for reporting a medication error, which usually involves notifying the prescribing provider; however, this is not the first action the nurse should take.
C. Assess the client
-The greatest risk to the client's safety is adverse effects from either receiving the wrong medication or not receiving the prescribed medication. The nurse should assess the client first for any possible adverse effects. This assessment also serves as a baseline for further monitoring for adverse effects.
D. Notify the charge nurse
-The nurse should follow the facility's protocol for reporting a medication error, which usually involves notifying the charge nurse; however, this is not the first action the nurse should take.

23. A nurse is performing a breast examination for a female client. Which of the following techniques should the nurse use first?
A. Inspect both breasts simultaneously
-According to evidence-based practice, the nurse should first inspect both breasts with the client's arms in several different positions to look for asymmetry, masses, retraction, lesions, inflammation, and dimpling.
B. Squeeze the nipples
-incorrect: The nurse should compress the nipples to identify the presence of any discharge. However, evidence-based practice indicates that the nurse should use a different technique before compression.
C. Palpate the breast and tail of Spence
-incorrect: The nurse should palpate the breast and tail of Spence to determine the consistency of breast tissue and assess the presence of masses. However, evidence-based practice indicates that the nurse should use a different technique before palpation of the breast because doing so can alter the accuracy or effectiveness of another phase of the examination.
D. Palpate the axillary lymph nodes
-incorrect: The nurse should palpate the axillary lymph nodes, which become involved when cancerous lesions metastasize. However, evidence-based practice indicates that the nurse should use a different technique before palpation of the axillary lymph nodes because doing so can alter the accuracy or effectiveness of another phase of the examination.

24. A nurse is helping a client change his hospital gown. The client has an IV infusion via an infusion pump. Which of the following actions should the nurse take first?
A. Remove the sleeve of the gown from the arm without the IV line.
-According to evidence-based practice, the nurse should first remove the gown from the client's arm without the IV line. Beginning this process will enable the nurse to move the gown fully off the client before stopping the system to remove the gown from the line, resulting in minimal interruption of the IV flow.
B. Slow the infusion using a roller clamp
-incorrect: The nurse should slow the infusion using the roller clamp to prevent a large volume infusion of IV solution while changing the gown. However, evidence-based practice indicates that the nurse should take a different action first.
C. Disconnect the IV line from the pump
-incorrect: The nurse should disconnect the IV line from the pump while removing and reapplying the gown quickly to maintain the infusion rate prescribed with the pump, however, evidence-based practice indicates that the nurse should take a different action first.
D. Bring the IV solution and tubing from the outside to the inside of the sleeve of the gown
-incorrect: The nurse should bring the IV solution and tubing through the outside to the inside of the sleeve of the gown to avoid tangling of the tubing and the gown. However, evidence-based practice indicates that the nurse should take a different action first.

25. A nurse is preparing to administer a unit of packed RBC's to a client when she discovers that the IV line is no longer patent. The IV team informs her that someone can come to initiate a new line in 30 min. Which of the following actions should the nurse take?

A. Return the blood to the laboratory
-Because the nurse knows that the delay will be more than a few minutes, she should return the unit of packed RBCs immediately to the laboratory where the technician will maintain it at the appropriate temperature until the client is ready to receive it.
B. Place the blood in the medication room
-incorrect: The unit of packed RBCs should not be at room temperature for any length of time because the lack of temperature control could damage the blood.
C. Place the blood in the refrigerator
Incorrect: Blood products require specific temperature regulation, which is not consistently possible in a standard nursing unit refrigerator.
D. Leave the blood at the client's bedside
-The nurse should never leave blood products or medication at the bedside due to the potential for loss, misuse, or contamination.

26. A hospice nurse is reviewing religious practices of a group of clients with a newly licensed nurse. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?
A. People who practice the Islamic faith pray over the deceased for a period of 5 days before burial.
-incorrect: For those who practice the Islamic faith, the body of the deceased is washed and wrapped during a ritual and then buried as soon as possible following death.
B. People who practice the Hindu faith bury the deceased with their head facing north.
-incorrect: People who practice the Hindu faith may place the body with the head facing north following death. However, cremation rather than burial is practiced by those of the Hindu faith.
C. People who practice Judaism stay with the body of the deceased until burial.
-In the Jewish faith, a family member often stays with the body until burial occurs.
D. People who are practicing the Buddhist faith have the female family members prepare the body following death.
-incorrect: Male family members prepare the body following death for individuals practicing the Buddhist faith.

27. A nurse is planning an in-service training session about nutrition. Which of the following statements should the nurse include in the teaching?
A. "Fats provide energy"
-Fat serves as a stored energy source for the body, providing 9 cal/g of energy.
B. "Carbohydrates repair body tissue"
-incorrect: Proteins play a role in tissue repair.
C. "Fats regulate fluid balance"
-incorrect: Protein is primarily responsible for regulating fluid balance.
D. "Carbohydrates prevent interstitial edema"
-incorrect: The presence of protein prevents interstitial edema. An appropriate amount of albumin in blood keeps interstitial edema from occurring.

28. A nurse is caring for a client who requires fluid restriction and may drink only 1 oz of water with each oral medication. How many milliliters of water should the nurse document as intake for the 3 separate medications the client receives during 12-hour night shift? (round to the nearest whole number)

90

29. A nurse is caring for a client who is dehydrated. The nurse should expect that insensible fluid loss of approximately 500 to 600 mL occurs each day through which of the following organs?
A. Kidney's
-incorrect: The kidneys excrete approximately 1,200 to 1,500 mL of urine daily. However, urine is not considered insensible fluid loss. This can increase depending on the client's intake of water.
B. Lungs
-incorrect: The lungs excrete approximately 400 mL of insensible fluid loss each day.
C. Gastrointestinal Tract
-incorrect: The GI tract loses approximately 100-200 mL of fluid each day through feces. However, this is not considered insensible fluid loss.
D. Skin
-The skin can excrete approximately 500 to 600 mL of insensible fluid loss. This type of fluid loss is continuous and can increase if the client is experiencing a fever or has had a recent burn to the skin.

30. A nurse is caring for an adult client who communicates an unmet spiritual need. Which of the following client statements should indicate to the nurse that the client is experiencing spiritual distress?
A. "Life has its ups and downs"
-incorrect: This statement suggests the client is experiencing and incorporating a sense of spiritual wellbeing by accepting life's ups and downs.
B. "I believe that I control my own destiny"
-incorrect: This statement suggests the client is experiencing and incorporating a sense of spiritual wellbeing by being in control of personal destiny.
C. "God is punishing me for something"
-Spiritual distress is an impaired ability to integrate meaning and purpose in life through various means, including belief systems and relationships. Manifestations of spiritual distress can include a feeling that a higher power is punishing the individual for some behavior.
D. "I like to keep my rosary beads in bed with me"
-incorrect: This statement suggests that the client is experiencing and incorporating a sense of spiritual wellbeing by engaging in prayer activities such as the rosary.

31. While in the hospital, a client who has a terminal illness tells the nurse, "I can't believe I'm dying. A lot of bad people in the world are healthy and here I am dying!" Which of the following responses should the nurse provide?
A. "Everyone dies sometimes; some die sooner than others."
-incorrect: This is a nontherapeutic response that dismisses and minimizes the client's feelings.

B. “Who do you think deserves to die more than you?”
-incorrect: This is a nontherapeutic response that could be perceived as confrontational by the client.
C. “It does seem unfair, doesn’t it?”
-incorrect: While this response acknowledges the client’s feelings, it is a closed-ended statement that does not facilitate further exploration of the client’s feelings.
D. “Tell me more about how you feel about dying?”
-This therapeutic response from the nurse seeks more information to form an accurate assessment of the client’s feelings.

32. A nurse is administering medication to a client who asks the nurse to leave the medication at the bedside to be taken at a later time. Which of the following responses should the nurse make?
A. “Call me when you are ready, and I will return with the medication.”
-The nurse is responsible for administering the medication and for following professional standards by adhering to the 6 rights of medication administration.
B. “Since you were taking this mediation at home, I will leave it for you to take.”
-incorrect: At home, the client is responsible and accountable for actions regarding self-administration of medications. In an inpatient setting, the nurse is responsible for administering medication to the client.
C. “I will come back in 30 mins to check that you took the medication so I can chart the time.”
-incorrect: If the nurse returns to the client’s room in 30 minutes, the nurse will not be able to verify that the client took the medication since the client could have hidden or discarded the medication.
D. “If you refuse to take the medication now, I can’t give it again until your next scheduled time.”
-incorrect: The nurse is responsible for administering the medication at the scheduled time. Although the policy about time may vary by facility, a medication generally may be given within 1 hour of the prescribed time.

33. A nurse is admitting a client who will undergo a craniotomy. During the planning phase of the nursing process, which of the following actions should the nurse take?
A. Establish client outcomes
-The planning phase of the nursing process includes developing goals and outcomes that help the nurse create the client’s plan of care.
B. Collect information about past health problems
-incorrect: The nurse should collect information about the client’s past health problems during the assessment phase of the nursing process.
C. Determine whether the client has met specific goals
-incorrect: The nurse should determine whether the client has met goals during the evaluation phase of the nursing process.
D. Identify the client’s specific health problems
-incorrect: The nurse should identify the client’s specific health problems during the analysis phase of the nursing process.

34. A nurse in a provider's office is teaching a client about foods that are high in fiber. Which of the following food choices made by the client indicate an understanding of the teaching? (SATA)
A. Canned peaches
-incorrect: Canned fruits, including peaches, are recommended for clients on a low-fiber diet. Fresh fruits contain more fiber.
B. White rice
-incorrect: White rice is recommended for clients on a low-fiber diet. Brown rice is higher in fiber.
C. Black beans
-Dried peas and beans, including black beans, are high in fiber.
D. Whole-grain bread
-Whole grains consist of the entire kernel and are also high in fiber.
E. Tomato juice
-incorrect: Canned juices, with the exception of prune juice, are recommended for clients on a low-fiber diet.

35. A nurse is preparing to provide chest physiotherapy for a client who has left lower lobe atelectasis. Which of the following actions should the nurse plan to take?
A. Place the client in the Trendelenburg position
-The nurse should place the client in a right-sided Trendelenburg position to promote drainage from the client's left lower lobe.
B. Perform percussions directly over the client's bare skin
-incorrect: The nurse should perform percussions over a single layer of clothing.
C. Use a flattened hand to perform percussions
-incorrect: The nurse should use a cupped hand to provide percussions.
D. Remind the client that chest percussions can cause mild pain
-incorrect: Chest percussions should not cause pain when the procedure is performed correctly.

36. A middle-aged adult client is discussing future plans with the nurse. Which of the following statements should the nurse identify as an indication that the client is having difficulty achieving Erikson's developmental task for this age group?
A. "We miss our daughter so much that we are going to move closer to her."
-According the Erikson, the stage of psychosocial development for middle adults is generativity vs. stagnation. Accepting the independence of adult children is part of the developmental task of middle age.
B. "I think this year I can plan on managing the funding at church."
-incorrect: Middle-aged adults should turn their focus to community and volunteer activities, according to Erikson's developmental task of generativity vs. stagnation for this age group.
C. "I really wish I could lose some of this weight."
-incorrect: Metabolism slows during middle age, and clients tend to gain unnecessary weight. Concern about this weight gain is an expected finding.
D. "I find I am spending more time at work now that my son is at college."
-incorrect: Middle-aged adults often focus more on work as they try to achieve Erikson's developmental task of generativity vs. stagnation.

37. A nurse is caring for a client who is receiving intermittent enteral feedings through an NG tube. The specific gravity of the client's urine is 1.035. Which of the following actions should the nurse take?
A. Deliver the formula at a slower rate
-incorrect: Slowing the delivery rate is an intervention for diarrhea.
B. Request a lower-fat formula
-incorrect: Instilling a lower-fat formula is an intervention for abdominal distention and bloating.
C. Provide more water with feedings
-The elevation in the client's specific gravity indicates dehydration. The nurse should provide more fluids either by adding free water to feedings or by instilling water between feedings. Another strategy is to request a formula that contains less protein.
D. Instill a lactose-free formula
-incorrect: Instilling a lactose-free formula is an intervention for nausea and vomiting.

38. A nurse is assessing a client who has a sudden onset of severe back pain of unknown origin. Which of the following questions should the nurse ask to encourage discussion with the client?
A. "Does the medication you're taking relieve the pain?"
-incorrect: Close-ended statements generally elicit a 1- or 2-word response and is restrictive when seeking more information. Closed-ended questions are used to obtain information quickly in an emergency situation.
B. "Can you point to where the pain is the worst?"
-incorrect: The nurse should use the pain scale or have the client describe the pain to elicit an open-ended conversation.
C. "What do you think caused the onset of your pain?"
-The nurse is using an open-ended question that allows the client to respond with a wide range of information by using more than a few words.
D. "Changing positions makes your pain worse, right?"
-incorrect: Closed-ended questions are used to obtain information quickly in an emergency situation. The nurse should ask the client to describe which position facilitates the greatest relief of the pain to elicit an open-ended conversation.

39. A nurse is reviewing the correct use of a fire extinguisher with a client. Which of the following actions should the nurse direct the client to take first?
A. Aim the hose at the base of the fire
-incorrect: Evidence-based practice indicates aiming the hose of the fire extinguisher is the second step the client should take.
B. Squeeze the handle of the extinguisher
-incorrect: Evidence-based practice indicates squeezing the handle of the extinguisher is the third step the client should take.
C. Remove the safety pin from the extinguisher
-Evidence-based practice indicates removing the safety pin from the extinguisher is the first action to take when using a fire extinguisher; therefore, this is an action the nurse should instruct the client to perform first.

D. Sweep the hose from side to side to dispense material
-incorrect: Evidence-based practice indicates sweeping the hose from side to side to dispense material is the fourth step the client should take.

40. A nurse is planning care for a client who is confused and requires a prescription for wrist restraints. Which of the following interventions should the nurse include in the plan of care?
A. Renew the prescription for the use of restraints within 24 hours
-The nurse should plan to renew the prescription for the restraints within 24 hours; only after the provider has evaluated the client.
B. Secure the restraint with the buckle side next to the client's skin
-incorrect: The nurse should secure the client's restraints with the softer side next to the client's skin with the buckle or Velcro closure on the outside.
C. ensure 4 fingers can be inserted under the secured restraint
-incorrect: The nurse should ensure 2 fingers can be inserted under the restraints to prevent the restraint from being too loose. If the nurse is unable to insert 2 fingers under the restraint, it could cause impaired circulation to the extremities.
D. Remove the restraint every 3 hours
-incorrect: The nurse should remove the restraint at least every 2 hours; at that time, the nurse should check the client's skin, change the client's position, and toilet or exercise the client.

41. A nurse is caring for a client who has a terminal illness. The client asks several questions about the nurse's religious beliefs related to death and dying. Which of the following actions should the nurse take?
A. Change the topic because the client is trying to divert attention from the illness.
-incorrect: Changing the subject is a nontherapeutic communication technique that will block the development of an open exchange between the nurse and the client.
B. Encourage the client to express thoughts about death and dying.
-The nurse should recognize the client's need to talk about impending death and encourage the client to discuss thoughts on the subject. This is the therapeutic technique of reflecting. Depending on the situation, the nurse can also share some thoughts on this topic. Self-disclosure is a communication skill that can encourage sharing when appropriate. If the nurse does not want to share personal beliefs, offering self and listening to the client's thoughts are appropriate.
C. Tell the client that religious beliefs are a personal matter.
-incorrect: This closed-ended response is a nontherapeutic technique that will block the communication with this client.
D. Offer to contact the client's minister or the facility's chaplain.
-incorrect: This response disregards the client's issue and could create barriers to communication between the nurse and the client.

42. A nurse is caring for a middle-aged adult client. The nurse should identify which of the following statements as an indication that the client has completed Erikson's developmental task for her age group?
A. "I am comfortable with my decision to choose a lifelong partner."

-incorrect: This statement relates to Erikson's developmental task for young adults, which is intimacy vs. isolation.
B. "I think I have done a good job with my children since they are all independent now."
-According to Erikson, the developmental task for middle adults is generativity vs. stagnation. Middle adults help shape future generations through community involvement, parenting, mentoring, and teaching. This statement about helping her children achieve independence indicates that the client has accomplished this developmental task.
C. "As I look back over my life, I can see that I have achieved most of the goals I set for myself."
-incorrect: This statement relates to Erikson's developmental task for older adults, which is integrity vs. despair.
D. "I love my work so much that it is difficult to think about retirement."
-incorrect: This statement relates to Erikson's developmental task for older adults, which is integrity vs. despair.

43. A nurse is inserting an NG tube into a client who begins to gag and cough. Which of the following actions should the nurse take?
A. Remove the NG tube
-incorrect: The nurse should not remove the NG tube if the client begins to cough and gag because this can result in increased discomfort for the client.
B. Advance the NG tube quickly
-incorrect: The nurse should not advance the NG tube while the client is coughing because this can result in inserting the tube into the client's trachea.
C. Pull the NG tube back slightly
-The nurse should slightly pull back the NG tube and instruct the client to breathe slowly. Once the client relaxes, the nurse should gently advance the tube as the client swallows.
D. Ask the client to tilt his head backward
-incorrect: The nurse should ask the client to tilt his head forward to aid the insertion of the NG tube into the esophagus.

44. An adolescent client in an outpatient mental health facility tells the nurse that he struggles to follow his treatment plans because his friends discourage him. Which of the following statements should the nurse make?
A. "Don't worry; teenagers often have friends who give bad advice."
-incorrect: This response is a barrier to communication. It is a stereotypical response and will not encourage open communication.
B. "I think you should stop seeing those friends since they discourage you from following your treatment plan."
-incorrect: While the adolescent should possibly stop seeing these friends, sharing personal advice will probably be rejected by the adolescent and will not encourage open communication.
C. "Tell me more about how your friends discourage you."
-The nurse should ask an open-ended question that encourages the client to elaborate on these problems.
D. "Where did you meet these friends?"
-incorrect: This response changes the subject, which will not encourage open communication.

45. A nurse is teaching a client about the use of a straight-legged cane. Which of the following client actions indicates an understanding of the teaching?
A. The client holds the cane on the unaffected side.
-The nurse should instruct the client to hold the cane on the unaffected side to provide a wide base of support and stability.
B. The client walks by stepping with the unaffected leg before the affected leg.
-incorrect: The nurse should instruct the client to walk by stepping with the affected leg before the unaffected leg to maintain stability.
C. The client holds the cane directly next to the foot.
-incorrect: The nurse should instruct the client to place the cane at about 15 cm (6 in) to the side of the foot to provide balance and support.
D. The client holds the cane with a straight elbow.
-incorrect: The nurse should instruct the client to hold the cane with the elbow slightly flexed to provide support and stability.

46. A nurse is preparing to administer sotalol to a client with a prescription for 320 mg/day divided equally every 12 hr. The medication is available in 80 mg tablets. How many tablets should the nurse administer per dose? (nearest tenth)

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47. A nurse is caring for a client who had a mastectomy and has a self-suction drainage evacuator in place. Which of the following actions should the nurse take to ensure proper operation of the device?
A. Irrigate the tubing with sterile normal water once during each shift.
-incorrect: The nurse should keep the diaphragm of the device compressed to maintain suction and prevent clotting of sanguineous drainage. This drainage system is not made for irrigating.
B. Cleanse the opening with soap and water after emptying.
-incorrect: The nurse should cleanse the drain opening with an alcohol wipe after opening it to decrease the entry of microorganisms.
C. Maintain the tubing above the level of the surgical incision.
-incorrect: The nurse should maintain the drainage tubing below the level of the incision to enhance drainage.
D. Collapse the device to remove air after emptying.
-The nurse should collapse the device to remove air after emptying the contents periodically. This will create enough suction to pull fluid exudate into the collection area of the device.

48. A nurse is planning weight-loss strategies for a group of clients who are obese. Which of the following actions by the nurse will improve the client's commitment to a long-term goal of weight loss?
A. Attempt to increase the client's self-motivation
-Motivation to learn is a key part of improving a client's commitment to achieving a health goal, as well as increasing the amount and speed of learning.

B. Keep detailed records of each client's progress
-incorrect: This will help each client track individual progress but does not improve client progress toward individual goals.
C. Test client learning after each teaching session
-incorrect: Testing learning helps to determine whether outcomes are reached but does not affect each client's commitment to the goal.
D. Avoid discussing topics that might increase client's anxiety
-incorrect: Anxiety can interfere with learning and should be addressed early in the teaching process.

49. A nurse is teaching a client how to perform range-of-motion exercises of the wrist. To perform adduction, which of the following instructions should the nurse include?
A. "With your palm facing down, move your wrist sideways toward your thumb."
-This motion describes adducting the wrist. The client should be able to move her wrist 30 to 50 degrees with this motion.
B. "Move your palm toward the inner part of your forearm."
-incorrect: This motion is flexing the wrist.
C. "With your palm facing down, move your wrist sideways toward your little finger."
-incorrect: This motion is abducting the wrist.
D. "Bring the back of your hand as far back toward the wrist as you can."
-incorrect: This motion is hyperextending the wrist.

50. A nurse is assessing a client for conductive hearing loss. When using the Rinne test, which of the following results should the nurse identify as an indication that the client has conductive hearing loss of the left ear?
A. Air conduction is less than bone conduction in the left ear.
-This finding indicates conductive hearing loss of the left ear.
B. Air conduction is greater than bone conduction in the left ear.
-incorrect: This finding does not indicate hearing loss of any type.
C. Sound is lateralizing to the right ear.
-incorrect: These are possible results of the Weber test, not the Rinne test.
D. Sound is lateralizing to the left ear.
-incorrect: These are possible results of the Weber test, not the Rinne test.

51. A nurse is preparing a client who is scheduled for a hysterectomy for transport to the operating room. The client states she no longer wants to have the surgery. Which of the following actions should the nurse take?
A. Tell the client it is too late for her to change her mind because the surgery is already scheduled.
-incorrect: The client has the right to refuse a procedure after giving consent.
B. Telephone the operating room and cancel the surgery.
-incorrect: This is not the responsibility of the nurse but a decision the surgeon and the client must make.
C. Inform the client's family about the situation.

-incorrect: To respect the client's confidentiality, the family can be notified only after the client requests that the nurse do so.
D. Notify the provider of the client's decision.
-While acting as the client's advocate, the nurse should support her decision and notify the provider.

52. A nurse is admitting a client who has decreased circulation in his left leg. Which of the following actions should the nurse take first?
A. Evaluate pedal pulses
-For a client who has decreased circulation in the leg, evaluating pedal pulses is critical in order to determine adequate blood supply to the foot. The nurse should apply the safety and risk reduction priority-setting framework. This framework assigns priority to the factor posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's Hierarchy of Needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client.
B. Obtain a medical history
-incorrect: The nurse should obtain the client's medical history. However, there is another action the nurse should take first.
C. Measure vital signs
-incorrect: The nurse should obtain baseline vital signs. However, there is another action the nurse should take first.
D. Assess for leg pain
-incorrect: The nurse should assess the client for pain. However, there is another action the nurse should take first.

53. A new resident provider asks the charge nurse for an access code to review clients' online records. The resident is not scheduled to attend the facility's orientation computer class until next week. Which of the following actions should the nurse take?
A. Explain that it is against policy to share access codes and refer the resident to his supervisor.
- Staff members should never share access codes and passwords or allow people who do not have their own access code to use the system. Allowing unauthorized access is a breach of federal guidelines for data security and client confidentiality.
B. Access the clients' online data and monitor the resident as he reads them.
-incorrect: Allowing an individual who does not have a personal access code to view the system is a breach of federal guidelines for data security and client confidentiality.
C. Access the online system and allow the resident to locate clients' data.
-incorrect: Allowing an individual to access the system without a personal access code is a breach of federal guidelines for data security and client confidentiality.
D. Ask each client to give permission for the resident to access medical records.
-incorrect: The resident should not have access to client information until he participates in the facility's training, which includes information about data security and client confidentiality. Even then, he should only have access to information directly needed to provide care to his specific clients.

54. A nurse is caring for a client who has injuries resulting from a motor-vehicle crash. Which of the following client statements should the nurse address first?
A. “I’m afraid this injury will cause me to lose my job.”
-incorrect: The client’s fear of job loss is associated with the client’s identity and economic survival. However, this is a self-esteem need; another need is the priority.
B. “I can’t sleep well because whenever I move in my sleep, the pain wakes me up.”
-The priority action the nurse should take when using Maslow’s hierarchy of needs id to meet the client’s physiological need for comfort. The nurse should re-evaluate the client’s pain management plan immediately.
C. “I don’t know what I will do if my car isn’t safe or even drivable after the crash.”
-incorrect: The client’s concern about the vehicle is a safety and security need; however, another need is the priority.
D. “I wonder how I am going to be able to take care of my family.”
-incorrect: The client’s need to care for family members in the same way as before is a love and belonging need; however, another need is the priority.

55. A nurse is preparing a client for discharge and providing instructions about performing dressing changes at home. Which of the following statements should the nurse identify as an indication that the client understands medical asepsis?
A. “I’ll wrap the old dressing in a paper bag and put it in the trash.”
-incorrect: Local regulations for disposal of contaminated items may vary. In general, placing the old dressing in a plastic bag and sealing it is an acceptable means of disposal in the household trash.
B. “I’ll wash my hands before I remove the old dressing and again before putting on the new one.”
-It is essential that the client understands the importance of hand hygiene before, during, and after any handling of the wound or its dressings.
C. “I’ll need to take a pain pill 30 minutes before I change the dressing.”
-incorrect: This might be a good practice if the dressing changes are painful; however, this statement does not address medical asepsis, only pain management.
D. “I’ll wear sterile gloves when I apply the new dressing.”
-incorrect: Clean gloves and dressings are standard for clients at home. If sterile dressings are necessary, a home health care nurse should perform the dressing changes.

56. A nurse is teaching an assistive personnel (AP) about proper hand hygiene. Which of the following statements by the AP indicates an understanding of the teaching?
A. “There are times I should use soap and water rather than an alcohol-based rub to clean my hands.”
-While alcohol-based hand rubs are as effective as soap and water in providing proper hand hygiene, the Centers Disease Control and Prevention recommend washing hands with soap and water at certain times, such as when the hands are visibly soiled with dirt or body fluids.
B. “I will use cold water when I wash my hands to protect my skin from becoming dry.”

-incorrect: Hand hygiene should be performed with warm water, which preserves the protective oil of the skin better than hot water.
C. “I will apply friction for at least 10 seconds while washing my hands.”
-incorrect: Friction is required to loosen and remove dirt and pathogens from the hands. To be effective, friction should be applied for at least 15 to 20 seconds.
D. “After washing my hands, I will dry them from the elbows down.”
-incorrect: Drying should be performed from the cleanest area (fingertips) to the least clean area (forearms) to prevent contamination of the newly cleaned hands.

57. A nurse on a rehabilitation unit is preparing to transfer a client who is unable to walk from a bed to a wheelchair. Which of the following techniques should the nurse use?
A. Stand toward the client’s stronger side.
-incorrect: Safely transferring a client from a bed to a wheelchair requires the nurse to stand in front of the client toward the side that requires the most support. This technique will help maintain balance during the transfer.
B. Instruct the client to lean backward from the hips.
-incorrect: Safely transferring a client from a bed to a wheelchair requires the nurse to instruct the client to lean forward from the hips. This technique positions the client in the proper direction of the movement.
C. Place the wheelchair at a 45-degree angle to the bed.
-Positioning the wheelchair at a 45-degree angle allows the client to pivot, lessening the amount of rotation required.
D. Assume a narrow stance with the feet 15 cm (6 in) apart.
-incorrect: Safely transferring a client from a bed to a wheelchair requires the nurse to assume a wide stance with one foot in front of the other. This technique protects the nurse from losing balance during the transfer.

58. A nurse is preparing to provide tracheostomy care for a client. Which of the following actions should the nurse perform first?
A. Open all sterile supplies and solutions.
-incorrect: The nurse should open all sterile supplies and solutions prior to providing tracheostomy care. However, there is another action the nurse should take first.
B. Stabilize the tracheostomy tube.
-incorrect: the nurse should stabilize the tracheostomy tube to prevent accidental extubation while providing tracheostomy care. However, there is another action the nurse should take first.
C. Put on sterile gloves
-incorrect: The nurse should put on sterile gloves prior to providing tracheostomy care to reduce the transmission of organisms. However, there is another action the nurse should take first.
D. Perform hand hygiene
-According to evidence-based practice, the nurse should first perform hand hygiene before touching the client or performing any skills, such as tracheostomy care. This is vital because contamination of the nurse’s hands is a primary source of infection.

59. A nurse is preparing to change the bed linens of a client who has AIDS and is incontinent of stool. Which of the following personal protective equipment (PPE) items should the nurse don prior to providing client care? (SATA)
A. Gown
-The nurse should follow standard precautions when caring for a client who has AIDS. Because the bed linens might be soiled, the nurse should don a gown. Because the nurse's hands will come in contact with the soiled bed linens, the nurse should don clean gloves in addition to other necessary PPE.
B. Gloves
-The nurse should follow standard precautions when caring for a client who has AIDS. Because the bed linens might be soiled, the nurse should don a gown. Because the nurse's hands will come in contact with the soiled bed linens, the nurse should don clean gloves in addition to other necessary PPE.
C. Mask
-incorrect: AIDS is not transmitted by droplets or inhalation, so a mask is not necessary when changing the client's bed linens.
D. Hair cover
-incorrect: A hair cover is not necessary when changing the client's bed linens.
E. Goggles
-incorrect: Goggles are not necessary since the splashing of bodily fluids is unlikely when changing the client's bed linens.

60. A nurse is caring for a client who has a methicillin-resistant Staphylococcus aureus (MRSA) infection. A dietary assistant asks the nurse what precautions are necessary for entering the client's room with the lunch tray. Which of the following instructions should the nurse give to the dietary assistant?
A. Don a gown before entering the room and remove it before exiting
-incorrect: Anyone who will have actual contact with this client must wear a gown. If the dietary assistant is just placing the lunch tray on the client's table, donning a gown is not necessary.
B. Wear a mask while in the client's room
-incorrect: MRSA does not spread via droplet or aerosol transmission; therefore, the dietary assistant does not need to wear a mask.
C. Don gloves when entering the room and use hand sanitizer when exiting
-Clients who have MRSA infection require contact precautions. In addition to the use of standard precautions and meticulous hand hygiene, contact precautions require any staff member who will have contact with the client's environment to don gloves prior to entering the room. Additional precautions, such as a gown, are required for contact with the client; a mask and goggles are needed if the secretions from the infected area could spray into the worker's face. Delivering the tray will require contact with the client's environment; therefore, the dietary assistant must wear gloves.
D. Take no special precautions unless engaging in direct contact with the client
-incorrect: Infections with multidrug-resistant organisms, such as MRSA, require special precautions to prevent transmission of the pathogen through contact with the client and the client's environment.

61. A charge nurse is observing a newly licensed nurse perform tracheostomy care for a client. Which of the following actions by the newly licensed nurse requires interventions?
A. Obtaining hydrogen peroxide for tracheostomy care
-incorrect: A half-strength peroxide solution is used to clean the inner cannula.
B. Obtaining cotton balls for tracheostomy care
-Cotton ball particles can be aspirated into the tracheostomy opening, possibly causing a tracheal abscess. The charge nurse should intervene for this action.
C. Obtaining sterile gloves for tracheostomy care
-incorrect: Tracheostomy care is a sterile procedure requiring the use of sterile gloves.
D. Obtaining a sterile brush for tracheostomy care
-incorrect: Pipe cleaners or a small sterile brush can be used to remove thick or crusty secretions from the inner cannula.

62. A nurse is providing nutritional teaching to a group of clients. Which of the following definitions for the recommended dietary allowance (RDA) should the nurse include in the teaching?
A. The RDA is a comprehensive term that includes various standards and scales.
-incorrect: Dietary reference intakes (DRIs) include 4 nutrition-based standards that are used to plan dietary intake and evaluate a client's nutritional status. These dietary standards include RDAs, estimated average requirements (EARs), adequate intake (AI), and tolerable upper intake levels (ULs).
B. The RDA defines the level of nutrient intake that meets the needs of healthy people in various groups.
-The RDA represents daily requirements considered adequate for healthy people. RDAs are based on estimated amounts for each nutrient, including additional amounts for individuals such as women or infants.
C. The RDA defines the levels of nutrients that should not be exceeded to prevent adverse health effects.
-incorrect: Tolerable upper intake levels (ULs), not RDAs, are the levels of nutrients that should not be exceeded to prevent adverse effects.
D. The RDA is the daily percentage of energy intake values for fat, carbohydrate, and protein.
-Acceptable macronutrient distribution ranges (AMDRs) are the daily percentage of energy intake values for fat, carbohydrate, and protein.

63. A nurse is reviewing a client's 24 hr dietary recall. The client reports eating a slice of toasted white bread with butter, a banana, a glass of milk, and a cup of coffee for breakfast; grilled chicken, a baked potato, and a glass of milk for lunch; an apple and cheddar cheese for a snack; and 2 servings of chicken, 2 cups of steamed broccoli, and a glass of milk for dinner. This client's diet is deficient in which of the following food groups?
A. Dairy
-incorrect: The client consumed 3 servings of dairy throughout the day, which is the recommended daily amount according to USDA dietary guidelines.
B. Vegetables

-incorrect: The client consumed 2.5 cups or more of vegetables, which is the recommended daily amount according to USDA dietary guidelines.
C. Fruits
-incorrect: The client consumed 2 servings of fruit, which is the recommended daily amount according to USDA dietary guidelines.
D. Grains
-This client only consumed 1 serving of grains on the day of the 24-hour dietary recall. USDA dietary guidelines recommend 3 or more ounce-equivalents of whole-grain products per day. Additionally, the choice of white bread is low in fiber, which can lead to constipation and an increased risk of developing hyperlipidemia. The USDA guidelines recommend that at least half of the grains consumed should be whole grain.

64. A nurse is assessing a client's pulses of the lower extremities. The nurse should identify which of the following as the location of the most distal pulse?
A. Popliteal
-incorrect: The nurse should identify that the popliteal pulse is located behind the knee. It is best felt with the client's knee slightly flexed and the foot resting on an examination table.
B. Posterior Tibial
-incorrect: The nurse should identify that the posterior tibial pulse is located on the inner side of the ankle. It is best felt with the client's foot relaxed and extended slightly.
C. Dorsalis Pedis
-The nurse should identify that the dorsalis pedis pulse is located on the top of the foot, following the groove between the tendons of the great toe. It is best felt by moving the fingertip between the first and second toe and slowly moving up the dorsum of the foot. However, this pulse is congenitally absent in some clients.
D. Femoral
-incorrect: The nurse should identify that the femoral pulse is located in the inguinal area. It is best felt with the client lying down and the inguinal area exposed.

65. A nurse is screening a client who has an S-shaped spinal column with unequal shoulder heights. The nurse should identify these findings as manifestations of which of the following abnormalities?
A. Scoliosis
-The nurse should identify the finding of an S-shaped or C-shaped spinal column and uneven shoulder or hip heights as manifestations scoliosis.
B. Lordosis
-incorrect: The nurse should expect a client who has lordosis to exhibit manifestations of an exaggeration of the anterior convex curvature in the lumbar region of the spine.
C. Torticollis
-incorrect: The nurse should expect a client who has torticollis to exhibit manifestations of the head inclining toward the affected side with a contraction of the sternocleidomastoid muscle.
D. Kyphosis
-incorrect: The nurse should expect a client who has kyphosis to exhibit manifestations of an increased convex curvature in the thoracic region of the spine.

66. A nurse observes an assistive personnel (AP) preparing to obtain blood pressure with a regular-sized cuff for a client who is obese. Which of the following explanations should the nurse give the AP?
A. “The reading will be inaudible if the cuff is too small for the client.”
-incorrect: Although the blood pressure reading for a client who is obese may be difficult to hear with any cuff, a cuff that is too small for the client will not yield an inaudible reading.
B. “The width of the cuff bladder should be 75% of the circumference of the client’s arm.”
-incorrect: The width of the cuff bladder should be 40% of the circumference of the client’s arm.
C. “As long as the cuff will circle the arm, the reading will be accurate.”
-incorrect: A cuff that is an incorrect size for the client will not yield an accurate reading.
D. “Using a cuff that is too small will result in an inaccurately high reading.”
-Blood pressure cuffs come in various sizes, and the correct size cuff is necessary to obtain a reliable measurement. Blood pressure readings can be falsely high if the cuff Is too small for the client.

67. A home health nurse is planning to provide health promotion activities for a group of clients in the community. Which of the following activities is an example of primary prevention?
A. Teaching clients to perform self-examinations of breasts and testicles
-incorrect: This activity is an example of secondary prevention, which focuses on measures that identify the early stages of a condition.
B. Educating clients about the recommended immunization schedule for adults
-Primary prevention includes health education about disease prevention.
C. Teaching clients who have type 1 diabetes mellitus about care of the feet
-This activity is an example of tertiary prevention, which occurs after diagnosis of a condition and focuses on limiting complications from the condition.
D. Recommending that clients over the age of 50 have a fecal occult blood test annually
-incorrect: This activity is an example of secondary prevention, which focuses on measures that identify the early stages of a condition.

68. A nurse is performing an admission assessment for a client who has asthma and reports several food allergies. Which of the following actions should the nurse take first?
A. Document the client’s food allergies in the medical record
-incorrect: The nurse should document the client’s food allergies in the medical record to communicate this information to other members of the health care team; however, there is another action that the nurse should perform first.
B. Ask the client to identify the specific food allergies
-The nurse should apply the nursing process priority-setting framework in order to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify the provider of a change in the client’s status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge to make an appropriate decision.

Therefore, the nurse should first assess the client's allergies and identify the specific allergens to ensure the specific foods are not offered to the client during meals.
C. Monitor the client for indications of anaphylaxis
-incorrect: The nurse should monitor the client for indications of anaphylaxis due to allergen exposure; however, there is another action that the nurse should perform first.
D. Have epinephrine available for administration
-incorrect: The nurse should have epinephrine available for administration to treat the manifestations of an allergic reaction; however, there is another action that the nurse should perform first.

69. A nurse is evaluating the development of a group of clients. According to Erikson, the developmental task of intimacy vs. isolation occurs during which of the following stages of development?
A. Middle adulthood
-incorrect: The developmental task of middle adulthood is generativity vs. self-absorption and stagnation.
B. Adolescence
-incorrect: The developmental task of adolescence is identity vs. role confusion.
C. Childhood
-incorrect: The developmental task of school-age children is industry vs. inferiority.
D. Young adulthood
-The developmental task of young adulthood is intimacy vs. isolation.

70. A nurse is caring for a client who has cancer and refuses visitors because of his debilitated physical appearance. Which of the following comments should the nurse make?
A. "You look just fine to me"
-incorrect: This statement is nontherapeutic and dismisses the client's concerns.
B. "Nobody expects you to look beautiful in the hospital"
-incorrect: This response is nontherapeutic and dismisses the client's concerns.
C. "I understand how you feel. I would feel the same way."
-incorrect: This statement is nontherapeutic and focuses on the nurse's feelings rather than the clients.
D. "Would you like to talk about how you feel?"
-This is a therapeutic response that will encourage the client to talk about his concerns and feelings.

71. A nurse in an oncology clinic is assessing a client who is undergoing treatment for ovarian cancer. Which of the following statements by the client indicates she is experiencing psychological distress?
A. "My parents are retired, and they have come to help with our children."
-incorrect: Clients who have social and emotional support systems tend to experience less psychological distress.
B. "I am going to ask my husband to go to counseling with me."

-incorrect: Open communication is an important method to improve relationships that might be strained. Seeking counseling is a positive strategy.
C. “I keep having nightmares about my upcoming surgery.”
-Nightmares and sleep disturbances are manifestations of anxiety and post-traumatic stress disorder. These indicate a risk of experiencing psychological distress.
D. “My girlfriends bought me a nice wig.”
--incorrect: Clients who have social and emotional support systems tend to experience less psychological distress.

72. A nurse is caring for a client who has a terminal illness. The family wants to care for the client at home. Which of the following statements indicates that the nurse understands family-centered care?
A. “Social services can contact various community resources that will be helpful.”
-incorrect: In family-centered care, the family and client are the focus; therefore, the family members must decide, with the input of the health care team, which community resources to contact. The nurse should still make suggestions and offer support.
B. “I will review the care plan to make the necessary changes.”
-incorrect: In family-centered care, the family and client are the focus. The nurse should provide suggestions and offer support but should not make the final decision about changes to the care plan.
C. “Let’s set up a meeting time with the doctor to discuss your options for home care.”
-In family-centered care, the nurse considers the health of the family as a unit; therefore, the client and family members help determine their outcomes and goals. Setting up a meeting to discuss this with the provider will give them a sense of autonomy and foster the family-centered nursing environment.
D. “I will make a list of things we need to do before discharge.”
-incorrect: In family-centered care, the family and client are the focus; therefore, the family must decide, with the nurse’s input, what to do before the client goes home.

73. A nurse is caring for a group of clients in a long-term care facility. One of the clients is walking along the hallway and bumping into walls and does not respond to his name. Which of the following actions should the nurse take first?
A. Offer the client a nutritious snack
-incorrect: The client is at risk of inadequate nutrition because of the fluid and calorie expenditure from wandering; however, there is another action that the nurse should take first.
B. Accompany the client back to his room
-The nurse should apply the safety and risk-reduction priority-setting framework, which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow’s hierarchy of needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client. Therefore, the nurse should first escort the client back to his room to protect him from injury due to wandering.
C. Reorient the client to his surroundings

-incorrect: The client is at risk of anxiety because of possible disorientation; however, there is another action that the nurse should take first.
D. Administer a PRN antianxiety medication
-incorrect: The client is at risk of anxiety because of possible disorientation; however, there is another action that the nurse should take first.

74. A nurse on a medical unit is caring for a client who has difficulty sleeping. Which of the following actions should the nurse take to promote the client's ability to fall asleep?
A. Encourage the client to ambulate in the hallway just before bedtime
-incorrect: Clients should avoid exercising for 2-3 hours before bedtime.
B. Allow the client to maintain the same bedtime routine as at home
-For many clients in an acute care facility, disrupting the usual sleep routine is the primary reason for a client's inability to sleep. Maintaining the home bedtime routine promotes sleep in ways that are effective for the client. Those whose usual bedtime routines include warm milk, massages, or pharmacological sleep aids might need and appreciate those interventions in inpatient settings.
C. Keep the room temperature warm
-incorrect: A cool room temperature is generally more conducive to sleep.
D. Offer the client a cup of hot chocolate before bedtime
-incorrect: Although the warm milk in hot cocoa or hot chocolate can promote sleep, the chocolate contains caffeine, which is stimulant and can keep the client awake.

75. A nurse is caring for a client who has cancer and is experiencing pain. The nurse should implement which of the following interventions to assist the client with pain relief?
A. Encourage the client to listen to soft music
-The nurse should encourage the client to use music therapy to reduce anxiety, provide a distraction, and relieve pain.
B. Instruct the client to practice tai chi
-incorrect: The nurse should instruct the client to practice tai chi to stimulate the immune system and to improve joint function and mobility. However, it is not effective for pain management.
C. Place a jasmine-scented air freshener in the client's room
-incorrect: The nurse can use aromatherapy to promote the client's comfort and healing. However, jasmine is used to. Improve mood and is not effective for pain management.
D. Offer the client ginger tea
-incorrect: The nurse should offer the client ginger tea, if it is not contraindicated, to reduce nausea. However, it is not effective for pain management.

76. A nurse is planning care for a client who has a wound infection following abdominal surgery. To promote healing and fight infection, which of the following vitamins and minerals should the nurse plan to increase in the client's diet?
A. Vitamin C and zinc

-The client's body needs both vitamin C and zinc to fight a wound infection. The client should receive a multivitamin and a mineral supplement of both these substances. In addition, vitamin E supplements also are needed to promote skin and wound healing.
B. Vitamin D
-incorrect: Vitamin D is used with calcium to prevent osteoporosis; however, it does not assist with wound healing. The main function of vitamin D is to maintain calcium and phosphorus levels in the blood, and it may protect against cancer.
C. Vitamin K and iron
-incorrect: Vitamin K is important for normal blood clotting and for impaired intestinal synthesis caused by antibiotics. Iron is needed to rebuild RBC's; however, neither is needed directly for wound healing.
D. Calcium
-incorrect: Calcium is administered to prevent osteoporosis when used with vitamin D; however, it does not aid wound healing.

77. A nurse is applying an ice bag to the ankle of a client following a sports injury. Which of the following actions should the nurse take?
A. Leave the bag in place for 45 mins
-incorrect: To reduce the risk of injury to the client's skin, the nurse should leave the ice bag ion place for no longer than 30 mins.
B. Fill the bag 2/3 full with ice
-The nurse should fill the bag 2/3 full with ice, which allows the bag to be molded around the clients ankle.
C. Place the ice bag uncovered on the client's ankle
-incorrect: The nurse should cover the ice bag with a towel or other type of cover before placing the ice bag on the client's ankle to prevent injury to the client's skin.
D. Tell the client numbness is expected when the ice bag is in place
-incorrect: The nurse should remove the ice bag if the client feels numbness since this is an indication that the client's skin is too cold and at risk for injury.

78. A nurse is caring for a client who has a terminal illness. The client is restless and reports severe pain but refuses the prescribed opioid pain medication. Which of the following actions should the nurse take first?
A. Ask why the client is refusing the pain medication
-Using the nursing process, the nurse should first assess the reason for the client's refusal of the opioid pain medication.
B. Administer a PRN antianxiety medication
-incorrect: The nurse should administer a PRN antianxiety medication if it is indicated to complement other pain management interventions; however, there is another action the nurse should take first.
C. Help the client change positions
-incorrect: The nurse should help the client change positions to complement other pain management interventions; however, there is another action the nurse should take first.
D. Offer the client a heat or cold pack to place on painful areas

-incorrect: The nurse should offer the client a heat or cold pack to complement other pain management interventions; however, there is another action the nurse should take first.

79. A nurse is monitoring a client's fluid intake. For breakfast, the client consumed 8 oz of milk, 10 oz of water, 4 oz of flavored gelatin, 1 scrambled egg, 1 crisp piece of bacon, and 2 biscuits with jelly. How many mL should the nurse record as the client's fluid intake? (Nearest whole number)

-660 mL

80. A nurse is teaching ROM exercises to a client who has osteoarthritis. Which of the following client positions demonstrates an understanding of supination of the hand?
A. The client holds the hand with the palm up
-The nurse should identify the client holding the hand with the palm up as a demonstration of supination of the hand
B. The client holds the hand with the palm down
-incorrect: Holding the hand with the palm down is a demonstration of pronation of the hand.
C. The client points the fingers toward the floor
-incorrect: Pointing the fingers toward the floor is a demonstration of flexion of the hand.
D. The client points the fingers toward the ceiling
-incorrect: Pointing the fingers toward the ceiling is a demonstration of extension of the hand.

81. A nurse has received a prescription for dextran to administer to a client. The nurse should recognize that dextran belongs in which of the following functional classifications?
A. Skeletal muscle relaxants
-incorrect: Dextran is not a skeletal muscle relaxant. Examples of skeletal muscle relaxants are cyclobenzaprine and metaxalone.
B. Beta-adrenergic blockers
-incorrect: Dextran is not a beta-adrenergic blocker. Example of beta-adrenergic blockers are propranolol and carvedilol.
C. Broad-spectrum anti-infective agents
-incorrect: Dextran is not a broad-spectrum anti-infective agent. Examples of broad-spectrum anti-infective agents include ampicillin and cefixime.
D. Plasma volume expanders
-Dextran and albumin are plasma volume expanders that help correct hypovolemia in emergency situations, such as after hemorrhage or burns.

82. A nurse is preparing to administer liquid medication from a bottle to a client. Which of the following actions should the nurse take first?
A. Hold the medication bottle with the label against the palm of the hand when pouring
-The nurse should hold a multidose bottle with the label against the palm of the hand when pouring to prevent contaminating the label with spilled medication that could cause information on the label to fade or become illegible.
B. Place the cap with the inside facing down on a hard surface

-incorrect: The nurse should remove the cap of the medication bottle and place it with the inside facing up on a hard surface to prevent contamination of the inside of the cap and to maintain cleanliness.
C. Fill the cup until the medication is even with the edge of the dosage scale
-incorrect: The nurse should fill the cup until the medication is even with the surface or meniscus base of the dosage scale to ensure the client receives an accurate dose.
D. Pour any excess liquid back into the bottle after measuring
-incorrect: The nurse should discard any excess liquid medication into the sink as wasted medication and wipe the lip of the bottle clean after measuring.

83. A nurse is teaching a client who is using a patient-controlled analgesia (PCA) pump to deliver morphine for pain management. Which of the following statements should the nurse identify as an indication that the client understands the instructions?
A. “I’ll limit pushing the button, so I don’t get an overdose.”
-incorrect: PCA devices have a timing control or lockout mechanism that allows a preset minimum interval between medication doses and limits the total dose per hour. This safety feature prevents analgesic overdosing.
B. “If I push the button and still have pain after 2 mins, I’ll push it again.”
-incorrect: PCA devices have a timing control or lockout mechanism that usually allows dosing every 6 to 8 minutes. If the client pushes the button after 2 mins, the pump will not deliver any medication.
C. “I’ll ask my niece to push the button when I am sleeping.”
-incorrect: The client is the only one who should operate the PCA pump. When someone else operates the pump, it bypasses a safety feature that requires the client to be awake and to decide whether more medication is needed.
D. “I can still use my transcutaneous electrical nerve stimulation unit while I’m pushing the PCA button.”
-The nurse should encourage the client to utilize nonpharmacological methods of pain management such as transcutaneous electrical nerve stimulation (TENS) while using a PCA pump to reduce the amount of opioid dosing the client needs.
84. A nurse is caring for a semiconscious client who had a small-bore NG tube placed yesterday for the administration of enteral feeding. Which of the following methods should the nurse use to verify correct tube placement? (SATA)
A. Auscultate injected air
-incorrect: Auscultating air injected into an NG tube is not a reliable method of determining correct NG tube placement.
B. Verify the initial X-Ray examination
C. Measure the length of the exposed tube
D. Determine the pH of aspirated fluid
-The nurse should confirm the NG tube placement by checking the X-ray results following the insertion of the NG tube. In addition, the nurse should check the length of the NG tube that is exposed by comparing the markings on the tube to the client’s nose to verify tube placement.
E. Check the aspirated fluid for glucose

-incorrect: Checking for glucose in the aspirated fluid is not a reliable method of determining correct NG tube placement.

85. A nurse is preparing to insert an NG tube for a client. Which of the following actions will help facilitate the insertion of the tube? (SATA)
A. coat the tip of the tube with a water-soluble lubricant
B. Ask the client to swallow water while the tube enters her throat
-Lubricating the tube eases its passage. A water-based gel because it will dissolve if the tube slips into the client's airway, while using petroleum jelly could cause respiratory problems. Swallowing water reduces the risk of gagging and aspiration and helps propel the tube down the esophagus. Hyperextending the neck reduces the curvature of the nasopharynx, which facilitates the insertion of the NG tube.
C. Place the coiled tube in ice chips prior to insertion
-incorrect: Ice makes NG tubes rigid, increasing the risk of trauma to mucous membranes.
D. Tell the client to tilt her head backward as insertion begins
-Lubricating the tube eases its passage. A water-based gel because it will dissolve if the tube slips into the client's airway, while using petroleum jelly could cause respiratory problems. Swallowing water reduces the risk of gagging and aspiration and helps propel the tube down the esophagus. Hyperextending the neck reduces the curvature of the nasopharynx, which facilitates the insertion of the NG tube.
E. Instruct the client to bear down during insertion
-incorrect: Bearing down is helpful during the insertion of a urinary catheter, not an NG tube.

86. A nurse is providing teaching to a group of unit nurses about wound healing by secondary intention. Which of the following pieces of information should the nurse include in the teaching?
A. The wound edges are well-approximated
-incorrect: Primary intention involves the closing of the wound using sutures or staples at the time the incision is made; the suture line edges become well-approximated during healing.
B. The wound is closed at a later date
-incorrect: Tertiary intention includes using sutures to close an open wound at a later date after the wound drains and starts to heal.
C. A skin graft is placed over the wound bed
-incorrect: Tertiary intention can include the provider placing grafted skin over the client's wound bed after a wound is left open to drain and start healing. Skin grafting is required for deeper wounds such as full-thickness burns and is only rarely required for surgical wounds that do not heal.
D. Granulation tissue fills the wound during healing
-A beefy, red tissue called granulation tissue fills the wound during healing. The wound is left open to drain and heal by secondary intention, which should occur within 5-21 days. Open wounds increase the risk of wound infection.

87. A nurse is caring for a client who is receiving IV fluid replacement. Which of the following findings should the nurse identify as infiltration of the IV infusion site?

A. Redness at the IV catheter entry site
-incorrect: A client who has redness at the IV catheter entry site might have a local infection. The nurse should remove the IV, clean the site with alcohol, and start a new IV line in another location.
B. Palpable cord along the vein used for the infusion
-incorrect: A client who has a palpable cord along the vein might have phlebitis, which is inflammation of the inner layer of a vein. The nurse should discontinue the infusion and start a new IV line in another location.
C. Taut skin around the IV catheter site that is cool to the touch
-A client who has taut skin around the IV catheter site that is cool to the touch might have an infiltrated IV site. The nurse should stop the IV infusion, elevate the extremity, and apply a warm moist compress or a cold compress (according to the type of infiltration).
D. Bleeding at the IV insertion site
-Bleeding at the IV insertion site might indicate the IV system is not intact. The nurse should check to determine if the IV system is intact and if the catheter is within the client's vein. The nurse might need to start a new IV line in another location if the bleeding does not stop after interventions.

88. A nurse is planning care for a client who has a single-lumen nasogastric (NG) tube for gastric decompression. Which of the following actions should the nurse include in the plan of care? (SATA)
A. Set the suction machine at 120 mmHg
-incorrect: Single-lumen NG tubes are used for intermittent suction, and the machine is set at 80 to 100 mmHg. Higher suction settings can traumatize the gastric lining.
B. Provide oral hygiene frequently
C. Measure the amount of drainage from the NG tube every shift
D. Secure the NG tube to the client's gown
-Frequent oral hygiene comfort for the client since mucous membranes become dry and uncomfortable when a client cannot drink fluids. Measuring the drainage at least every shift helps the provider calculate fluid loss and prescribe appropriate replacement therapy. An unsecured NG tube can irritate the nares if the tube is pulled or caught on the bed or other equipment. The tube can also be dislodged if not secured appropriately.
E. Apply petroleum jelly to the client's nares
-incorrect: The client could aspirate an oil-based lubricant like petroleum jelly into the lungs, which could result in lipid pneumonia. A water-soluble lubricant should be applied to the nares to help prevent or relieve dry skin.

89. A nurse is preparing to remove an NG tube for a client who had a partial colectomy. Which of the following actions should the nurse take?
A. Maintain suction while removing the NG tube
-incorrect: The nurse should disconnect the NG tube from the suction apparatus before removal to decrease the risk of injury to the gastrointestinal mucosa.
B. Instill 100 mL of air into the NG tube before removal

-incorrect: The nurse should instill 50 mL of air into the tube to clear the contents of gastric drainage and decrease the risk of aspiration on removal of the tube.
C. Pinch the NG tube while removing the tube
-The nurse should pinch the NG tube while removing the tube to decrease the risk of aspiration of any gastric contents.
D. Instruct the client to breathe in and out during the removal of the NG tube
-incorrect: The nurse should instruct the client to take and hold a deep breath during the removal of the NG tube to close the glottis and decrease the risk of aspiration of any gastric contents.

90. A nurse is planning care for a client who has a prescription for collection of a sputum specimen for culture and sensitivity. Which of the following actions should the nurse take when obtaining the specimen?
A. Collect the specimen when the client rises in the morning
-The nurse should plan to collect the sputum specimen when the client arises in the morning because the client will be able to cough up the secretions that have accumulated during the night. Generally, the deepest specimens are obtained in the early morning, and it is preferable to collect the specimen before breakfast. The nurse should instruct the client to rinse the mouth, take a deep breath, and cough prior to expectorating into the sterile container.
B. Force fluids during the day and collect the specimen in the evening
-incorrect: The nurse should encourage the client to force fluids, especially clear liquids, to help thin respiratory secretions. However, evening hours are not the preferred time for obtaining deep sputum specimens.
C. Collect the specimen after antibiotics have been started
-incorrect: The nurse should collect the sputum specimen ordered for culture and sensitivity before the client receives antibiotic therapy to prevent interference with the laboratory results.
D. Collect 2 mL of sputum before sending the specimen to the laboratory
-incorrect: The nurse should collect 4-10 mL of sputum before sending the specimen to the laboratory to provide an adequate amount of sputum for culture and sensitivity.

91. After assessing a client, the nurse documents “1+ pedal edema bilaterally.” This indicates that the nurse observed an indentation of which of the following depths after applying pressure?
A. 2mm
-The nurse should document a 2mm indentation after applying and removing pressure as 1+ pedal edema.
B. 4mm
-incorrect: The nurse should document a 4mm indentation after applying and removing pressure as 2+ pedal edema.
C. 6mm
-incorrect: The nurse should document a 6mm indentation after applying and removing pressure as 3+ pedal edema.
D. 8mm

-incorrect: The nurse should document an 8mm indentation after applying and removing pressure as 4+ pedal edema.

92. A nurse is caring for an adult client who has an NG tube in place and a prescription for continuous enteral feedings. Which of the following actions should the nurse perform to reduce the client's risk of aspiration?
A. Irrigate the tubing with 30 mL of sterile water
-incorrect: Irrigating the tubing will not reduce the client's risk of aspiration. Irrigation can help prevent or resolve clogging of the tube.
B. Elevate the head of the bed to 30 or 40 degrees
-Elevating the head of the bed to at least 30 and preferably 45 degrees helps prevent the gravitational reflux of gastric contents, thereby decreasing the risk of aspiration.
C. Suggest changing the feeding to lactose-free formula
-incorrect: Changing the feeding to lactose-free formula will not decrease the client's risk of aspiration. It will reduce gastrointestinal irritation or upset in clients who are sensitive to lactose.
D. Warm the enteral formula to room temperature before feeding
-incorrect: Warming the enteral formula before feeding will not decrease the client's risk of aspiration. It can help reduce abdominal cramping and discomfort from cold formula ingestion.

93. A nurse is caring for a client who requires a dressing change. Which of the following actions should the nurse take?
A. Clean the incision from bottom to top
-incorrect: The nurse should clean the incision from top to bottom to prevent any contamination of the area that has already been cleansed. The top of an incision is cleaner because drainage tends to collect at the bottom of the wound.
B. Apply sterile gloves prior to opening dressing packages
-incorrect: The nurse should apply sterile gloves after opening dressing packages. To open the packages, the nurse must touch the nonsterile outside packaging of the sterile supplies. If the nurse donned the sterile gloves prior to opening the packages, opening the package would contaminate the gloves.
C. Remove the tape by pulling away from the wound
-incorrect: The nurse should pull the tape toward the wound to avoid straining the wound and its sutures, which could lead to dehiscence.
D. Clean the drain site from the center outward
-The nurse should clean the drain site from the center outward to avoid introducing microorganisms from the periphery of the wound into the center of the wound.

94. A nurse is planning care for a group of clients receiving oxygen therapy. Which of the following clients should the nurse plan to see first?
A. A client who has heart failure and is receiving 100% oxygen via partial rebreather mask
-The nurse should apply the safety and risk-reduction priority-setting framework, which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse

should use Maslow's hierarchy of needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client.

-The nurse should frequently check the bag on a rebreather mask to ensure it inflates properly. If the bag is deflated, the client will rebreathe exhaled carbon dioxide instead of receiving the prescribed oxygen dose. Therefore, the nurse should first see the client who that can cause toxicity and is highly combustible, and higher concentrations of oxygen increase the risk of client injury.
B. A client who has emphysema and is receiving oxygen at 3L/min via transtracheal oxygen cannula
-incorrect: Routine treatment for chronic lung conditions can include the use of a transtracheal oxygen cannula; therefore, there is another client the nurse should plan to see first. The client will learn to use the device alone, and the system can provide adequate oxygenation with a low flow rate of oxygen. Three liters per minute of oxygen is the equivalent of 32% oxygen delivery.
C. A client who has an old tracheostomy and is receiving 40% humidified oxygen via tracheostomy collar
-incorrect: Routine treatment for a client who has an old tracheostomy includes the administration of humidified oxygen or air via tracheostomy collar. Therefore, there is another client the nurse should plan to see first. The nurse should sue the humidification to promote loosening of respiratory secretions and prevent cannula obstruction. Forty percent oxygen is the equivalent of administering oxygen at 6L/min.
D. A client who has COPD and is receiving oxygen at 2L/min via nasal cannula
-incorrect: Routine treatment for a client who has COPD involves the administration of low-dose therapy. Therefore, there is another client the nurse should plan to see first. Clients who have COPD depend on low oxygen level to drive their respiratory rate. Two liters per minute of oxygen is the equivalent of 28% oxygen delivery.

95. A nurse is assisting a client who is eating at mealtime. Suddenly, the client grabs her neck with both hands and appears frightened. Which of the following actions should the nurse take first?
A. Place an oxygen mask on the client
B. Check the client's pulses
C. Determine whether the client is able to breathe
-Caring for this client requires the application of the nursing process priority-setting framework. The nurse can use the nursing process to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify a provider of a change in the client's status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge needed to make an appropriate decision.

-This client is demonstrating a universal choking gesture. If the client is unable to move air in or out, severe airway obstruction is present. The client would need emergency interventions to clear a partial obstruction, as indicated by stridor or minimal airway passage. As long as there is

good air exchange and the client can cough and breathe spontaneously, the nurse should stay with the client and monitor her condition.
D. Wrap arms around the client from behind
-incorrect: The nurse should wrap arms around the client from behind to perform an abdominal thrust if breathing is obstructed. However, there is another action the nurse should take first.

96. A nurse is caring for an older adult client who has dysphagia following a cerebrovascular accident. Which of the following actions should the nurse take when assisting the client at mealtime?
A. Encourage the client to drink fluids before swallowing food
-incorrect: A client who has impaired pharyngeal swallowing is at risk of choking when liquids (especially thin fluids) are offered while eating solid foods. It is preferable to suggest "dry swallows" to clear the mouth between bites of food.
B. Offer the client tart or sour foods first
-A client who has impaired pharyngeal swallowing should consume tart and sour foods at the beginning of the meal to stimulate saliva production, which aids to chewing and swallowing.
C. Tilt the client's head backward when swallowing
-incorrect: A client who has impaired pharyngeal swallowing should tilt the head forward to promote swallowing.
D. Turn on the television
-incorrect: A client who has impaired pharyngeal swallowing should minimize distractions at mealtimes to concentrate on chewing thoroughly and swallowing.

97. A nurse is caring for a client who reports feeling a pop after coughing without properly splinting an abdominal incision. On assessment, the nurse notes that the client's wound has eviscerated. Which of the following actions should the nurse take? (SATA)
A. Carefully reinsert the intestine through the opening in the wound
-incorrect: The nurse should not attempt to reinsert the intestine into the client's abdominal cavity because this action can cause perforation of the intestine. The nurse should plan to transfer the client to surgery, where the surgeon will reinsert the intestine under sterile technique.
B. Place the client in a supine position with the hips and knees flexed
C. Leave the room to call the surgeon
-incorrect: The nurse should delegate another person to notify the surgeon immediately. The nurse should stay with the client and observe for further complications such as shock.
D. Cover the wound and intestine with a sterile, moistened dressing
E. Monitor the client for manifestations of shock
-The nurse should place the client in a supine position with the hips and knees flexed. This position can help to prevent further tearing of the incision and wound evisceration by lessening tension on the wound. The nurse should cover the protruding intestine with sterile dressing that is moistened with 0.9% sodium chloride to prevent further contamination of the wound and to keep the protruding intestine from drying out.

-The nurse should monitor the client for a physiological stimulus (ex: bleeding from the tearing or opening of the wound) or a psychological stimulus (ex: viewing the intestine protruding outside the body), which can increase the risk of shock. The nurse should monitor the client for increased heart rate and respiratory rate, changes in blood pressure or mentation and cool or clammy skin.

98. A nurse documents the presence of clubbing of the fingernails for a client who has emphysema. Which of the following is the underlying cause of this finding?
A. Trauma
-incorrect: Trauma does not cause clubbing of the fingernails. Trauma can cause Beau's lines, which are another type of nail alteration that involves transverse depressions in the nail. Trauma can also cause paronychia, an inflammation of the skin at the base of the nail.
B. Severe infection
-incorrect: Severe infection does not cause clubbing of the fingernails but can cause Beau's lines.
C. Iron-deficiency anemia
-incorrect: Iron-deficiency anemia does not cause clubbing of the fingernails. Iron-deficiency anemia can cause koilonychia (spoon nail), which is another type of nail alteration that involves concave curves in the nail.
D. Chronic hypoxemia
-Clubbing of the nails of the fingers and toes is the result of chronic hypoxemia (low oxygen supply) such as COPD. It is a change in the angle between the nail and the nail base often with enlargement of the fingertips.

99. A nurse delegates the collection of a client's temperature to an AP. The nurse notes in the documentation that the AP obtained the client's axillary temperature; however, the nurse wanted an oral temperature. The nurse should identify that which of the following rights of delegation should have prevented this situation from occurring?
A. Right task
-incorrect: The nurse delegated the right task. The nurse can delegate a task to an AP that is repetitive, requires minimal supervision, is relatively noninvasive, has predictable results and has minimal potential for risk. Obtaining a client's temperature is within the range of function for an AP.
B. Right circumstance
-incorrect: The nurse correctly delegated the task in the right circumstance. This entails consideration of the appropriate client setting, the available resources, and other factors relevant to the situation.
C. Right person
-incorrect: The nurse delegated the taking of a client's temperature to the right person. This entails delegating the right task to the right person to be performed on the right person. Obtaining a client's temperature is within the range of function for an AP and the client's temperature was recorded as collected.
D. Right communication

-The situation could have been avoided if the right communication was given by the nurse to the AP. The right communication entails providing clear, concise instructions regarding the task, including the objectives, limits, and expectations.

100. A nurse in a long-term care facility is in the dining room while residents are eating lunch. One resident begins to choke and is coughing strongly. Which of the following actions should the nurse take?
A. Assist the client to the floor
-incorrect: The nurse should assist the client to the floor if the client is losing consciousness and might fall to the floor.
B. Perform an abdominal pain
-incorrect: The nurse should perform an abdominal thrust if the client is choking and unable to speak or cough strongly.
C. Open the airway with a head-chin tilt
-incorrect: The nurse should open the airway with a head-chin tilt to look for a foreign object that may be impeding breathing if the client is choking and unable to speak or cough strongly.
D. Observe the client closely
-The nurse should observe the client closely at this point in time. As long as the client is able to cough strongly, the nurse does not need to intervene.

101. A nurse in an urgent-care center is caring for a 15-year-old client whose symptoms suggest a sexually transmitted infection (STI). The client's parent is unavailable, but the client's grandmother accompanied the client to the clinic. Which of the following actions should the nurse take?
A. Explain that the treatment can wait until the parent is available.
-incorrect: Ideally, a parent or legal guardian should give informed consent for an unemancipated minor to undergo invasive diagnostic and therapeutic procedures. However, in the case of an infection that could be worsening, a delay is not advisable.
B. Inform the grandmother that she may give consent for the treatment
-incorrect: A parent or legal guardian must give consent for an unemancipated minor. Unless the grandmother is the child's legal guardian, the nurse should not tell the grandmother she may give consent.
C. Invoke the principle of implied consent and prepare the client for treatment
-incorrect: Implied consent is pertinent in an emergency situation when an adult client is unable to sign (ex: due to unconsciousness) and no one is available to give informed consent. This circumstance does not apply to this situation.
D. Ask the adolescent to sign the consent form
-Unemancipated minors (ex: those who do not live on their own, are not married, and are not in the military) can legally give informed consent for diagnostic procedures and treatment in some situations. These situations include treatment for STIs and substance use disorders.

102. A nurse on a medical-surgical unit is admitting a client. Which of the following pieces of information should the nurse document in the client's record first?
A. Assessment

-When caring for a client, the nurse should apply the nursing process priority-setting framework. The nursing process is used to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify a provider of a change in the client's status, he or she must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge to make am appropriate decision.
B. Plan of Care
-incorrect: The nurse should document the plan of care for the client. However, there is another action the nurse should document first.
C. Nursing interventions performed
-incorrect: The nurse should document interventions performed for the client. However, there is another action the nurse should document first.
D. Evaluation of progress
-incorrect: The nurse should document the evaluation of the client's progress. However, there is another action the nurse should document first.

103. A charge nurse is teaching adult cardiopulmonary resuscitation (CPR) to a group of newly licensed nurses. Which of the following actions should the charge nurse teach as the first response in CPR?
A. Call for assistance
-incorrect: The nurse should call for assistance by activating the emergency response team. However, there is another action the nurse should take first.
B. Begin chest compressions
-incorrect: The nurse should begin chest compressions. However, there is another action the nurse should take first.
C. Confirm unresponsiveness
-The nurse should apply the nursing process priority-setting framework to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify a provider of a change in the client's status, he or she must first collect adequate data from the client to obtain the knowledge needed to make an appropriate decision. Establishing unresponsiveness is required before beginning CPR. If a client is unresponsive, the nurse should activate the emergency response team.
D. Give rescue breaths
-incorrect: The nurse should give rescue breaths. However, there is another action the nurse should take first.

104. A nurse is explaining the use of written consent forms to a newly licensed nurse. The nurse should ensure that a written consent form has been signed by which of the following clients?
A. A client who has a prescription for a transfusion of packed RBCs
-Administration of blood is a procedure that carries risk; therefore, the client must sign a consent form prior to the procedure.
B. A client who is being transported for a radiograph of the kidneys, ureters, and bladder

-incorrect: Clients admitted to a hospital sign a general consent form when admitted. This form gives consent for this diagnostic examination.
C. A client who has a prescription for a tuberculin skin test
-incorrect: Implied consent is given when the client cooperates through actions, such as holding out an arm to allow the nurse to perform the procedure.
D. A client who has a distended bladder and needs urinary catheterization
-incorrect: Implied consent is given when the client cooperates through actions, such as positioning himself/herself to allow the nurse to perform the procedure.

105. A nurse is providing teaching to a client about a surgical procedure that she is scheduled for later in the day. The client states that no one has spoken to her about the procedure before. Which of the following actions should the nurse take?
A. Continue the teaching, but check afterward with the surgeon about informed consent
-incorrect: The client's statement indicates that she has not given informed consent; therefore, the nurse should interrupt the teaching.
B. Stop the teaching and check with the surgeon about informed consent
-The client's statement indicates that she has not given informed consent; therefore, the nurse should interrupt the teaching and notify the surgeon.
C. Stop the teaching and ask the client to sign an informed consent form
-It is not within the nurse's scope of practice to obtain informed consent from the client.
D. Continue the teaching and check the client's medical record afterward for a signed consent form
-The client's statement indicates that she has not given informed consent; therefore, the nurse should interrupt the teaching.

106. A home health nurse is visiting an older adult client with severe dementia. The client's son, who serves as her primary caregiver, reports being "exhausted" from working part-time and caring for his mother at home. Which of the following options should the nurse suggest to the caregiver?
A. Rehabilitation
-incorrect: Rehabilitation programs help clients return to optimal functioning after an illness or injury. However, severe dementia will not improve with rehabilitative services.
B. Assisted living facility
-incorrect: An assisted living facility provides independence for clients who need only limited personal care. A client who has severe dementia needs total care.
C. Respite care
-Respite care is a service for caregivers who need time to rest from multiple responsibilities related to the care of a family member who needs assistance.
D. Adult day care facility
-incorrect: Although adult day care facilities do help family caregivers maintain some aspects of their lifestyle and independence, these facilitates provide care and supervision for clients who need minimal assistance (ex: taking medication, receiving physical therapy, or receiving counseling). They do not provide care for clients who have severe dementia.

107. A nurse is collecting health history data from a client who is deaf and uses American Sign Language (ASL) to communicate. The nurse will be working with an ASL interpreter. Which of the following actions should the nurse take when working with the interpreter?
A. Face away from the client to avoid distraction
-incorrect: The nurse should face the client while speaking to offer the client the opportunity to observe facial expressions and gestures.
B. Pace speech to allow time for the interpreter to convey the words
-The nurse should speak clearly and allow time for the interpreter to convey the message and for the client to receive it.
C. Make eye contact with the interpreter when explaining the procedure
-incorrect: To enhance the nurse-client relationship, the nurse should direct questions, instructions, and information to the client, not to the interpreter. The client's focus will be on the interpreter, but it is respectful to continue to address the client and not the interpreter.
D. Stand in the background while the interpreter translates the message
-incorrect: The nurse should sit at the same level as the client to give the client the opportunity to observe facial expressions and gestures.

108. A nurse is supervising a newly licensed nurse who is caring for a client with streptococcal pharyngitis and is on transmission-based precautions. Which of the following actions by the newly licensed nurse indicates an understanding of droplet precautions?
A. Shaking soiled linen before putting it in a hamper
-incorrect: The nurse should not shake soiled linen because this action can transfer microorganisms.
B. Removing a face mask when standing 0.5 m (1.6 ft) from the client
-incorrect: The nurse should wear a mask when working within 1m (3.3 ft) of a client who is on droplet precautions to reduce the risk of transferring the particle droplets.
C. Assigning another client with the same infection to share the room with the client
-The nurse can place clients who are infected with the same pathogen in the same room if a private room is not available.
D. Allowing the client to visit a family member in the lobby of the facility
-incorrect: The nurse should strictly limit the client's activity outside the room to reduce the risk of transferring microorganisms. Whenever the client has to leave the room, the nurse should place a mask on the client.

109. A nurse is receiving a client from the PACU who is postoperative following abdominal surgery. Which of the following actions should the nurse perform to transfer the client from the stretcher to the bed?
A. Lock the wheels on the bed and stretcher
-Locking the wheels prevents the client from falling on the floor by not allowing the cart or bed to move apart or away from the client.
B. Instruct the client to raise his arms above his head
-incorrect: The nurse should ask the client to cross his arms across his chest to avoid injuring the arms during transfer.
C. Elevate the stretcher 2.5 cm (1in) above the height of the bed

-incorrect: The stretcher should be no more than 1.3 cm (0.5in) above the height of the bed.
D. Log-roll the client
-incorrect: Log-rolling is a technique used to prevent injury when moving a client who requires immobilization of the neck, back, or spine. It is not indicated for a client following abdominal surgery.

110. A nurse in a rehabilitation facility is observing an assistive personnel (AP) help a client transfer from a bed to a wheelchair. Which of the following actions indicates to the nurse that the AP understands how to perform this task?
A. Locking the brakes on the bed and the wheelchair before moving the client
-Prior to starting the transfer, the AP should make sure that both the wheelchair and the bed are stationary and will not shift when the client moves into the chair.
B. Lowering the footplates of the wheelchair before the transfer
-incorrect: The AP should lower the footplates after the transfer and lift the client's feet onto them.
C. Placing the wheelchair perpendicular to the bed
-incorrect: The AP should place the wheelchair parallel to the bed.
D. Placing the wheelchair on the client's weaker side prior to the transfer
-incorrect: The AP should place the wheelchair on the client's stronger side prior to the transfer to allow the client to move toward the stronger side.

111. A nurse is beginning her shift and reviewing the medication administration records (MARs) for her clients. She notes a dosage of medication above the safe range and sees that a nurse administered that dosage during the previous shift. Which of the following actions should the nurse take?
A. Call the nurse to verify that the client received that dosage
-incorrect: The MAR indicates what dosage the nurse administered.
B. Give the medication in a safe dosage
-incorrect: It is not within the nurse's scope of practice to change the medication dosage.
C. Give the dose the provider prescribed
-incorrect: The nurse has identified a potential problem with the prescribed dosage; therefore, the nurse should not give that dosage.
D. Call the provider to clarify the dosage
- After assessing the client for adverse effects of the medication, the nurse should notify the provider about her observations to determine the next step.

112. A nurse is assessing a client who is undergoing a physical examination. Following the inspection, which of the following techniques should the nurse use next when assessing the client's abdomen?
A. Auscultation
-According to evidence-based practice, the nurse should listen for bowel sounds in all 4 quadrants before palpating the client's abdomen. Palpation and percussion can stimulate the bowel and increase the frequency of bowel sounds, leading to false results.
B. Light Palpation

-incorrect: The nurse should palpate the client's abdomen to identify any areas of tenderness. However, evidence-based practice indicates that the nurse should use a different technique before palpation.
C. Percussion
-incorrect: The nurse should percuss the abdomen to identify tympany or dullness. However, evidence-based practice indicates that the nurse should use a different technique before percussion.
D. Deep palpation
-incorrect: The nurse should palpate the abdomen to identify any areas of tenderness, but deep palpitation generally requires an experienced technician. However, evidence-based practice indicates that the nurse should use a different technique before palpation.

113. During a physical examination of a client, the nurse suspects strabismus. Which of the following tests should the nurse use to collect additional data?
A. Confrontation test
-incorrect: A confrontation test compares the visual fields of the client with that of the examiner.
B. Symmetry of palpebral fissures
-incorrect: The palpebral fissure is the space between the eyelids, which is unequal in clients who have ptosis (ex: drooping of one or both of the eyelids)
C. Corneal light reflex
-The corneal light reflex requires the nurse to shine a penlight at the client's eyes and visualize whether the light shines on the same spot bilaterally. This test will indicate the alignment of the client's eyes as well as any deviation inward or outward. With strabismus, the eyes will not align when the client focuses.
D. Accommodation test
-incorrect: The test for accommodation determines whether the client's pupils constrict as they focus on an object the examiner brings closer to the eyes.

114. A nurse is performing a comprehensive physical assessment of a client. The nurse should use inspection to assess which of the following?
A. Liver size
-incorrect: Evaluating liver size requires palpation
B. Pedal edema
-incorrect: Evaluating pedal edema requires palpation
C. Skin texture
-incorrect: Evaluating skin texture requires palpation
D. Gait
-Inspection is the technique of looking or observing. Gait inspection involves watching the client's walking movements and observing any unusual findings.

115. A nurse is teaching a client about lifestyle changes to manage a chronic illness. Which of the following strategies should the nurse use first to help the client make a commitment to these lifestyle changes?

A. Identify the risks of nonadherence
-incorrect: It is important for the client to understand all aspects of the illness as well as the consequences of nonadherence to recommend lifestyle changes. However, when the nurse is trying to motivate the client to make lifestyle changes, the client might perceive warnings about the dangers of nonadherence as a threat. Instead, the nurse should present this information after the client commits to making the recommended changes.
B. Schedule learning sessions to demonstrate the psychomotor skills the client will need
-incorrect: Scheduling meetings about psychomotor skills is important for showing the client how to practice self-care. However, this is unlikely to encourage the client to make an initial commitment. This strategy will likely strengthen the client's adherence to the recommended life changes after the client has made an initial commitment to them.
C. Provide clearly written and easy-to-understand materials
-incorrect: It is important for the client to understand all aspects of the illness, and clearly written and easy-to-understand instructional materials can be helpful. However, the nurse should present this information after the client is committed to change.
D. Help the client identify ways that these changes will result in positive personal outcomes
-According to evidence-based practice, the motivation to change must precede taking steps to make the change. Therefore, helping clients identify ways that's the changes will promote positive outcomes should precede other educational strategies for making the changes. The client should first see how the changes directly affect his/her life, thus enhancing the motivation to make the changes.

116. A community health nurse is preparing a campaign about seasonal influenza. Which of the following plans should the nurse include as a form of secondary prevention?
A. Holding a community clinic to administer influenza immunizations
-incorrect: Administering influenza immunizations is an example of primary prevention for people who are healthy but in danger of becoming ill.
B. Screening groups of older adults in nursing care facilities for early influenza manifestations
-Screening older adults who have some manifestations of illness to determine if they have influenza is an example of secondary prevention. Secondary prevention is focused on preventing complications of an illness or providing care to prevent an illness from becoming severe.
C. Educating parents of young children about the dangers of influenza
-incorrect: Educating clients about the dangers of influenza is an example of primary prevention for people who are healthy but in danger of becoming ill.
D. Finding rehabilitation programs for older adults who have complications related to influenza
-incorrect: This is an example of tertiary prevention, which seeks to prevent complications and help people recover from an existing illness.

117. A nurse is obtaining the blood pressure in a client's lower extremity. Which of the following actions should the nurse take?
A. Auscultate the blood pressure at the dorsalis pedis artery
-incorrect: The nurse should auscultate the blood pressure at the popliteal artery.
B. Measure the blood pressure with the client sitting on the side of the bed

-incorrect: The nurse should measure the blood pressure with the client prone if possible. Otherwise, the client should lie supine with the knee flexed.
C. Place the cuff 7.6 cm (3in) above the popliteal artery
-incorrect: The nurse should position the cuff 2.5 cm (1 in) above the popliteal artery.
D. Place the bladder of the cuff over the posterior aspect of the thigh
-This is the correct position for the bladder of the cuff when the nurse is measuring a lower-extremity blood pressure.

118. A nurse is performing a spiritual assessment of a client. Which of the following questions should the nurse ask?
A. “When did you start to believe in your faith?”
-incorrect: This is a nontherapeutic response that assumes the client has a religion-based belief system. Spirituality can include religious beliefs but does not depend on their existence.
B. “How often do you perform religious rituals?”
-incorrect: This is a nontherapeutic response that assumes the client has a religion-based belief system. Spirituality can include religious beliefs but does not depend on their existence.
C. “Which church do you regularly attend?”
-incorrect: This is a nontherapeutic response that assumes the client has a religion-based belief system. Spirituality encompasses many aspects of the client’s ideas about life and can include religious beliefs but does not depend on their existence.
D. “What is your source of strength and hope?”
-This is a broad, open-ended question that encourages the client to express feelings without any assumptions on the nurse’s part. It correctly focuses on a global view of spirituality as a complex concept that encompasses the client’s life experiences and beliefs about strength, love, and hope.

119. A nurse on a mental health unit is preparing to terminate the nurse-client relationship with a client who no longer requires care. Which of the following concepts should the nurse and client discuss in the termination phase of the relationship?
A. Loss
-At the close of a relationship, even when planned, loss is an expected feeling for both the client and the nurse. It is important for both the nurse and the client to terminate the relationship without feelings of guilt or anxiety.
B. Trust
-incorrect: The nurse should address the concept of trust during the introductory phase of the relationship.
C. Self-disclosure
-incorrect: The nurse should address the concept of appropriate self-disclosure during the working phase of the relationship
D. Risk-taking
-incorrect: The nurse should address the concept of risk-taking in the working phase of the relationship.

120. A nurse is caring for a client who is in the terminal stage of cancer. Which of the following actions should the nurse take when she observes the client crying?
A. Contact the family and ask someone to stay with the client
-incorrect: This action does not respond to the client's immediate needs and shifts the responsibility of helping the client to others.
B. Offer to call the client's minister
-incorrect: This response uses the nontherapeutic communication block of putting the client's needs on hold and shifts that responsibility of helping the client to someone else.
C. Sit and hold the client's hand
-This action uses the therapeutic communication techniques of silence, touch, and offering of self to the client.
D. Leave the room and allow the client to cry privately
-incorrect: This is not an appropriate nursing action and fails to acknowledge the client's distress.

121. A nurse is beginning a therapeutic relationship with a client. Which of the following actions should the nurse take to convey empathy when using the therapeutic communication technique of active listening?
A. Assume an open position
-The nurse should sit with arms and legs uncrossed. Crossing them suggests a defensive posture.
B. Sit upright and lean back into the chair
-incorrect: The nurse should lean toward the client to convey interest and involvement in the interactions.
C. Avoid direct eye contact until the client initiates it
-incorrect: The nurse should establish direct eye contact with the client to convey involvement and a willingness to listen.
D. Sit next to the client
-incorrect: To convey interest and desire to listen, the nurse should face the client.

122. A nurse is providing oral care for a client who is unconscious. Which of the following actions should the nurse take?
A. Place the client in lateral position with the head turned to the side before beginning the procedure.
-The nurse should place the client in a lateral position with the head turned to the side to reduce the risk of aspiration of fluids and secretions.
B. Use the thumb and index finger to keep the client's mouth open.
-incorrect: The nurse should use a padded tongue blade, not a thumb or an index finger, to keep the client's mouth open. If the client suddenly bites down, the nurse's fingers could be injured.
C. Rinse the client's mouth with an alcohol-based mouthwash following the procedure.
-incorrect: The nurse should use either water or alcohol-free mouthwash to rinse the client's mouth.
D. Cleanse the client's mucous membranes with lemon-glycerin sponges.

-incorrect: The nurse should use a foam swab because lemon-glycerin swabs dry and irritate the mouth and can damage the teeth.

123. A hospice nurse is visiting with the family member of a client. The family member states that the client has insomnia almost nightly. Which of the following practices should the nurse identify as contributing to the client's insomnia?
A. The client watches television in her bed during the day.
-To promote sleep, the client should avoid watching television in bed. She should use the bed only for sleep or sexual activities.
B. The client drinks warm milk before bedtime.
-incorrect: Warm milk provides L-tryptophan, an amino acid that promotes sleep.
C. The client goes to bed at 2200 every night.
-incorrect: General sleep strategies include establishing a regular sleep schedule. A nightly bedtime of 2200 could be part of a bedtime routine to promote sleep.
D. The client gets up to use the bathroom once during the night.
-incorrect: Although this can cause nighttime disruptions, waking once or twice to use the bathroom at night is common. Adults who do not have insomnia issues fall back to sleep readily.

124. A nurse is preparing to administer a feeding via gastrostomy tube to a client who had a stroke. Which of the following actions should the nurse take prior to initiating the feeding?
A. Warm the feeding in a microwave oven
-incorrect: Although cold enteral formula could cause cramping, it is not necessary to warm the feeding prior to administration. The formula should be at room temperature to improve the client's tolerance of gastrostomy feedings. Also, warming the formula in a microwave oven can cause uneven heat distribution and excessive heat; therefore, it's not a safe way to warm enteral feedings.
B. Elevate the head of the client's bed
-Clients who have a brain injury are typically unable to swallow effectively and thus cannot protect their airway from aspiration. Even though this route bypasses the nasopharynx, it is still possible for the client to cough or vomit enteral formula into the oral cavity. Consequently, the nurse should strive to prevent aspiration by elevating the head of the bed prior to initiating the feeding.
C. Flush the tube with 0.9% sodium chloride for irrigation
-incorrect: The nurse should flush the tube with water prior to initiating the feeding to ensure the patency of the tube.
D. Verify that the client's gastric pH is above 4
-incorrect: Due to the acidity of gastric secretions, the pH of gastric contents should be below 4 to indicate proper placement of the gastrostomy tube. A pH above 4 suggests that the end of the tube is not in the stomach.

125. A nurse is assessing a client's nutritional status. The nurse determines the client is consuming 500 calories more per day than his energy level requires. If his dietary habits do not change, how long will it take the client to gain 4.5 kg (10lb)?
A. 10 months

B. 5 months
-incorrect: At the rate of 1 lb per week, the client would gain 20-25 lb in 5 months.
C. 5 weeks
-incorrect: At the rate of 1 lb per week, the client would gain 5 lbs in 5 weeks
D. 10 weeks
- Because 1 lb of body fat is equivalent to 3,500 calories, consuming 500 extra calories each day for 7 days would lead to a total of 3,500 calories and a 1 lb gain per week. At the rate of 1 lb per week, the client would gain 10 lb in 10 weeks.

126. A nurse is caring for a client who has a deficiency of vitamin D. Which of the following foods should the nurse recommend the client include in his diet?
A. Whole Milk
-The fat-soluble vitamins (A,D,E, and K) require fatty substances or tissues to be dissolved and also require the presence of bile in the small intestine for absorption. Whole milk contains vitamins A and K and is often fortified with vitamin D.
B. Chicken
-incorrect: The water-soluble vitamins (B complex and C) readily dissolve in water and are absorbed into the bloodstream from the small intestine. Chicken contains many of the B complex vitamins, including B2, B3, B6, B12 and pantothenic acid.
C. Oranges
-incorrect: The water-soluble vitamins (B complex and C) readily dissolve in water and are absorbed into the bloodstream from the small intestine. Oranges are a good source of vitamin C.
D. Dried peas
-incorrect: The water-soluble vitamins (B complex and C) readily dissolve in water and are absorbed into the bloodstream from the small intestine. Dried peas are a good source of many of the B complex vitamins, including B1, folate, and pantothenic acid.

127. A nurse is caring for a client whose intake and output flow sheet for 0700 to 1500 indicates the following: voided x3 mL, 200 mL, 150 mL; wound drainage 2 tsp; and emesis 2 oz. What total output in milliliters should the nurse document for this 8 hr period? (nearest whole number)

-770mL

128. A nurse is preparing to administer 700 mL of 0.9% sodium chloride IV to a child to infuse over 24 hr. The drop factor of the manual IV tubing is 60gtt/mL. The nurse should set the manual IV infusion to deliver how many gtt/min? (nearest whole number)

- 29gtt/min

129. A client who has glaucoma of the right eye self-administers timolol eye drops by looking at the ceiling, instilling a drop onto the center of the conjunctival sac, and applying gentle pressure

to the lower lid with a facial tissue. After observing this process, which of the following actions should the nurse take?
A. Confirm that the client performed the procedure correctly
-incorrect: One of the actions the client performed is incorrect
B. Instruct the client to look at the floor while instilling the eye drop
-incorrect: The nurse should instruct the client to look up when instilling the eye drops
C. Remind the client to avoid using a facial tissue after instillation
-incorrect: The client may use a tissue to remove excess mediation after instillation
D. Instruct the client to apply pressure to the inside corner of the eye after instillation
-The client should apply gentle pressure over the nasolacrimal duct to prevent the medication from flowing into the nasal passages where systemic absorption could result.

130. A nurse is preparing to administer a unit of packed RBCs to a client. Which of the following pieces of information must the nurse verify with another nurse prior to the administration? (SATA)
A. The client's ID number
B. The client's room number
-incorrect: Nurses should never use a client's room number as an identifier because clients can change rooms.
C. The client's name
D. ABO compatibility
E. Rh compatibility
-Two nurses must verify this information, including the client's facility identification number, name, ABO compatibility, and RH compatibility, to prevent transfusion reactions due to human error.
131. A nurse is caring for a client who has a stage III pressure ulcer on the heel. When preparing to irrigate the wound, which of the following actions should the nurse take first?
A. Obtain the prescribed irrigation solution
-incorrect: The nurse should obtain the prescribed irrigation solution prior to performing the procedure; however, there is another action the nurse should take first.
B. Don personal protective equipment
-incorrect: The nurse should don personal protective equipment prior to performing the procedure to prevent exposure to blood or bodily fluids from the client's wound; however, there is another action the nurse should take first.
C. Check the client's pain level
-The nurse should apply the nursing process priority-setting framework to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify the provider of a change in the client's status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge to make an appropriate decision. Therefore, the nurse should determine the client's level of pain prior to the procedure to evaluate the need for administration of an analgesic. Medicating the client approximately 30 minutes prior to wound care will decrease pain and increase comfort.

D. Place a waterproof pad under the client's extremity
-incorrect: The nurse should place a waterproof pad under the client's extremity to protect the linens from moisture and contamination during the irrigation; however, there is another action the nurse should take first.

132. A nurse is preparing to instill a vaginal medication in suppository form to a client. Which of the following actions should the nurse take during this procedure?
A. Don sterile gloves
-incorrect: The nurse should wear clean gloves for this procedure, not sterile gloves
B. Use the dominant hand to retract the labia
-incorrect: The nurse should use the nondominant hand to retract the labia and the dominant hand to insert the suppository.
C. Use the index finger to insert the suppository
-To ensure adequate distribution of the vaginal medication, the nurse should insert the suppository until the length of the nurse's index finger is inside the vagina or as far inside as possible.
D. Ease the suppository along the anterior vaginal wall
-incorrect: The nurse should ease the suppository along the posterior vaginal wall

133. A nurse is teaching a client who is postoperative about the importance of turning, coughing, and breathing deeply. Which of the following statements should the nurse identify as an indication that the client understands the instructions?
A. "If I do this often, I won't experience muscle wasting."
-incorrect: Turning, coughing, and breathing deeply do not prevent muscle wasting. Exercising the muscles actively or passively helps prevent muscle wasting.
B. "If I do this often, I won't get pneumonia."
-Turning, coughing, and breathing deeply help prevent respiratory complications such as pneumonia by promoting lung expansion and secretion removal.
C. "If I do this often, I won't get constipation."
-incorrect: Turning, coughing, and deep breathing do not prevent constipation. Resuming a progressive diet with an adequate fluid intake and early ambulation will help prevent constipation. Fiber supplements and stool softeners can also help.
D. "If I do this often, I won't have a fast heartbeat."
-incorrect: Turning, coughing, and deep breathing do not prevent tachycardia. A rapid heart rate is not usually a major postoperative concern. However, prevention includes avoiding stressors that might cause it such as unrelieved pain or sudden exertion. Careful pain management and gradual resumption of activities can also help.

134. A nurse is taking a client's vital signs. Which of the following findings should the nurse identify as outside the expected reference range?
A. Pulse rate 90/min
-incorrect: This pulse rate is within the expected reference range.
B. Rectal Temp 38 C (100.4 F)
-incorrect: This temp. is within the expected reference range.

C. Pulse oximetry 95%
-incorrect: This pulse oximetry is within the expected reference range.
D. BP 145/90 mmHg
-This blood pressure is greater than the expected reference range and should be reported to the provider.

135. A nurse is instructing a client about collecting a 24-hour urine specimen for creatinine clearance. Which of the following statements should the nurse identify as an indication that the client understands the procedure?
A. "The next time I urinate will be the first specimen of the collection."
-incorrect: The collection begins after the next time the client urinates.
B. "I'll make sure to keep the collection bottle in the container of ice they gave me."
-The urine collection must remain chilled to prevent any change in urine composition during the collection.
C. "Once the container is half full, I no longer have to add any more urine."
-incorrect: The urine collection for creatinine clearance specifies the duration of collection, not a minimal volume of urine.
D. "It's okay if a piece of toilet paper gets in the bottle. The lab people will remove it when they do the test."
-incorrect: The presence of toilet tissue, menstrual blood and feces will contaminate the specimen.

136. A nurse is performing a straight catherization for a female client who has urinary retention. Which of the following actions indicates the nurse is maintaining sterile technique?
A. Applying sterile gloves to open catheter package
-incorrect: The nurse should apply sterile gloves after opening the catheter package to maintain aseptic technique, as the outside of the package is not considered sterile.
B. Wiping the labia minora in an anteroposterior direction
-The nurse should wipe anteroposteriorly both the right and left labia minora with separate cotton swabs to destroy any microorganisms in the area that would contaminate the catheter.
C. Spreading the labia with the dominant hand
-incorrect: The nurse should use the nondominant hand to spread the labia and provide the optimal view of the urethral meatus. The nondominant hand is considered contaminated once the hand touches the client's skin.
D. Using a cotton ball to wipe the right and left labia majora
-incorrect: The nurse should use a separate cotton ball to wipe the right and left labia majora to destroy any microorganisms on the skin surface that would contaminate the catheter.

137. A nurse is caring for a postoperative client who has an indwelling urinary catheter for gravity drainage. The nurse notes no urine output in the past 2 hr. Which of the following actions should the nurse take first?
A. Check to determine if the catheter tubing is kinked
-The nurse should apply the least invasive priority-setting framework when caring for this client, which assigns priority to nursing interventions that are least invasive to the client, as long as

those interventions do not jeopardize client safety. This approach reduces the number of organisms introduced into the body, decreasing the number of facility-acquired infections. Hence, the first action the nurse should take is to inspect the tubing carefully, straighten any kinks, and ensure there are no dependent loops. A lack of drainage is often due to a kink in the tubing or the client lying on it.
B. Palpate the bladder
-incorrect: The nurse should obtain a prescription to irrigate the catheter to determine if the absent urine output is due to an obstruction from blood clots or sloughing of bladder tissue. However, there is another action the nurse should take first.
C. Obtain a prescription to irrigate the catheter with 0.9% sodium chloride
-incorrect: The nurse should obtain a prescription to irrigate the catheter to determine if the absent urine output is due to an obstruction from blood clots or sloughing of bladder tissue. However, there is another action the nurse should take first.
D. Encourage the client to drink more fluids
-incorrect: The nurse can encourage the client to drink more fluids or obtain a prescription to increase the IV fluid rate if fluid overload is not a problem for the client to help increase kidney profusion and filtration of urine. However, there is another action the nurse should take first.

138. A nurse is cleaning a client's wound by swabbing from the area of least contamination to an area of greater contamination. Which of the following rationales should the nurse identify for using this technique?
A. Preventing the transfer of microorganisms to the nurse
-incorrect: Wearing appropriate personal protective equipment while performing wound care helps prevent the transfer of microorganisms from the client to the nurse.
B. Keeping microorganisms from entering the wound
-Starting at the area of least contamination and working toward the area of greatest contamination prevents the spread of microorganisms within the wound.
C. Applying minimal pressure to the wound
-incorrect: The cleansing sequence does not affect the amount of pressure applied to the wound. Pressure should be gentle. However, when necrotic tissue is removed, various methods of debridement are prescribed, some of which involve additional pressure being applied to the wound.
D. Keeping excess moisture from entering the wound
-incorrect: When excess moisture poses a hazard to a wound, a drain can be used to divert fluid away from the wound.

139. After assessing a client's radial pulses, the nurse documents "radial pulses 4+ bilaterally." The nurse should document this finding when a client's pulses have which of the following qualities?
A. Bounding
-A pulse of 4+ is bounding and does not disappear with moderate pressure. Pulse strength ranges from absent (0) to bounding (4+).
B. Full
-incorrect: Full pulse strength is 3+

C. Variable
-incorrect: Variable typically describes the pulse's rate or rhythm, not its strength.
D. Weak
-incorrect: A weak pulse is 1+

140. A nurse is using a portable ultrasound bladder scanner to measure a client's post-void residual volume. Which of the following actions should the nurse take?
A. Have the client urinate 20 min before the scan
-incorrect: The nurse should instruct the client to urinate 10 mins before the bladder scanning procedure. The nurse should then document the amount of urine the client passed at that time.
B. Assist the client into a semi-fowler's position
-incorrect: For the bladder scanning procedure, the nurse should assist the client into a supine position with the head slightly elevated.
C. Position the scanner head at the symphysis pubis
-incorrect: The nurse should position the scanner head 2.5-4 cm (1-1.6 in) above the symphysis pubis.
D. Apply light pressure to the scanner head once it is in position
-The nurse should apply light pressure and hold the scanner steadily while pointing it slightly down toward the client's bladder.

141. A nurse is replacing the surgical dressings on a client who had abdominal surgery. Which of the following actions should the nurse take?
A. Don clean gloves to remove the old dressing
-The nurse should use standard precautions by applying clean gloves when faced with the possibility of coming into contact with secretions. Removing a soiled dressing is a procedure that requires wearing clean gloves. Sterile gloves are not necessary until the nurse applies the new sterile dressing.
B. Loosen the dressing by pulling the tape away from the wound
-incorrect: The nurse should remove the tape by loosening and pulling toward the wound or dressing to decrease tension or stress on the healing wound edges.
C. Remove the entire old dressing at once
-incorrect: The nurse should remove the old dressing a layer at a time to prevent the removal of drains and allow assessment of the drainage.
D. Open sterile supplies after applying sterile gloves
-incorrect: The nurse should open the sterile supplies after removing the old dressings and washing the hands and before donning sterile gloves to apply the sterile dressing. These measures help prevent microorganisms from contaminating the sterile field.

142. A nurse is performing suctioning for a client who has a tracheostomy. Which of the following actions should the nurse take?
A. Pull suction catheter back 1 cm (0.5 in) if the client starts coughing
-The nurse should pull the suction catheter back 1 cm (0.5in) when the client starts to cough, or resistance is met. This will remove the catheter from the mucosal wall of the trachea prior to suctioning.

B. Allow 30 sec between suctioning passes
-incorrect: The nurse should allow at least 1 minute between suctioning passes to prevent hypoxia and to hyperventilate the client.
C. Hyperventilate the client with 50% oxygen for 30 sec
-incorrect: The nurse should hyperventilate the client with 100% oxygen for at least 2 mins before suctioning to decrease hypoxia.
D. Perform maximum of 4 passes with the suction catheter
-incorrect: The nurse should perform a maximum of 3 passes with the suction catheter because suctioning can cause hypoxia and induce dysrhythmia.

143. A nurse is teaching a client who is postoperative following a knee arthroplasty about the muscles he will need to strengthen in physical therapy. Which of the following muscle groups is responsible for movement at the knee joint?
A. Antigravity
-incorrect: The antigravity muscle group is responsible for stabilizing the knee joint.
B. Antagonistic
-The nurse should teach the client that the antagonistic muscle group is responsible for movement of the knee joint by contracting while other muscles relax.
C. Synergistic
-incorrect: The synergistic muscle group is responsible for contracting in sync to cause the same movement. Therefore, 2 muscles contract as other muscles relax. However, this is not occurring within a joint.
D. Skeletal
-incorrect: The skeletal muscle group is responsible for supporting posture and producing voluntary movement.
144. A nurse is preparing to irrigate a client's wound. Which of the following actions should the nurse take?
A. Use a 10 mL syringe
-incorrect: The nurse should use a syringe that has at least a 30 mL capacity.
B. Attach a 22-gauge catheter to the syringe
-incorrect: The nurse should use an 18- or 19-gauge catheter. A smaller catheter will exert too much pressure on the wound.
C. Warm the irrigating solution to 37 C (98.6 F)
-The nurse should prepare about 200 mL of irrigating solution and warm it to body temperature to minimize discomfort and vascular constriction.
D. Administer an analgesic 10 mins before the irrigation
-incorrect: The nurse should administer an analgesic 20 to 30 minutes before the irrigation to give the medication enough time to provide pain management during the procedure.

145. A nurse in the emergency department is caring for an inmate who has a laceration and is bleeding. The client was brought to the facility by a guard who asks the nurse about the client's HIV infection status. Which of the following actions should the nurse take?
A. Inform the guard that the warden must request this information.

-incorrect: The nurse cannot discuss the client's HIV status with the guard or the warden without the client's consent. The client can share personal medical information if desired.
B. Ask the guard to sign a release of information form
-incorrect: The client can sign a release of information form to obtain medical records. Asking the guard to sign this form does not give the nurse permission to share the client's HIV status.
C. Instruct the guard to ask the inmate
-The nurse is not able to supply this information to the guard. In order for the guard to obtain this information, the client must offer the information freely. Therefore, the nurse should instruct the guard to ask the client for the information.
D. Complete an incident report
-incorrect: The nurse would have no cause to complete an incident report in this situation. Incident reports are completed to record an event that is not consistent with standard procedures. An incident report would need to be completed if the nurse were to share the client's HIV status with the guard.

146. A nurse is caring for a client who just received a diagnosis of cancer. The client states, "I just don't know what I'm going to do now." Which of the following responses should the nurse make?
A. "In time you'll know the right thing to do."
-incorrect: This is a nontherapeutic response. Providing an automatic or cliché response can be seen as belittling the client's feelings and can make it seem as though the nurse is not taking the client's concerns seriously.
B. "I am sorry. Would you like me to call someone for you?"
-incorrect: This is a nontherapeutic response. Offering sympathy can come across as pity and not as empathy. Offering to call someone for the client places the responsibility of addressing the client's concerns onto someone other than the nurse.
C. "There are multiple treatment options for you to consider."
-incorrect: This is a nontherapeutic response. By changing the subject, this response does not allow the client to express concerns about the diagnosis and shows a lack of empathy on the part of the nurse. This kind of response can block further communication with the client.
D. "Can you explain the concerns you're having right now?"
-This response uses therapeutic communication technique of asking a relevant question. By using an open-ended question to ask the client to explain any present concerns, the nurse is encouraging the client to respond and provide additional information.

147. A nurse is preparing to administer an antibiotic to an adult client who has otitis media. Which of the following actions should the nurse plan to take?
A. Hold the dropper 1 cm (0.5 in) above the ear canal during administration
-The nurse should administer the otic medication by holding the dropper 1 cm (0.5in) above the ear canal.
B. Apply pressure to the nasolacrimal duct following administration
-incorrect: The nurse should apply pressure to the nasolacrimal duct following the administration of eye drops, not for an otic antibiotic.
C. Place a cotton ball into the inner ear canal for 30 mins following administration

-incorrect: If necessary, the nurse can apply a cotton ball into the outermost part of the ear canal and remove is after 15 mins.
D. Straighten the ear by pulling the auricle down and back prior to administration
-incorrect: The nurse should straighten the ear canal by pulling the auricle down and back prior to administering otic medication for a child who is younger than 3 years of age.

148. A nurse is caring for a client who requires a peripheral IV insertion. When choosing the site, which of the following sites should the nurse select?
A. Select a vein in the client's dominant arm
-incorrect: The nurse should place a peripheral IV into a client's non-dominant arm unless contraindicated for reasons such as mastectomy or a dialysis fistula.
B. Choose the most proximal vein in the extremity
-incorrect: The nurse should select a vein that is distal to areas where the tip of the catheter will not be at a point of flexion.
C. Choose a vein that is soft on palpation
- The nurse should select a vein that is soft and has a "bouncy" feeling when pressure is released upon palpation.
D. Select a site distal to previous venipuncture attempts
-incorrect: The nurse should avoid a site that is distal to a previous venipuncture attempt or site. These areas often cause infiltration around a newly place IV site. ‘

149. A nurse is preparing to insert an indwelling urinary catheter. Which of the following instructions should the nurse give the client to ease to passage of the catheter through the urinary meatus?
A. "Bear down"
-The nurse should ask the client to "bear down" gently as if to void. This can enable the nurse to better visualize the urinary meatus and promote relaxation of the external urinary sphincter. Additionally, this will ease the passage of the catheter through the urinary meatus.
B. "Perform Kegel exercises"
-incorrect: Kegel exercises are a technique used the strengthen the pelvic muscles. However, these exercises will not ease the passage of the catheter through the urinary meatus.
C. "Hold your breath"
-incorrect: The nurse should ask the client to take slow, deep breaths to promote relaxation. This can help relax the sphincter, which can ease the passage of the catheter through the urinary meatus.
D. "Raise your head off the pillow"
-incorrect: The nurse should encourage the client to relax during the procedure. There is no need to ask the client to raise the head off the pillow.

150. A nurse is providing discharge teaching to an older adult client about personal safety. Which of the following statements by the client indicates an understanding of the teaching?
A. "I will have the steps to my house painted a dark color."

-incorrect: The nurse should instruct the client to paint or mark only the edges of the steps with a light color to make them more prominent. Physiological changes associated with aging can affect an older adult client's ability to see edges of the steps.
B. "I will put a night-light in the hallway."
-The nurse should instruct the client to use night-lights in and around the home as an important safety measure to reduce the risk of falls in the home. Physiological changes associated with aging can affect the older adult client's ability to see surroundings. Older adults and infants are at an increased risk of serious injury from falls, and most falls occur in the client's home.
C. "I will put on socks when I get out of bed."
-incorrect: The nurse should instruct the client to wear well0fitting slippers with non-skid soles as an important safety measure to reduce the risk of falls in the home. Physiological changes associated with aging can affect an older adult client's ability to balance, increasing the risk of falls.
D. "I will secure any wires in my home under rugs."
-incorrect: The nurse should instruct the client that securing wires under a rug can create an electrical hazard and should be avoided. Physiological changes associated with aging can affect an older adult client's ability to see surroundings and to react quickly to hazards when walking.

151. A nurse in a provider's clinic is taking a client's age, height, weight, and vital signs. The nurse should identify this action as part of which of the following components of the nursing process?
A. Planning
-incorrect: Planning is the portion of the nursing process in which the nurse establishes goals and outcomes for the client and selects interventions that will help achieve those goals and outcomes. Planning also involves setting priorities.
B. Evaluation
-incorrect: Evaluation is the portion of the nursing process in which the nurse uses critical thinking skills to determine if goals and outcomes have been met. The nurse examines the results, compares the data, identifies errors, and considers the client's situation when performing the evaluation portion of the nursing process.
C. Assessment
-Collecting this data is included in the assessment portion of the nursing process. In addition, the nurse should explore the client's health history and perform a physical examination.
D. Implementation
-incorrect: Implementation is the portion of the nursing process in which the nurse provides client care based on assessment data and analysis and the plan of care developed in the previous step. The nurse also uses interpersonal and technical skills when implementing nursing interventions.

152. A nurse on a medical-surgical unit is caring for a client. Which of the following actions should the nurse prioritize when using the nursing process?
A. Identify goals for client care
-incorrect: While identifying goals is an appropriate step in the nursing process, it is not the first step.

B. Obtain client information
-The nursing process is based on the scientific process. The first step in the scientific process is collecting data. Therefore, the first step in the nursing process is assessing and obtaining information about the client.
C. Document nursing care needs
-incorrect: While documenting the client's care needs is an appropriate step in the nursing process, it is not the first step.
D. Evaluate the effectiveness of care
-incorrect: While evaluating the effectiveness of the client's care is an appropriate step in the nursing process, it is not the first step.

153. A nurse is providing discharge teaching to a client who does not speak the same language as the nurse. The client's neighbor, who speaks both the client's native language and the nurse's, arrives to drive the client home. Which of the following actions should the nurse take?
A. Ask the client's neighbor to call a family member to interpret
-incorrect: Using a family member to interpret could breach the client's confidentiality. In addition, the family member might not be familiar enough with medical terminology to translate information accurately.
B. Ask the client's neighbor to translate the information
-incorrect: Although the neighbor can speak both languages, this action could breach the client's confidentiality. In addition, the neighbor might not be familiar enough with medical terminology to translate information accurately.
C. Obtain the services of an interpreter
-Federal mandates require that a professional medical interpreter translate the client's health care information into the client's native language.
D. Document the inability to perform discharge instructions
-incorrect: The nurse is responsible for providing discharge instructions that the client can understand.

154. A nurse is presenting an in-service training about nutrition. Which of the following simple sugars should the nurse identify as the carbohydrate found in milk?
A. Lactose
-The nurse should identify that lactose is a form of sugar that is found in milk.
B. Sucrose
-incorrect: Sucrose is table sugar and is also found in fruits and vegetables.
C. Maltose
-incorrect: Maltose is found in germinating cereals, such as barely.
D. Fructose
-incorrect: Fructose is found in honey and fruit.

155. A nurse is working with the facility's language interpreter to explain a wound-care procedure to a client who does not speak the same language as the nurse. Which of the following actions should the nurse take when describing the procedure to the client?
A. Make eye contact with the interpreter

-incorrect: To enhance the nurse-client relationship, the nurse should direct information, instructions, and questions to the client, not to the interpreter.
B. Break sentences into shorter segments to allow time for interpretation
-incorrect: The nurse should make every effort to speak in short sentences but should not break sentences into fragments to allow time for interpretation.
C. Ensure the interpreter and client speak the same dialect
-To encourage effective communication and promote client understanding, the nurse should first ensure the interpreter and the client speak the same dialect.
D. Speak in a loud tone of voice
-incorrect: The nurse should speak slowly and distinctly and avoid the use of metaphors that might be challenging to translate. The nurse should speak clearly, not loudly.

156. A nurse on a medical-surgical unit is caring for a client who has been coughing intermittently during meals, attempting to clear her throat repeatedly, and eating only a small portion of each meal. The nurse should recommend a referral to which of the following members of the interprofessional team to evaluate the client for dysphagia?
A. Speech-language pathologist
-A speech-language pathologist can perform a thorough evaluation of the client for dysphagia and help the client learn to eat safely. For example, a speech-language pathologist can instruct the client in learning the supraglottic swallow: take a breath, hold the breath while swallowing, cough after swallowing, and swallow again to clear the mouth.
B. Social worker
-incorrect: A social worker can assist the client with finding and accessing community services (ex: meal delivery and functional services) once the client is at home but cannot evaluate the skills the client needs to swallow and eat safely.
C. Physical therapist
-incorrect: A physical therapist can evaluate the strength and mobility of a client who has musculoskeletal problems but cannot evaluate the skills the client needs to swallow and eat safely.
D. Occupational therapist
-incorrect: An occupational therapist can help clients who have physical limitations or disabilities gain the optimal level of independence in performing ADLs but cannot evaluate the skills the client needs to swallow and eat safely.

157. A nurse manager is providing teaching to a group of newly licensed nurses about ways that clients acquire health care-associated infections (HAIs. Which of the following routes of infection should the manager identify as an iatrogenic HAI?
A. Infection acquired from improper hand hygiene
-incorrect: Breaks in infection-control protocols, such as improper hand hygiene, are not considered a source of iatrogenic HAIs because they are not due to a diagnostic or therapeutic procedure.
B. Infection acquired by drug resistance
-incorrect: Drug resistance is not considered a source of iatrogenic HAIs because it is not the result of a diagnostic or therapeutic procedure.

C. Infection acquired by inappropriate waste disposal
-incorrect: Inappropriate waste disposal is not considered a source of iatrogenic HAIs because it is not the result of a diagnostic or therapeutic procedure
D. Infection acquired from a diagnostic procedure
-Iatrogenic HAIs directly result from diagnostic or therapeutic procedures.

158. A nurse is caring for a client who is unstable and has vital signs measured every 15 minutes by an electronic blood pressure machine. The nurse notices the machine begins to measure the blood pressure at varied intervals, and the readings are inconsistent. Which of the following actions should the nurse take?
A. Turn on the machine every 15 min to measure the client's blood pressure
-incorrect: Because the measurement and operation of the machine appear questionable, operating the equipment differently cannot ensure the accuracy of the readings. The nurse should tag the machine and remove it from use.
B. Record only the blood pressure readings needed for 15-min intervals
-incorrect: Although the equipment is obtaining blood pressure readings, the increased measurements and dissimilar results suggest that the machine is malfunctioning. Thus, all the readings are possibly inaccurate. The nurse should tag the machine and remove it from use.
C. Obtain manual and automatic readings and compare them
-incorrect: Although this option appears to provide a means of checking the machine, it is not operating correctly, which already suggest that the accuracy of the reading is questionable. The nurse should tag the machine and remove it from use.
D. Disconnect the machine and measure the blood pressure manually every 15 mins
-If the nurse questions the reliability of the monitoring equipment, a manual process should be used. Also, malfunctioning equipment can pose a safety risk for the client, so it must be tagged and removed.
159. A nurse on a medical-surgical unit is washing her hands prior to assisting with a surgical procedure. Which of the following actions by the nurse demonstrates proper surgical handwashing technique?
A. The nurse washes each part of her hands with 5 strokes.
-incorrect: Surgical scrubbing requires the nails be scrubbed with 15 strokes and each other part of the hand with 10 strokes.
B. The nurse washes from the elbows down to the hands.
-incorrect: An important principle of surgical handwashing is to scrub the hands first and then work toward the elbows.
C. The nurse holds her hands higher than her elbows while washing
-The nurse who is performing a surgical handwashing technique should wash while holding her hands higher than the elbows so that water and soapsuds can drain away from the clean area toward the dirty area.
D. The nurse uses minimal friction when washing her hands.
-incorrect: Scrubbing is performed with a specially designed and premedicated brush when performing surgical handwashing. The use of mechanical friction is necessary to decontaminate the skin effectively.

160. A nurse is caring for an older adult client who is violent and attempting to disconnect her IV lines. The provider prescribes soft wrist restraints. Which of the following actions should the nurse take while the client is in restraints?
A. Tie the restraints to the side rails
-incorrect: The nurse should not tie the restraints to the side rails because this can injure the client if the rails are lowered.
B. Perform ROM exercises to the wrists every 3 hours
-incorrect: The nurse should ensure the restraints are removed and ROM exercises are performed every 2 hours.
C. Remove the restraints one at a time
-The nurse should remove one restraint at a time for a client who is violent or noncompliant.
D. Obtain a PRN prescription for the restraints
-incorrect: Restraint prescriptions can only be written for a 24 hours period and cannot be a PRN prescription.

161. A client is being discharged home with oxygen therapy delivered through a nasal cannula. Which of the following instructions should the nurse provide to the client and family members?
A. Use battery-operated equipment for personal care.
-incorrect: Electrical equipment in good condition with no frayed wires is acceptable for personal care when oxygen is administered.
B. Apply mineral oil to protect the facial skin from irritation.
-incorrect: Most oils and petroleum products are flammable when used on the body, which is a contraindication for use because oxygen is a highly combustible gas.
C. Remove the television set from the client's bedroom.
-incorrect: As long as the television is in proper working order, there is no oxygen-related need to remove it from the client's bedroom.
D. Wear cotton clothing to avoid static electricity.
-The use of cotton clothing will limit the buildup of static electricity. Oxygen is a highly combustible gas. The use of oxygen in high concentrations has great combustion potential and readily fuels fire. Although it will not spontaneously burn or cause an explosion, it can easily cause a fire in a client's room if it contacts a spark.

162. A nurse is discussing fire safety with newly hired nurses. Which of the following actions is the priority if a fire occurs in the health care facility?
A. Close the fire door on the unit
-incorrect: The nurse should close the fire doors and doors to rooms on the unit in attempt to confine the fire; however, there is another action that is a priority.
B. Use a fire extinguisher on the fire
-incorrect: The nurse should attempt to extinguish the fire; however, there is another action that is the priority.
C. Pull the nearest fire alarm
-incorrect: The nurse should activate the fire alarm and report the location of the fire; however, there is another action that is the priority.
D. Evacuate clients from the unit

-The nurse should apply the safety and risk-reduction priority-setting framework, which assigns priority to the factor or situation posing greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's hierarchy of needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client. The greatest risk during a fire is injury to clients; therefore, the nurse's priority action is to evacuate clients from the unit. The nurse should follow the RACE protocol when responding to a fire: rescue, activate, confine, and extinguish.

163. A nurse on a medical-surgical unit is caring for a client who is at risk of experiencing seizures. Which of the following pieces of equipment must be available at the client's bedside at all times?
A. Suction equipment
-The greatest risk to a client who is having a seizure is an injury from aspirating secretions or emesis; therefore, the nurse must have suction equipment available for clearing the mouth of secretions or emesis to reduce this risk.
B. Clean gloves
-incorrect: The nurse should have clean gloves available to check the client's mouth for injuries to the mucous membranes or teeth; however, other equipment is the nurse's priority.
C. Blankets
-incorrect: The nurse should have blankets and linens available to pad the side rails if a seizure begins while the client is in bed to help prevent injury; however, other equipment is the nurse's priority.
D. Oxygen
-incorrect: During and after a seizure, some clients require supplemental oxygen to maintain oxygen saturation; therefore, the nurse should have oxygen ready to administer. However, other equipment is the nurse's priority.

164. A nurse is preparing a sterile field for a procedure the provider will perform at the client's bedside. Which of the following actions should the nurse take?
A. Hold the sterile drape above the waist and away from the body
-Contamination occurs when the nurse holds any object that will be part of the sterile field below the waist or allows it to touch anything other than a sterile object.
B. Drop sterile objects toward the edges of the sterile field
-incorrect: The nurse should drop sterile objects toward the center of the sterile field, as the 2.5 cm (1 in) border around the periphery of the field is not sterile.
C. Hold packaged supplies 7.6 cm (3 in) above the sterile field
-incorrect: The nurse should hold packaged supplies 15cm (6in) above the sterile field before opening them and dropping them onto the sterile field.
D. Hold sterile objects over the field before setting them down on the field
-incorrect: The nurse should add sterile objects at an angle from the side of the sterile field to avoid reaching over the sterile field and contaminating it.

165. A nurse is providing teaching about nutritious diets to a group of adult women. Which of the following statements should the nurse include?
A. “Include at least 3g of sodium in you daily diet.”
-incorrect: The nurse should instruct the women to consume sodium in moderation. The AHA recommends consuming less than 2.5g of sodium daily, and the adequate intake (AI) is 1.5g. Excessive intake of sodium can lead to hypertension.
B. “Limit wine consumption to 230 mL daily.”
-incorrect: Although certain alcoholic beverages, such as red wine, contain phytochemicals that can reduce the risk of cardiovascular disease and offer anti-inflammatory properties, excessive intake can lead to a deficiency in other nutrients. The recommended amount of alcohol for women is a drink per day, which is equivalent to 350 mL (12oz) of beer, 148 mL (5oz) of wine, or 44 mL (1.5oz) of hard alcohol that is over 80 proof.
C. “Include 2.5 cups of vegetables in your daily diet.”
-Nutritious diets contain a variety of foods to ensure the required daily allowance of nutrients is ingested. The nurse should instruct the women to include 2.5 cups of vegetables and 2 cups of fruit in their daily diets. Fruits and vegetables should be a variety of colors to provide an assortment of nutrients.
D. “Limit water intake to 1.5 L each day.”
-incorrect: Water is an important component of a nutritious diet because it is necessary for the digestion, absorption, and transport of nutrients. The nurse should instruct these women to drink between 2-3 L of water daily to maintain homeostasis, based on client comorbidities, the climate, and the client’s activity level.

166. A nurse is caring for a client who has a BMI of 29 and expresses a desire to lose weight. Which of the following actions should the nurse take first?
A. Refer the client to a nutritionist
-incorrect: Effective weight management involves establishing and following healthy eating habits. The nurse should refer the client to a nutritionist for an evaluation of the client’s dietary needs and dietary recommendations to promote weight loss. However, this is not the first action the nurse should take.
B. Discuss eating strategies with the client
-incorrect: The nurse should discuss various eating strategies, such as portion control and the reduction or elimination of sugar-sweetened beverages, as a means of reducing weight. However, this is not the first action the nurse should take.
C. Determine the client’s intention to change current eating habits
-When using the nursing process, the nurse should first assess the client’s readiness to commit to change in behavior.
D. Instruct the client to perform 30 mins of vigorous exercise daily
-incorrect: Although the nurse should recommend increasing activity to promote overall health and weight loss, this is not the first action the nurse should take.

167. A nurse is performing an otoscopic examination of a client’s right ear. The light reflex is visible in the right lower quadrant of the tympanic membrane. Which of the following actions should the nurse take in response to this finding?

A. Obtain an audiology referral
-incorrect: Difficulty hearing or understanding speech indicates the need for a referral to an audiologist for audiometry testing.
B. Document this as an expected finding
-The light of the otoscope reflects off the tympanic membrane, which is cone-shaped or triangular. In the right ear, it is visible in the right lower quadrant of the eardrum. In the left ear, it is visible in the left lower quadrant.
C. Irrigate the ear with warm water
-incorrect: Cerumen blocking visualization of the eardrum indicates the need for irrigation.
D. Document mild inflammation
-incorrect: A pink eardrum, not a visible triangle of light, indicates mild inflammation.

168. A nurse is assessing a client's respiratory system. Which of the following breath sounds should the nurse expect to hear over the periphery of the major lung fields?
A. Vesicular
-The nurse will hear vesicular sounds over the periphery of the major lung fields. These sounds are soft and low-pitched.
B. Bronchial
-incorrect: The nurse will hear bronchial sounds over the trachea. These sounds are high-pitched, hollow, and loud.
C. Rhonchi
-incorrect: The nurse will hear rhonchi or gurgling sounds over the trachea and the bronchi if the airways are narrow due to secretions or swelling.
D. Bronchovesicular
-incorrect: The nurse will hear bronchovesicular sounds on either side of the sternal border anteriorly and between the scapulae posteriorly. These sounds are moderately loud with a medium pitch.

169. A nurse is teaching a middle-aged female client about disease prevention and health maintenance. Which of the following diagnostic tests should the nurse recommend as part of this client's routine health screening?
A. Annual Papanicolaou (Pap) testing
-incorrect: Women ages 30-65 years should have a pap test every 3 years.
B. Mammogram every 2 years
-incorrect: Women ages 45 years and older should have an annual mammogram. At age 55, clients may decide to change this schedule to every 2 years or continue with annual mammograms.
C. Eye examination every 2 years
-This is essential not only for monitoring vision but also for checking for glaucoma. The client should have annual eye exams from the age of 65 onward.
D. Annual colonoscopy
-incorrect: The client should have a colonoscopy every 10 years. If the client has risk factors for colorectal cancer, testing should occur more often and with other evaluations.

170. A nurse is providing nutrition counseling to a middle-aged adult client who has a sedentary job. Which of the following factors should the nurse consider?
A. The risk of eating disorders increases at this age
-incorrect: Eating disorders such as anorexia more commonly develop during adolescence and young adulthood.
B. The client's basal metabolic rate could decrease
-The basal metabolic rate decreases as adipose tissue replaces skeletal muscle mass. This places the client at risk of weight gain if a healthy diet is not maintained.
C. Daily vitamins will become necessary to meet nutritional needs
-incorrect: Daily vitamins are not necessary if middle-aged adults consume a balanced diet.
D. Limiting the intake or fish to once per week reduces cardiovascular risks
-incorrect: To reduce the risk of hypertension and coronary artery disease, the client should consume fish at least twice per week.

171. A nurse is providing preoperative teaching to a client who is scheduled for arthroplasty in the next month and may require a blood transfusion. The client expresses concern about the risk of acquiring an infection from the blood transfusion. Which of the following statements should the nurse share with the client?
A. "Ask your provider to prescribe epoetin before the surgery."
-incorrect: Epoetin is a hematopoietic growth factor used for the treatment of anemia. While taking epoetin prior to surgery can boost the client's hematocrit levels, it is inappropriate if the client already has an adequate hematocrit level. Furthermore, this action might not eliminate the need for a blood transfusion and its related risks.
B. "You should ask your provider about taking iron supplements prior to the surgery."
-incorrect: While taking an iron supplement prior to surgery can boost the client's hemoglobin levels, it is inappropriate if the client already has an adequate hemoglobin level and dietary intake of iron. Furthermore, this action might not eliminate the need for a blood transfusion and its related risks.
C. "Ask a family member to donate blood for you."
-incorrect: A blood donation from a family member does not eliminate the risk of acquiring an infection.
D. "Donate autologous blood before the surgery."
-Autologous blood transfusion is the collection and reinfusion of the client's blood. With preoperative autologous blood donation, the blood is drawn from the client 3 to 5 weeks before an elective surgical procedure and stored for transfusion at the time of surgery. Autologous blood is the safest form of blood transfusion because exclusive use of a client's own blood eliminates exposure to a transfusion-transmitted infection.

172. A nurse is teaching a group of older adults about expected age-related changes. Which of the following statements by a group member indicates that the teaching has been effective?
A. "I should expect my heart rate to take longer to return to normal after exercise as I get older."
-Older adults experience decreased cardiac output, which causes an increased pulse rate during exercise. The pulse rate also takes longer to return to normal after exercise.
B. "Urinary incontinence is something I will have to live with as I grow older."

-incorrect: Although bladder capacity decreases in older adults, urinary incontinence is not an expected finding, and older adults should report incontinence so that it can be investigated and treated.
C. “I can expect to have less ear wax as I get older.”
-incorrect: Older adults have an increased buildup of cerumen in the ears, which may increase problems with hearing loss.
D. “My stomach will empty more quickly after meals as I grow older.”
-incorrect: Decrease gastric emptying is an expected finding in older adults.

173. A nurse is assessing a client. Which of the following findings should the nurse identify as an indication of protein-calorie malnourishment? (SATA)
A. Gingivitis
-incorrect: Gingivitis is a manifestation of Vitamin C deficiency
B. Dry, brittle hair
C. Edema
D. Spoon-shaped nails
-incorrect: Spoon-shaped nails are a manifestation of iron deficiency
E. Poor wound healing
-Dry, brittle hair that falls out easily suggests inadequate protein intake and malnutrition. Edema can occur when albumin levels are lower than expected reference range and indicates protein-calorie malnutrition. Adequate wound healing depends on the ingestion of sufficient protein, calories, water, vitamins (especially C and A), iron and zinc.

174. A nurse is assessing a client’s thyroid gland. Which of the following instructions should the nurse give the client before inspecting and palpating this gland?
A. “Tilt your head slightly forward.”
-incorrect: To palpate the supraclavicular lymph nodes, the nurse should instruct the client to tilt her head forward and relax her shoulders.
B. “Keep your head straight and look ahead of you.”
-incorrect: To palpate the trachea for any deviation to the side, the nurse should instruct the client to keep her head in an erect, neutral position.
C. “Tilt your head back and swallow.”
-To examine the thyroid gland, the nurse should instruct the client to extend her head backward and to swallow. The Nurse should be able to feel the thyroid gland ascend as the client swallows and observe any enlargement of the gland.
D. “Turn your head to the side against my hand.”
-incorrect: To evaluate the strength of the neck muscles, the nurse should place a hand on the side of the client’s head and ask her to turn her head against the resistance from the hand. The nurse should then repeat this step on the other side of the client’s head.

175. A nurse is providing discharge teaching for a client who has type 2 diabetes mellitus and will be caring for herself at home. The client expresses concerns about preparing an appropriate diet for her diabetes due to her cultural beliefs and preferences. Which of the following responses should the nurse offer?

A. “The home health dietitian will visit and help you learn to cook all over again.”
-incorrect: Telling the client she should learn to cook all over again does not show sensitivity to the client’s cultural needs. It implies a judgment that the client’s cooking is substandard or unacceptable.
B. “The dietitian will give you a list of foods and dietary choices to keep your diabetes under control. “
-incorrect: Giving the client a standard list of foods and dietary choices does not show sensitivity to the client’s cultural needs. It implies that replacing the client’s cultural food preferences is the only therapeutic option.
C. “The dietitian will help you choose foods you are used to that also meet your health needs.”
-This response shows respect for the client’s food preferences and cultural needs by offering choices from among the client’s usual foods.
D. “It may be difficult, but I know you can change your eating and cooking habits with some help from the dietitian.”
-incorrect: Telling the client she will need to change her eating and cooking habits does not show sensitivity to the client’s cultural needs. It implies a judgment that the client’s eating and cooking habits are substandard or unacceptable.

176. A nurse is talking with a client whose provider recently informed him of terminal pancreatic cancer. When the client reports that he understands the full impact of this diagnosis, the nurse should identify that the client is in which of the following stages of dying?
A. Anger
-incorrect: During the stage of anger, the client has realized the full impact of the loss and might express hopelessness and despair.
B. Bargaining
-incorrect: During the stage of bargaining, the client stalls awareness of the loss by trying to keep it from occurring.
C. Depression
-During the stage of depression, the client has realized the full impact of the loss and might express hopelessness and despair.
D. Acceptance
-incorrect: During the stage of acceptance, the client will integrate the loss (ex: by making final arrangements).

177. A nurse is caring for an older adult client who becomes agitated when the nurse requests that the client’s dentures be removed prior to surgery. Which of the following responses should the nurse provide?
A. “It’s for your safety. Dentures can slip and block your airway during surgery.”
-incorrect: This represents the nontherapeutic communication technique of ignoring or dismissing the client’s feelings and does not address the client’s agitation.
B. “You wouldn’t want your teeth to be lost or broken during surgery, would you?”
-incorrect: This represents the nontherapeutic communication technique of disagreeing with the client and offering unsolicited advice. It does not address the client’s agitation.
C. “The anesthesiologist requires all clients to remove their dentures.”

-incorrect: This represents the nontherapeutic communication technique of focusing on inappropriate issues or individuals (the anesthesiologist). It does not address the client's agitation.
D. "What worries you about being without your teeth?"
-This response by the nurse is therapeutic because it validates the client's feelings of agitation and seeks a reason.

178. A nurse is planning to insert a nasogastric tube for client after explaining the procedure. The client states, "You are not putting that hose down my throat." Which of the following statements should the nurse make?
A. "Let's get the process over with because you won't get better without this tube."
-incorrect: This nontherapeutic response blocks communication by giving advice and threatening the client.
B. "You should talk to your provider about your fears."
-incorrect: This response blocks communication by rejecting the client's concerns and putting the client's feelings on hold, referring the client to another person at a later time.
C. "Why don't you want the tube to be inserted?"
-incorrect: The nurse should avoid "why" questions. This response also passes judgment, which is a barrier to communication.
D. "I can see that this is upsetting you."
-This response uses the therapeutic communication techniques of reflecting and restating, which encourages further communication by the client.

179. A nurse is planning an in-service training session about various dietary practices. Which of the following pieces of information should the nurse include in the teaching?
A. Ovo-vegetarian diets exclude eggs.
-incorrect: Ovo-vegetarian diets are primarily vegetable-based diets that exclude meat and dairy except for eggs.
B. Kosher diets have restrictions regarding how the food must be prepared.
-Kosher diets are guided by a set of laws regarding the processing, preparation, and eating of food.
C. Macrobiotic diets are plant-based and exclude all animals and seafood.
-incorrect: Macrobiotic diets are primarily plant-based but do include fish and seafood.
D. Flexitarian diets exclude the consumption of dairy products.
-incorrect: Flexitarian diets are primarily plant-based with the occasional consumption of meat. fish, and dairy products.

180. A nurse is planning care for a client who has anorexia and nausea due to cancer treatment. Which of the following interventions should the nurse include?
A. Serve foods at warm or hot temperatures
-incorrect: The nurse should make sure the client receives cold or room-temperature foods.
B. Offer the client low-density foods

-incorrect: To increase the nutritional value of food and the client's caloric intake, the nurse should make sure that the client receives high-protein, high-calorie, nutrient-dense foods. The client should also eat nutrient-dense foods first during meals.
C. Make sure the client lies supine after meals
-incorrect: To reduce nausea, the client should sit upright for 1 hour after meals. The client should also rest before meals to conserve energy for eating and digesting food.
D. Limit drinking liquids with food
-Drinking beverages with food leads to early satiety and bloating, which results in the client consuming fewer calories.

181. A nurse is calculating the protein needs of a young adult client who weighs 132lbs. The RDA for protein for an adult who has no medical conditions is 0.8g/kg. How many grams of protein per day should the nurse recommend for this client?

-48 g

182. A nurse is caring for a client who has protein malnutrition. Which of the following foods should the nurse identify as a source of complete protein?
A. Eggs
-Complete proteins contain all the essential amino acids to support growth and homeostasis. Examples of complete proteins include eggs, meat, poultry, seafood, milk, yogurt, cheese, soybeans, and soybean products.
B. Cereal
-incorrect: Incomplete proteins are missing one or more of the essential amino acids necessary to support growth and maintain homeostasis. Cereal is an example of an incomplete protein. However, it can be combined with skim milk to make a complete protein.
C. Peanut Butter
-incorrect: Peanut butter is an example of an incomplete protein. However, it can be combined with whole-wheat bread to make a complete protein.
D. Pasta
-incorrect: Pasta is an example of an incomplete protein. However, it can be combined with cheese to make a complete protein.

183. A nurse is caring for a client who is receiving total parenteral nutrition (TPN). Which of the following actions should the nurse take?
A. Administer 0.9% sodium chloride until TPN is available from the pharmacy.
-incorrect: The nurse should administer 10% dextrose in water or 20% dextrose in water if TPN is temporarily unavailable from the pharmacy.
B. Check the client's capillary blood glucose level every 4 hr
-The nurse should check the client's capillary blood glucose level every 4 hours or according to facility policy due to the client's risk of hyperglycemia while receiving TPN. The dextrose concentration in TPN increases the risk of this complication.
C. Obtain the client's weight each week

-incorrect: A client who is receiving TPN is at risk for fluid imbalance due to the fluid administration and hyperosmolarity of the TPN; therefore, the nurse should monitor the client's weight daily.
D. Change the IV tubing every 3 days
-incorrect: The nurse should change the IV tubing used for TPN every 24 hours to decrease the client's risk of infection.

184. A nurse is supervising a newly licensed nurse who is suctioning a client's tracheostomy. Which of the following actions by the newly licensed nurse indicates an understanding of the procedure?
A. Using clean technique to perform the procedure
-incorrect: The nurse should instruct the newly licensed nurse to use sterile technique rather than clean technique to suction a tracheostomy to reduce the risk of infection.
B. Applying suction while inserting the catheter
-incorrect: The nurse should instruct the newly licensed nurse to insert the catheter gently without applying suction to reduce the risk of hypoxia and tissue damage.
C. Lubricating the suction catheter with an oil-based lubricating jelly
-incorrect: The nurse should instruct the newly licensed nurse to lubricate the suction catheter with sterile saline rather than oil-based lubricating jelly to reduce the risk of aspiration pneumonia.
D. Administering high-flow oxygen prior to the procedure
-The nurse should instruct the newly licensed nurse to administer 3 to 4 breaths of 100% oxygen via a resuscitation bag before suctioning to the client to reduce the risk of hypoxia.

185. A nurse in a same-day procedure unit is caring for several clients who are undergoing different types of procedures. The nurse should anticipate that the client who has which of the following devices can safely undergo magnetic resonance imaging (MRI)?
A. Coronary artery stents
-incorrect: A coronary artery stent is a contraindication for undergoing MRI. The powerful magnetic field of the MRI system could pull on the metal stent and dislodge it.
B. Aneurysm clip
-incorrect: An aneurysm clip is contraindicated for undergoing MRI. The powerful magnetic field of the MRI system could pull on the metal clip and dislodge it.
C. Hearing aids
-A client who has hearing aids can undergo MRI because the hearing aids can be removed. The powerful magnetic field of the MRI system could damage the hearing aids, so they should be removed prior to the client undergoing MRI.
D. Automated internal defibrillator
-incorrect: An automated internal defibrillator is a contraindication for undergoing MRI. The powerful magnetic field of the MRI system could damage the defibrillator and cause it to malfunction.

186. A nurse is caring for a client who is postoperative following a vaginal hysterectomy and asks for a drink. Her postoperative diet prescription states “clear liquids; advance diet as tolerated.” Which of the following responses should the nurse make?
A. “Lunch trays should be here within the hour.”
-incorrect: This response is the nontherapeutic and indicates that the client’s immediate needs are not important.
B. “I am going to listen to your abdomen.”
-A common reason clients experience nausea and vomiting after surgery is delayed gastric emptying time or decreased peristalsis. The nurse should auscultate the client’s abdomen to determine the presence of bowel sounds before clear liquids can be administered.
C. “I’ll get you some water to drink.”
-incorrect: When a client is ready to resume a postsurgical diet, the nurse should offer clear liquids rather than water. Water provides hydration but no other nutrients.
D. “Let’s wait a bit so you don’t feel sick.”
-This response provides nontherapeutic communication by offering unsolicited advice to the client.

187. A nurse is changing the dressings for a client recovering from an appendectomy following a ruptured appendix. The client’s surgical would is healing by secondary intention. Which of the following observations should the nurse report to the provider?
A. Tenderness when touched
-incorrect: Tenderness when touched is an expected finding in a postoperative wound that is healing by secondary intention. Sever pain might indicate infection or underlying tissue destruction and should be reported.
B. Pink, shiny tissue with a granular appearance
-incorrect: Pink, shiny tissue with a grainy appearance is granulation tissue and indicates the proliferative stage of wound healing. This is an expected finding in a postoperative wound healing by secondary intention.
C. Serosanguineous drainage
-incorrect: Serosanguineous drainage, which is made up of RBCs and plasm, is an expected finding in a postoperative wound healing by secondary intention. Purulent drainage suggest infection and should be reported.
D. Halo of erythema on the surrounding skin
-The nurse should report to the provider when the client has a ring of erythema (redness) on the surrounding skin, which might indicate underlying infection. This and any other manifestation of infection (ex: purulent drainage, swelling, warmth, or a strong odor) should be reported to the provider.

188. A nurse is caring for a client with dehydration who has developed hypovolemic shock. Which of the following laboratory values should the nurse expect for this client?
A.BUN 18 mg/dL
-incorrect: This BUN falls within the expected reference range; therefore, it does not indicate hypovolemia.
B. Capillary refill 1.5 sec

-incorrect: This capillary refill time is within the expected reference range. With dehydration, it tends to be longer.
C. Hct 55%
-An elevated hematocrit indicates hypovolemia. Other indications of hypovolemia are a weak pulse, tachycardia, hypotension, tachypnea, slow capillary refill, elevated BUN, increased urine specific gravity, and decreased urine output.
D. Urine specific gravity 1.001
-incorrect: This low urine specific gravity indicates hypervolemia, not hypovolemia.

189. A nurse is caring for a client who was transferred to the surgical unit by stretcher from the PACU. Which of the following actions should the nurse perform immediately following the transfer?
A. Administer pain medication
-incorrect: The nurse should assess the client's pain and administer medication to relieve pain and promote comfort as needed. However, the nurse should take another action first.
B. Check the client's vital signs
-The greatest risk to this client is an injury from unstable vital signs (ex: hypotension and respiratory depression) after receiving anesthesia and medication. Therefore, the first action the nurse should take is to check the client's vital signs and compare them with the readings during the PACU stay.
C. Instruct the client to use the incentive spirometer every 1 hr
-incorrect: The nurse should instruct the client about using the incentive spirometer to prevent the development of atelectasis. However, the nurse should take another action first.
D. Provide ice chips as per provider prescription
-incorrect: The nurse should provide ice chips to the client as per provider prescription to promote comfort. However, the nurse should take another action first.

190. A nurse is performing a focused assessment of a client's peripheral vascular system. In which of the following locations should the nurse palpate the posterior tibial pulse?
A. Below the medial malleolus
-The nurse should palpate tibial pulse by curving the fingers around the medial malleolus on the inner surface of the client's ankle.
B. In the popliteal fossa
-incorrect: The nurse should evaluate the client's popliteal pulse by palpating behind the knee in the area of the popliteal fossa.
C. In the antecubital space
-incorrect: The nurse should evaluate the client's brachial pulse by palpating in the groove between the biceps and triceps muscles in the area of the antecubital fossa.
D. On the dorsum of the foot
-incorrect: The nurse should evaluate the client's dorsalis pedis pulse by palpating on the dorsum of the foot.

191. A nurse is measuring the blood pressure of several clients. Which of the following results is within the expected reference range for blood pressure?

A. 142/85 mmHg
B. 116/70 mmHg
-This blood pressure is within the expected reference range, which is any value <120 mmHg systolic and <80 mmHg diastolic
C. 130/76 mmHg
D. 124/82 mmHg

192. A nurse is obtaining a capillary blood sample to determine a client's blood glucose level. The nurse prepares and punctures the client's finger for the procedure but does not obtain an adequate amount of blood. Which of the following actions should the nurse take next?
A. Smear the small amount of blood onto the testing strip
-incorrect: Smearing the blood on the reagent strip will lead to an inaccurate result.
B. Hold the finger above heart level
-incorrect: To improve blood flow, the nurse should keep the client's hand in a dependent position.
C. Massage the client's fingertip
-incorrect: Massaging can hemolyze the specimen, leading to an inaccurate result.
D. Wrap the client's finger in a warm washcloth
-Warmth helps increase the blood flow to the client's finger.

193. A nurse is caring for a client who has a cuffed endotracheal tube in place. The nurse should identify that the purpose of inflating the cuff includes which of the following? (SATA)
A. Allowing the client to speak
-incorrect: The client cannot speak when an endotracheal tube is in place.
B. Stabilizing the position of the tube
C. Preventing aspiration of secretions
D. Preventing air leaks
-An inflated cuff helps prevent movement of the endotracheal tube, reduces the risk of aspiration of oropharyngeal secretions, and keeps air from leaking around the outer portion of the endotracheal tube.
E. Preventing tracheal injury
-incorrect: An inflated cuff does not prevent tracheal injury. If the cuff is overinflated and exerting a pressure that exceeds 25 mmHg, it can cause tracheal ischemia and necrosis.

194. A nurse is reviewing the laboratory values of a client who has positive Chvostek's sign. Which of the following laboratory findings should the nurse expect?
A. Decreased calcium
-Calcium is necessary for nerve conduction and muscle contractions. When the client's total calcium level is <8.4 mg/dL, tetany and muscle spasms may occur. The nurse should tap the facial nerve in front of the client's ear. If facial muscle twitching follows this stimulus, it if a positive Chvostek's sign and an indication of hypocalcemia.
B. Decreased potassium

-incorrect: Hypokalemia occurs when the client's potassium is <3.5 mEq/L. The nurse should assess the client for muscle weakness and other clinical manifestations of hypokalemia, not a positive Chvostek's sign.
C. Increased potassium
-incorrect: Hyperkalemia occurs when the client's potassium is >5.0mEq/L. The nurse should assess the client for muscle weakness, cardiac dysrhythmias, and other clinical manifestations of hyperkalemia but not a positive Chvostek's sign.
D. Increased calcium
-incorrect: Hypercalcemia occurs when the client's total calcium level is <10.5mg/dL. The nurse should assess the client for lethargy, weakness, and other clinical manifestations of hypercalcemia but not a positive Chvostek's sign.

195. A nurse is assessing a client who has fluid-volume excess. Which of the following findings should the nurse expect?
A. Crackles in the lung fields
-Manifestations of fluid-volume excess include crackles in the lungs, dependent edema, full neck veins when the client is upright, elevated blood pressure, and sudden weight gain.
B. Flat neck veins
-incorrect: Flat neck veins when the client is supine are a manifestation of fluid-volume deficit, not FVE.
C. Postural hypotension
-incorrect: Postural hypotension is a manifestation of FVD, not FVE.
D. Dark yellow urine
-incorrect: Dark yellow urine is a manifestation of FVD, not FVE.

196. A nurse is admitting a client who is experiencing an exacerbation of heart failure. At which of the following times should the nurse initiate discharge planning?
A. During the admission process
-The nurse should initiate discharge planning as soon as the client is admitted to the facility. This is intended to ensure the continuity of care and meet the client's care needs. This process should include each member of the client's health care team.
B. As soon as the client's condition is stable
-incorrect: The nurse should initiate discharge planning as soon as the client is admitted to the facility. Continuity of care can require a transfer of the client to another facility that can meet the client's health-care needs, especially for a client whose condition is not stable.
C. During the initial team conference
-incorrect: Although this process should include each member of the client's health care team, the nurse should initiate discharge planning as soon as the client is admitted to the facility.
D. On the day prior to discharge
-incorrect: The nurse should initiate discharge planning as soon as the client is admitted to the facility. Waiting until the day prior to discharge might not allow enough time to meet the client's needs upon discharge.

197. A nurse is caring for a client who is scheduled to receive transcutaneous electrical nerve stimulation (TENS) for pain management. The client asks the nurse how a TENS unit helps to relieve pain. Which of the following responses should the nurse take?
A. “It provides a distraction from the pain.”
-incorrect: The nurse should inform the client that distraction is a method that can draw the client’s attention away from the pain and help decrease the perception of pain. Methods can include visual, auditory, tactile, and intellectual distraction. However, this is not the way that a TENS unit helps relieve pain.
B. “It modulates the transmission of the pain impulse.”
-The nurse should inform the client that a TENS unit applies low-voltage electrical stimulation directly over a location of pain at an acupressure point. It modulates the transmission of the pain impulse and can also cause a release of endorphins to assist with pain relief.
C. “It promotes increased circulation to the painful area.”
D. “It elicits a relaxation response.”
-incorrect C/D: The nurse should inform the client that massage can be applied to facilitate relaxation, which decreases muscle tension. It can also decrease pain intensity by increasing superficial circulation to an area of the body experiencing pain. However, this is not the way that a TENS unit helps relieve pain.

198. A nurse is evaluating a client’s use of crutches. The nurse should identify that which of the following actions by the client indicates safe usage of this equipment?
A. The client places a crutch on each side when assuming a sitting position.
-incorrect: The client should place the crutches together in a hand and use the other hand to grasp the arm of the chair.
B. The client moves the unaffected leg onto a step first when descending stairs.
-incorrect: The client should move the crutches onto a step first when descending stairs, followed by the affected leg.
C. The client places weight on the axillae when walking.
-incorrect: The client should avoid placing weight on the axillae when walking. Continual pressure on the axillae can cause damage to the radial nerve, which can lead to crutch palsy or weakness of the muscles of the forearm, wrist, and hand.
D. The client has slightly flexed elbows when ambulating with the crutches.
-The client should have slightly flexed elbows when ambulating with crutches. This allows the client to bear weight on the hands and not on the axillae.

199. A nurse is developing a plan of care for a client. Which of the following pieces of information should the nurse consider when planning care that is culturally congruent?
A. Illness is not influenced by culture.
-incorrect: A client’s culture affects the social determinants of health and contributes to how an individual defines illness. Culture and life experiences play an important role in a client’s view about health, illness and health care.
B. The meaning of disease can vary widely across cultures.

- A client may define and react to disease based on his or her unique cultural perspective. The nurse should seek to understand a client's culture and life experiences in order to provide care that is effective, evidence-based, and culturally congruent.
C. Assigning clients to specific cultural categories facilitates communication.
-incorrect: The nurse cannot make the assumption that all clients within a specific culture have the same beliefs. The nurse should consider each client as an individual and respect individual life patterns, values, and definitions of illness in order to provide culturally congruent care.
D. Predetermined criteria should generate client care activities.
-incorrect: The nurse should consider that patterns of daily life and meaning are generated by the client, not predetermined criteria. To provide culturally congruent care, the nurse should adjust client care activities such as medication administration or bath time to the client's daily patterns.

200. A nurse is teaching an assistive personnel (AP) how to obtain a capillary finger-stick blood sample. Which of the following actions by the AP requires the nurse to intervene?
A. Elevating the finger above heart level
-The nurse should intervene if the client elevates the finger about the level of the heart. Holding the finger below the level of the heart in a dependent position will help increase blood flow to the area and ensure an adequate specimen for collection.
B. Rubbing the fingertip with an alcohol pad
-incorrect: The client should clean the finger with an antiseptic swab or with soap and water. The client should allow the finger to dry completely.
C. Puncturing the side of the fingertip
-incorrect: The client should puncture the side of the finger, avoiding sites beside bone.
D. Wrapping the finger in a warm cloth
-incorrect: The client should wrap the finger in a warm cloth to increase blood flow to the area.

201. A nurse is leading an education session about disposing of biohazardous materials. Which of the following instructions should the nurse include in the teaching?
A. Use isopropyl alcohol to clean blood spills
-incorrect: Chlorine bleach should be used to clean blood spills to reduce the risk of transmission of microorganisms.
B. Discard empty blood bags in a bedside trash can
-incorrect: Empty blood bags should be returned to the blood bank in case transfusion reaction occurs and to reduce the risk of transmission of microorganisms.
C. Break used needles before disposing
-incorrect: To reduce the risk of injury, used needles should not be broken or bent.
D. Place soiled linen in a single linen bag
-Soiled linen should be placed in a single bag that is tightly secured to reduce the risk of transmission of microorganisms.

202. A nurse is reviewing measures to prevent back injuries with assistive personnel (AP). Which of the following instructions should the nurse include?
A. Stand 3 feet from the client when assisting with lifting

-incorrect: The AP should stand as close as possible to the client to reduce back strain.
B. Lock your knees when standing for long periods of time
-incorrect: The AP should bend the knees and hips and rest the feet one at a time on a footrest when standing for long periods of time.
C. Life up to 22.6 kg (50lb) without the use of assistive devices
-The AP should use an assistive device or another person to lift an object weighing more than 15.8 kg (35 lb)
D. When lifting an object, spread your feet apart to provide a wide base of support
-The AP should spread the feet apart because a wide base of support increases stability.

203. A nurse is inserting an IV catheter for a client that results in a blood spill on her gloved hand. The client has no documented bloodstream infection. Which of the following actions should the nurse take?
A. Wash the gloved hands and then throw the gloves away
-incorrect: Washing the hands while still gloved is not a recommended action.
B. Prepare an incident report to document the event
-incorrect: Unless there is a break in the nurse's skin, there is no need for an incident report.
C. Carefully remove the gloves and proceed with hand hygiene
-Standard precautions require the use of gloves and hand hygiene in the care of all clients.
D. Ask the provider to order a blood culture to determine the risk of infection
-incorrect: Unless there is a break in the nurse's skin, there is no need for further investigation.

204. A community health nurse is conducting a class about body mechanics for county office workers. Which of the following instructions should the nurse include? (SATA)
A. "Sit with your back supported"
B. "Keep your knees at hip level"
C. "Use an ergonomically designed computer keyboard"
-Using lumbar support in a straight-back chair helps maintain posture and prevent back pain. Keeping the knees at the level of the hips or higher helps reduce the risk of lordosis, which is an exaggeration of the curve of the lumbar spine. Using a keyboard that maintains ergonomic positioning of the wrists can help prevent carpal tunnel syndrome.
D. "Keep your elbows away from your body."
-incorrect: Keeping the upper arms and elbows close to the body limits straining of the shoulders and the upper back muscles.
E. "Adjust the monitor screen so that you have to tilt your head slightly to look at it"
-incorrect: Tilting the screen and tilting the head to look at it can strain the cervical spine.

205. A nurse is caring for a client who requires wrist restraints. Which of the following actions should the nurse take?
A. Tie a secure knot with the restraint straps
-incorrect: The nurse must attach the restraint with a quick-release buckle or a knot that does not tighten when pulled.
B. Attach the restraint's straps to the bedside rails
-incorrect: Attaching the restraints straps to the bedside rails can lead to client injury.

C. Make sure 3 fingers fir beneath the restraints
-incorrect: The nurse should make sure 2 fingers fit under the restraints. If 3 fingers fit, the restraints are too loose. If only 1 finger fits, the restraints are too tight.
D. Remove the restraints at least every 2 hours
-The nurse should remove the restraints at least every 2 hours to reposition the client, provide fluids and nutrients, assist with ROM exercises, and evaluate the client's overall wellbeing.

206. A nurse is admitting a client who has measles. Which of the following types of transmission precautions should the nurse initiate?
A. Airborne
-Airborne precautions are required for clients who have infections that spread via droplet nuclei that are smaller than 5 microns in diameter, including varicella, tuberculosis, and measles.
B. Droplet
-incorrect: Droplet precautions are required for clients who have infections that spread via droplet nuclei that are larger than 5 microns in diameter, including rubella, meningococcal pneumonia, and streptococcal pharyngitis.
C. Contact
-incorrect: Contact precautions are required for clients who have infections that spread via direct contact or contact with the environment, including vancomycin-resistant Enterococci, methicillin-resistant staphylococcus aureus, and scabies.
D. Protective environment
-incorrect: Clients who have a compromised immune-system (ex: after an allogeneic hematopoietic stem cell transplant) require a protective environment.

207. A nurse rates a client's biceps reflex as 2+. Which of the following characteristics should the nurse document about the client's reflexes?
A. Diminished
-incorrect: diminished reflexes are 1+ or less.
B. Average
-Reflexes range on a scale of 0-4+. Active or expected reflexes are 2+.
C. Brisk
-incorrect: Brisk reflexes are 3+ or more
D. Hyperactive
-incorrect: Hyperactive reflexes are 4+.

208. A nurse is examining a client for signs of costovertebral angle tenderness. The nurse should place the client in which of the following positions for evaluation?
A. Sims
-incorrect: Sims position is used for rectal examinations and procedures.
B. Supine
-incorrect: Supine positioning is used for other types of assessment, such as thoracic and abdominal examinations.
C. Sitting

-The costovertebral angle is the area where the spine and the twelfth rib intersect. A sitting position promotes relaxation and allows access to the back for percussion of that region.
D. Standing
-incorrect: A standing position is used for observation of the client's posture.

209. A nurse is employing a thorough, systematic method while obtaining objective data about a client. Through which of the following methods should the nurse collect this information?
A. Health history
-incorrect: A health history uses subjective data, which come verbally from the client or client's representative.
B. Physical Examination
-Physical findings are objective, and the nurse should collect this information in a systematic way.
C. Review of systems
-incorrect: A review of systems uses subjective data that the nurse collects during the interview about the client's body system and mental status. These subjective data come from the client or client's representative.
D. Interview
-incorrect: The interview is a process by which the nurse collects subjective data from the client.

210. A nurse is assessing a client who is unconscious. Family members are present and answer the nurse's questions about the client's medical history. The nurse should document this information as which of the following types of data?
A. Secondary-source data
-Information provided by someone other than the client is secondary-source data.
B. Experimental data
-incorrect: Experimental data are information that the nurse collects and processes while caring for clients.
C. Primary-source data
-incorrect: Primary source data come from the client, not another person or group.
D. Quantitative data
-incorrect: Quantitative data are information the nurse can measure and document in numerals (ex: vital signs).

211. A nurse is conducting a health promotion class for a group of college students. Which of the following statements by a student should the nurse identify as a potential problem with achieving Erikson's developmental task for this age group?
A. "I am in no hurry to get married. I think I'll enjoy single life for a while."
-incorrect: Making choices about finding a partner and raising a family is part of fulfilling Erikson's developmental task of intimacy vs. isolation for this age group.
B. "I go home on the weekends to be with my family because I do not have any good friends here on campus."

-According to Erikson, the stage of psychosocial development for young adults is intimacy vs. isolation. This statement indicates that the student is having difficulty establishing relationships outside of the immediate family.
C. “I am interested in politics and may consider becoming an elected official.”
-incorrect: Making choices about civic responsibilities is part of fulfilling Erikson’s developmental task of intimacy vs. isolation for this age group.
D. “I am looking forward to finishing school and going to work for my family’s business.”
-incorrect: Making occupational choices is part of fulfilling Erikson’s developmental task of intimacy vs. isolation for this age group.

212. A nurse is teaching a newly licensed nurse about pain management in clients age 65 and older. Which of the following pieces of information should the nurse include in the teaching?
A. Clients who are age 65 or older experience a decreased ability to perceive pain compared to young adult clients.
-incorrect: Clients age 65 and older do not experience a decrease in pain perception.
B. Clients who are age 65 or older are reluctant to report pain.
-The nurse should instruct the newly licensed nurse that clients age 65 or older frequently can be reluctant to report pain because they might not want to bother or anger caregivers and might believe that pain is expected.
C. Clients who are age 65 or older should not receive opioid narcotics.
-incorrect: Clients age 65 and older can receive opioid narcotics for pain relief. However, these clients metabolize medications slowly and might require lower doses than younger adults.
D. Clients who are age 65 or older experience a shorter duration of action with medications than young adult clients.
-incorrect: Renal and liver function declines with age. Therefore, medications have a longer duration of action in clients who are age 65 and older. The nurse should frequently monitor these clients for adverse reactions and may need to administer a lower dosage of the medication at longer intervals compared to young adult clients.

213. A nurse at a screening clinic is assessing a client who reports a history of a heart murmur related to aortic valve stenosis. At which of the following anatomical areas should the nurse place the stethoscope to auscultate the aortic valve?
A. Fifth intercostal space just medial to the midclavicular line
-incorrect: The mitral valve is located in the fifth intercostal space just medial to the midclavicular line.
B. Second intercostal space to the left of the sternum
-incorrect: The pulmonic valve is located in the second intercostal space to the left of the sternum.
C. Fifth intercostal space to the left of the sternum
-incorrect: The tricuspid valve is located in the fifth intercostal space to the left of the sternum.
D. Second intercostal space to the right of the sternum
-The aortic valve is located in the second intercostal space to the right of the sternum. Aortic stenosis produces a mid-systolic ejection murmur that can be heard clearly at the aortic area with the client leaning forward.

214. A nurse is caring for a group of clients in a long-term care facility. The nurse should understand that which of the following clients is eligible for hospice services at this time?
A. A client who has multiple sclerosis and uses a wheelchair
-incorrect: Although multiple sclerosis is a chronic debilitating disease, the client is not likely to be eligible for hospice services.
B. A client who has end-stage cirrhosis
-A client who has end stage cirrhosis likely has a life expectancy of <6 months. Therefore, this client is eligible for hospice services.
C. A client who has hemiplegia due to a stroke
-incorrect: A client who has hemiplegia due to a stroke might recover partially or fully. Therefore, this client is not likely to be eligible for hospice services.
D. A client who has cancer and receives weekly radiation therapy
-incorrect: This client is currently undergoing treatment for cancer. Therefore, this client is not likely to be eligible for hospice services.

215. A nurse on a telemetry unit is caring for a client who had a myocardial infarction. The client states, “All this equipment is making me nervous.” Which of the following responses should the nurse offer?
A. “You won’t need the equipment for very long.”
-incorrect: This statement illustrates the communication block of giving false reassurance. The nurse cannot accurately predict how long the client will need the equipment.
B. “All of this equipment can be frightening.”
- This statement is therapeutic because the nurse is reflecting the client’s statement. The client is feeling fearful, and this response shows the nurse understands those feelings, which will encourage the client to communicate more.
C. “Why does the equipment bother you?”
-incorrect: This illustrates the communication block of requesting an explanation.
D. “Let me tell you about what each machine does.”
-incorrect: This response does not address the client’s concerns about feeling nervous and changes the subject.

216. A nurse is caring for a client who has terminal cancer. The client is proceeding with plans to build a new home. The nurse should identify that this behavior typically indicates which of the following stages of grief?
A. Acceptance
-incorrect: During the acceptance stage of grief, a client integrates the loss into his or her life (ex: by making final arrangements). Building a house does not usually reflect acceptance in a client who is dying.
B. Bargaining
-incorrect: During the bargaining stage of grief, a client stalls awareness of the loss by trying to keep it from occurring. Building a house does not usually reflect bargaining in a client who is dying.
C. Anger

-incorrect: During the anger stage of grief, a client shoes resistance or blames other people, a higher power, or the situation itself. Building a house does not usually reflect anger in a client who is dying.
D. Denial
-During the denial stage of grief, a client is unable to accept the reality of the loss. A client who has terminal disease has a limited amount of time, so building a house is unrealistic and denies reality.

217. A nurse is caring for a client who is producing large amounts of urine. The nurse should document this finding as which of the following?
A. Retention
-incorrect: Retention is an accumulation of urine in the bladder as a result of incomplete emptying of the bladder or a cessation of the ability to urinate.
B. Oliguria
-incorrect: Oliguria is a diminishing urine output despite an acceptable fluid intake.
C. Diuresis
-Diuresis or polyuria is the excretion of a high volume of urine. This condition has many causes, including metabolic and hormonal imbalances and diuretic therapy for treating renal, cardiovascular, and pulmonary disorders.
D. Dysuria
-incorrect: Dysuria is painful or difficult urination, often as a result of a urinary tract infection or injury.

218. A nurse is caring for a client who states that she does not want to get out of bed due to pain from arthritis. Which of the following actions should the nurse take?
A. Tell the client the provider does not want her to remain in bed
-incorrect: This is a nontherapeutic response that implies the client should do what the provider wants and suggest the client has no input or control over her situation.
B. Allow the client to remain in bed until her pain subsides
-incorrect: Allowing the client to remain in bed could place the client at risk of complications of immobility, such as thrombus formation.
C. Instruct the family to perform ADLs for the client
-incorrect: Having the family perform ADLs for the client limits the client's independence.
D. Advise the client to perform ROM exercises while in bed
-Performing ROM exercises will help the client maintain mobility until her pain is under control and she is able to ambulate without excessive discomfort.

219. A nurse is providing teaching about food choices to a client who has a prescription for a clear liquid diet. Which of the following selections by the client indicates an understanding of the teaching?
A. Cream of rice
-incorrect: cream of rice is allowed on a full liquid diet.
B. Cottage cheese
-incorrect: Cottage cheese is allowed on a soft diet.

C. Gelatin
-Foods allowed on a clear liquid diet are clear and liquid at room temperature.
D. Ice cream
-incorrect: Ice cream is allowed on a full liquid diet

220. A nurse in a provider's office is talking with an older adult client who reports having trouble sleeping. Which of the following statements should the nurse identify as possible cause of the client's sleeping difficulties?
A. "I take a warm shower when getting ready for bed."
-incorrect: A warm shower or bath can help the client relax and promotes sleep.
B. "I often have a cup of coffee with my dessert before going to bed."
-The client should avoid beverages that contain caffeine in the late afternoon and evening because caffeine stimulates the CNS and can result in sleep disturbances. Caffeine is also a diuretic and can cause nighttime awakenings for urination.
C. "I usually read a chapter in a book before I go to bed."
-incorrect: Reading before going to bed fosters relaxation in many individuals and might help promote sleep.
D. "I make sure I do my exercises in the morning."
-incorrect: Exercising vigorously within 2 hours of bedtime can interfere with sleep.

221. A nurse is caring for a client who is immobile. The nurse should recognize that immobility places the client at risk of which of the following health alterations?
A. Increased intestinal motility
-incorrect: Intestinal motility and peristalsis decrease with immobility.
B. Respiratory alkalosis
-incorrect: Immobility decreases respiratory movement, leading to poor oxygenation and carbon dioxide retention. If not corrected, the hypoventilation can eventually cause an immobile client to develop respiratory acidosis.
C. Decreased cardiac output
-During immobility, the client's heart rate increases to compensate for increased venous pooling. The reduction in circulating volume increases the workload of the heart, resulting in orthostatic hypotension and decreased cardiac output.
D. Hypocalcemia
-incorrect: Hypercalcemia occurs with immobility because bones demineralize from lack of weight-bearing. The excess calcium can deposit in joints, causing stiffness and pain.

222. A nurse is assessing a client who is postoperative. Which of the following findings should the nurse identify as an indication that the client is experiencing pain?
A. Diarrhea
-incorrect: Diarrhea is not a common indication of pain. Initial responses to the stress that results from unrelieved or chronic pain can trigger gastrointestinal alterations, which can include constipation and flatus.
B. Pupillary constriction
-incorrect: Pupillary dilation is a more common indication of pain.

C. Flushing
-incorrect: Flushing is not a common indicator of pain. Initial responses to the stress resulting from unrelieved or chronic pain can cause pallor due to the release of norepinephrine, which constricts superficial blood vessels.
D. Grimacing
-Besides the client's self-report of pain, facial expressions such as grimacing, clenching the jaw, and lip biting can be indications of pain.

223. During the completion of a health history with a nurse, a client reports intermittent chest pain for the past week. Which of the following questions is the nurse's priority?
A. "Did you report the chest pain episodes to your physician?"
-incorrect: Asking if the client notified the provider is important prior to the nurse reporting this finding to the provider. However, it is not the nurse's priority response. This question does not address the fact that the client is experiencing pain.
B. "Is there a history of heart disease in your family?"
-incorrect: Asking about a history of heart disease in the client's family is important for documenting the client's health history. However, it is not the nurse's priority response. This question does not address the fact that the client is currently experiencing pain.
C. "Have you had this pain before?"
-incorrect: Asking if the client had pain before these recent episodes is important for documenting the client's health history. However, it is not the nurse's priority response and does not address the fact that the client is currently having pain.
D. "Can you tell me what the pain felt like and show me exactly where it was?"
-Using the urgent vs. non-urgent approach to client care, the nurse should determine that the priority question for evaluating the client's pain is to quantify its characteristics, onset, duration, surrounding events, and location. This will help the nurse determine what action to take next.

224. A client has 1 L of dextrose 5% in 0.45% sodium chloride infusing IV at 125 mL/hr. How many hours will it take for the liter to infuse? (nearest whole number)

-8 mL/hr

225. A nurse is preparing to administer 40 mL of 0.9% sodium chloride IV to infuse over 20 mins. The drop factor of the manual IV tubing is 15 gtt/mL. The nurse should set the manual IV infusion to deliver how many gtt/min? (Nearest whole number)

-30 gtt/min

226. A nurse is preparing to administer eye drops to a client following surgery. Which of the following actions should the nurse take when instilling the eye drops?
A. Drop the eye medication into the lower conjunctival sac
-The nurse should drop the eye medication in the lower conjunctival sac to avoid placing the drops on the cornea and causing damage.
B. Apply gentle pressure to the outer opening of the eye for 2 min

-incorrect: The nurse should apply gentle pressure to the nasolacrimal duct after instilling the eye medication for 30-60 seconds to keep the medication from running down the duct or out of the eye.
C. Hold the eyedropper 0.5 cm (0.2 in) from the cornea
-incorrect: The nurse should hold the eyedropper 1 to 2 cm (0.4-0.8 in) from the lower conjunctival sac to protect the cornea of the eye from injury by preventing the tip of the dropper touching the eye.
D. Instruct the client to close the eyes tightly after administration
-incorrect: The nurse should instruct the client to close the eyes gently when applying ointment or liquid to distribute the medication and to avoid expelling the medication or injuring the eye.

227. A nurse is preparing to administer a medication to a client. Which of the following administration schedules should the nurse identify as a prescription to administer the medication once and as soon as possible?
A. Stat prescription
-A stat medication prescription is carried out immediately or as soon as possible and for one time only.
B. PRN prescription
-incorrect: A PRN medication prescription refers to administering a medication as needed.
C. Standing prescription
-incorrect: A standing medication prescription indicates the frequency a prescribed medication is administered on a daily basis and might not have any specific date of cancelation.
D. Single prescription
-incorrect: A single medication prescription refers to administering a medication once and at a specified time.

228. A nurse is performing a physical assessment of a client. The nurse should recognize that which of the following findings places the client at risk of impaired skin integrity?
A. 3+ Achilles reflex
-incorrect: A 3+ Achilles reflex does not indicate a risk of impaired skin integrity. Reflex testing provides information about the sensory and motor functions of the neurological system. A 3+ reflex indicates a more active reflex than expected.
B. Faint pedal pulses
-Faint pedal pulses can indicate poo circulation and tissue perfusion, which puts the client at risk of impaired skin integrity.
C. Feet warm to touch bilaterally
-incorrect: Feet are warm to touch bilaterally do not indicate a risk of impaired skin integrity. This finding provides an indication of the adequacy of the client's peripheral circulation.
D. Capillary refill of <2 sec
-incorrect: A capillary refill of <2 seconds does not indicate a risk of impaired skin integrity. This finding provides information about the adequacy of tissue perfusion.

229. A nurse is performing a physical assessment of a client. Which of the following actions should the nurse take to assess the client's tissue perfusion?

A. Perform a Romberg test
-incorrect: A Romberg test is used to assess a client's balance and gross motor function. It is not used to assess tissue perfusion.
B. Check nails for Beau's lines
-incorrect: Beau's lines are depressions in the nail from temporary disturbance of nail growth. Beau's lines are caused by systemic illness or injury and are not indicators of tissue perfusion.
C. Palpate for respiratory excursion
-incorrect: Respiratory excursion is palpated to determine thoracic expansion and depth of breathing. It is not used to assess tissue perfusion.
D. Perform a blanch test
-The blanch test is used to check capillary refill, which is an indicator of peripheral circulation and tissue perfusion.

230. A nurse is teaching a client who has low back pain about heat therapy. Which of the following statements by the client indicates an understanding of the teaching?
A. "I need to place a towel between the heating pad and my skin."
-The nurse should instruct the client to place a towel between the heating pad and the skin to reduce the risk of burns.
B. "I'll need to turn up the temperature if I can't feel the heat."
-incorrect: The nurse should instruct the client not to increase the temperature because this can cause burns.
C. "I'll sleep on top of the heating pas to increase the heat penetration."
-incorrect: The nurse should instruct the client not to sleep on top of the heating pad because this can result in burns.
D. "Keeping the heat continuously on my back will help it heal."
-incorrect: The nurse should instruct the client to apply heat for 30 mins at a time to reduce the risk of burns.

231. A nurse is using the Braden scale to predict the pressure ulcer risk of a client in a long-term care facility. Using this scale, which of the following parameters should the nurse evaluate?
A. Incontinence
-incorrect: Incontinence is a parameter on the Norton scale, not the Braden scale.
B. Mental state
-incorrect: Mental state is a parameter on the Norton scale, not the Baden scale.
C. Nutrition
-Nutrition, sensory perception, moisture, activity, mobility, and friction and shear are the parameters on the Braden scale for determining a client's risk of developing pressure ulcers.
D. General physical condition
-incorrect: General physical condition is a parameter on the Norton scale, not the Braden scale.

232. A nurse is teaching a client how to self-administer insulin. Which of the following actions should the nurse take to evaluate the client's understanding of the process within the psychomotor domain of learning?
A. Ask the client if he wants to self-administer his insulin

-incorrect: Asking the client if he wants to self- administer his insulin evaluates the client's understanding within the affective domain of learning.
B. Have the client list the steps of the procedure
-incorrect: Having the client list the steps of the procedure evaluates the client's learning within the cognitive domain.
C. Have the client demonstrate the procedure
-Having the client demonstrate the procedure provides the nurse the ability to evaluate the client's understanding within the psychomotor domain of learning.
D. Ask the client if he understands the purpose of insulin
-incorrect: Asking the client if he understands the purpose of insulin evaluates the client's understanding within the cognitive domain of learning.

233. A nurse is teaching a client who is postoperative how to use a flor-oriented incentive spirometer. Which of the following instructions should the nurse include?
A. Blow into the spirometer to elevate the balls in the device
-incorrect: The nurse should instruct the client to inhale deeply to elevate the balls in the device.
B. Cough deeply after each use
-Proper use of the incentive spirometer loosens secretions in the client's lungs. The client should cough deeply to facilitate the removal of secretions from his lungs.
C. Clean the mouthpiece with an alcohol swab after each use
-incorrect: The nurse should instruct the client to clean the mouthpiece with water and dry it after each use.
D. Use the spirometer every 8 hr
-incorrect: The nurse should instruct the client to use the spirometer several times every hour while awake.

234. A nurse is administering a cleansing enema to a client who is scheduled for a diagnostic procedure. Which of the following actions should the nurse take?
A. Lubricate up to 3.2 cm (1.25 in) of the tip of the rectal tube
-incorrect: The nurse should lubricate 5-8 cm (2-3 in) of the tip of the rectal tube before inserting it to decrease the risk of irritation or injury to the mucosa.
B. Position the client on the right side
-incorrect: The nurse should position the client on the left side and in the Sims position to allow the solution to flow downward into the sigmoid colon and rectum and promote retention of the enema
C. Insert the tip of the tubing 8 cm (3.1 in)
-The nurse should insert the tip of the tubing 7-10 cm (3-4 in) along the rectal wall to prevent dislodging of the tube during procedure and avoid injury to the rectal mucosa.
D. Hold the enema container 61 cm (24in) above the rectum
-incorrect: The nurse should hold the enema container a maximum of 45 cm (18 in) above the rectum to prevent painful distention of the colon.

235. A nurse is caring for a client who is 48 hr postoperative following a small bowel resection. The client reports gas pains in the periumbilical area. The nurse should plan care based on which of the following factors contributing to this postoperative complication?
A. Blood loss
-incorrect: Blood loss can cause shock but does not contribute to the findings demonstrated by this client.
B. NPO status after surgery
-incorrect: NPO status after surgery can cause dehydration but does not contribute to the findings demonstrated by this client.
C. Nasogastric tube suctioning
-incorrect: Nasogastric tube suctioning keeps the stomach and intestines decompressed and can help prevent the findings demonstrated by this client.
D. Impaired peristalsis of the intestines
-Normal bowel function is delayed for up to several days following a bowel resection. When peristalsis is absent or sluggish, intestinal gas builds up, producing pain and abdominal distention. The nurse should plan to help the client ambulate to promote peristalsis.

236. A nurse in the emergency department is assessing a client who has deep, rapid respirations. Arterial blood gas analysis includes the following values: pH 7.25, $PaCO_2$ 40, and HCO_3^- 18. Which of the following acid-base imbalances should the nurse identify and report to the provider?
A. Respiratory alkalosis
-incorrect: With respiratory alkalosis, the pH is elevated.
B. Metabolic alkalosis
-incorrect: With metabolic alkalosis, the pH is elevated.
C. Respiratory acidosis
-incorrect: With respiratory acidosis, the $PaCO_2$ is elevated.
D. Metabolic acidosis
-A pH of 7.25 indicates acidosis. If the cause is respiratory, pH and $PaCO_2$ values will deviate in opposite directions. Since $PaCO_2$ is within the expected reference range, despite the low pH, the cause must be metabolic. Therefore, the nurse should report to the provider that the client has metabolic acidosis.

237. A nurse is measuring a client's vital signs. The client's heart rate is 105/min. The nurse should document this finding as which of the following alterations?
A. Palpitation
-incorrect: A palpitation is a subjective feeling of the heart "skipping a beat" or fluttering.
B. Bradycardia
-incorrect: Bradycardia is a heart rate under 60/min in adults.
C. Tachycardia
-Tachycardia is a heart rate over 100/min in adults.
D. Dysrhythmia
-incorrect: Dysrhythmia is an irregularly or erratic heart rhythm.

238. A nurse is caring for a client who begins having a tonic-clonic seizure while sitting in a chair at the bedside. Which of the following actions should the nurse take first?
A. Provide oxygen
-incorrect: The nurse might need to provide oxygen to the client during the postictal phase; however, there is another action the nurse should take first.
B. Place the client in a side-lying position
-incorrect: The nurse should place the client in a side-lying position if possible, to keep the airway clear; however, there is another action the nurse should take first.
C. Provide privacy
-incorrect: The nurse should provide pirvacy by closing the privacy curtain or the door to the client's room; however, there is another action the nurse should take first.
D. Lower the client to the floor
-The nurse should apply the safety and risk reduction priority-setting framework. Which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's hierarchy of needs, the ABC priority setting-framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client. Therefore, if a client begins to have a seizure while sitting or standing, the nurse should first lower the client to the floor to protect the client from injury.

239. A nurse is caring for a client who has peripheral edema. The nurse should identify that which of the following nutrients regulates extracellular fluid volume?
A. Sodium
-Sodium regulates extracellular fluid balance, nerve impulse transmission, acid-base balance, and various other cellular activities.
B. Calcium
-incorrect: Calcium supports bone and tooth formation and facilitates nerve impulse transmission. However, it does not affect extracellular fluid volume.
C. Potassium
-incorrect: Potassium affects storage of glycogen, nerve impulse transmission, cardiac conduction, and smooth muscle contraction. However, it does not affect extracellular fluid volume.
D. Magnesium
-incorrect: Magnesium affects enzyme and neurochemical activities and the excitability of cardiac and skeletal muscles. However, it does not affect extracellular fluid volume.

240. A nurse is caring for a client who requires ventilatory assistance with breathing following a motor vehicle crash. The nurse should suspect an injury to which of the following parts of the brain?
A. Hypothalamus
-incorrect: The nurse should suspect an injury to the hypothalamus if a client is experiencing difficulty with sleeping. This area of the brain serves as the sleep center in the body by secreting hypocretins, which promote rapid eye movement (REM).
B. Cerebral cortex

-incorrect: The nurse should suspect an injury to the cerebral cortex if a client is experiencing difficulty with expression. This area of the brain contains the neural networks that facilitate complex behaviors like learning, memory, and language.
C. Brainstem
-The nurse should identify an injury to the medulla and pons of the brainstem for a client who is experiencing difficulty with breathing. The brainstem serves as the respiratory control center, and a neurological injury can impair this center and inhibit respiratory effort.
D. Cerebellum
-incorrect: The nurse should suspect an injury to the cerebellum if a client is experiencing difficulty controlling balance and coordination. A client's movements can become uncoordinated, unsure, and clumsy following an injury to this area of the brain.

241. A nurse is caring for a client who has xerostomia with a lack of saliva. Which of the following nutrients will be affected by the lack of salivary amylase?
A. Fat
-incorrect: Lipase breaks down fat.
B. Protein
-incorrect: Pepsin breaks down proteins.
C. Starch
-Salivary amylase begins the process of digestion in the mouth with the initial breakdown of starches. The majority of starch breakdown occurs in the small intestine with pancreatic amylase.
D. Fiber
-incorrect: Fiber is not digestible, but fermentation occurs in the large intestine by intestinal microbes, which results in the release of methane, hydrogen, water, and fatty acids.

242. A nurse is preparing to administer an afternoon dose of ampicillin to a client. The client appears upset and refuses to take the medication before throwing the pill on the floor. Which of the following entries should the nurse enter into the client's medical record?
A. The client refused to take medication today.
-incorrect: The nurse should be specific when documenting information in the client's medical record. The nurse should document the name of the medication, the dose, and the time the client refused to take the medication.
B. The client stated, "I will not take this pill."
-incorrect: The nurse should only document information that is factual. The nurse should not quote a client as having stated something that the client did not say. Even though the client implied a refusal of the medication, the nurse should document the occurrence accurately in the medical record.
C. The client seemed angry and hostile.
-incorrect: The nurse should avoid the use of vague terminology when documenting an occurrence in the client's medical record because this can indicate the nurse is stating an opinion.
D. The client threw the medication on the floor.

-The nurse should document exactly what took place to provide an accurate, factual account of the events. Thus, the nurse should document the client's actions in the medical record.

243. A nurse is caring for a client who has breast cancer. The client has been receiving radiation therapy for several months and now refuses to undergo further treatment. Which of the following actions should the nurse take?
A. Suggest the client talk with someone who has survived breast cancer
-incorrect: By suggesting that the client talks with a cancer survivor, the nurse is challenging the client's decision, which indicates the nurse is not considering the client's feeling.
B. Encourage the client not to give up
-incorrect: By encouraging the client not to give up, the nurse is passing judgment on the client, which indicates that the nurse disapproves of the client's decision.
C. Support the client's decision
- The nurse has the responsibility to support the client's decision and respect the client's right of refusal. The nurse should notify the provider of the client's decision and document the refusal in the client's medical record.
D. Refer the client to a counselor
-incorrect: By referring the client to a counselor, the nurse is challenging the client's decision, which will make the client feel defensive.

244. A nurse is assisting a client who has right-sided weakness while ambulating using a cane. Which of the following client actions should indicate to the nurse that the client understands the procedure of cane walking?
A. The client holds the cane on the affected side
-incorrect: When ambulating with a cane, the client should hold the cane on the unaffected or stronger side of the body.
B. The client advances the unaffected leg followed by the cane
-incorrect: When ambulating with a cane, the client should advance the cane and then follow it with the unaffected or stronger leg.
C. The client supports this weight on the unaffected leg when moving the cane forward
-incorrect: When ambulating with a cane, the client should support weight on both legs when moving the cane forward.
D. The client keeps 2 points of support on the ground
-When ambulating with a cane, the client should keep 2 points of support on the ground at all times, which can be either both feet or a foot and the cane.

245. A nurse is assessing a client who reports nausea and vomiting for 2 days. Which of the following findings should indicate to the nurse that the client is experiencing fluid volume deficit?
A. Decreased urine specific gravity
-incorrect: An increase in urine gravity should indicate to the nurse that the client is experiencing fluid volume deficit.
B. Increased heart rate

-An increased heart rate should indicate to the nurse that the client is experiencing fluid volume deficit. Other findings can include an increased BUN level, dry mucous membranes, and dark yellow urine.
C. Decreased hematocrit
-incorrect: An increased hematocrit should indicate to the nurse that the client is experiencing fluid volume deficit.
D. Increased skin turgor
-Poor skin turgor should indicate to the nurse that the client is experiencing fluid volume deficit.

246. A nurse is caring for a client who has a temperature of 38.7 C (101.7 F). Which of the following action should the nurse take?
A. Apply an alcohol-water solution to the client's skin
-incorrect: This therapy is no longer recommended as an intervention for a fever because it can lead to shivering, which is counterproductive and can cause an increase in energy expenditure.
B. Keep the client's bed linens dry
-The nurse should maximize the client's heat loss by keeping the client's clothes and bed linens dry. The nurse should also reduce external coverings on the client's bed without causing shivering.
C. Apply ice packs to the groin
-incorrect: This therapy is no longer recommended as an intervention for fever because it can lead to shivering, which is counterproductive and can cause an increase in energy expenditure.
D. Limit the client's fluid intake to 1183 mL (40 0z) of fluid per day
-incorrect: The nurse should satisfy the client's increased metabolic needs by providing the client with at least 1893 mL (64 oz) of fluid per day.
247. A nurse is teaching an assistive personnel (AP) how to obtain a capillary finger-stick blood sample. Which of the following actions by the AP requires the nurse to intervene?
A. Elevating the finger above heart level
-The nurse should intervene if the client elevates the finger above the level of the heart. Holding the finger below the level of the heart, in a dependent position; will help increase blood flow to the area and ensure an adequate specimen for collection.
B. Rubbing the fingertip with an alcohol pad
-incorrect: The client should clean the finger with an antiseptic swab or with soap and water. The client should allow the fingertip to dry completely.
C. Puncturing the side of the fingertip
-incorrect: The client should puncture the side of the finger, avoiding sites beside bone.
D. Wrapping the finger in a warm cloth
-incorrect: The client should wrap the finger in a warm cloth to increase blood flow to the area.

248. A nurse is auscultating a client's lungs and identifies rhonchi over the trachea and bronchi. Which of the following actions should the nurse take?
A. Limit the client's fluid intake
-incorrect: The nurse should not limit the client's fluid intake for rhonchi heard over the trachea and bronchi. The nurse should attempt to clear the adventitious sounds by asking the client to cough.

B. Assist the client into a supine position
-incorrect: The nurse should not assist the client into a supine position for rhonchi heard over the trachea and bronchi. The nurse should assist the client into an upright position to facilitate breathing.
C. Administer oxygen at 2 L/min
-incorrect: The nurse should administer oxygen to a client who is experiencing shortness of breath or is displaying an oxygen saturation level below the expected reference range of 95% to 100%.
D. Encourage the client to cough
-Rhonchi are loud, low-pitched, rumbling sounds primarily detected over the trachea and bronchi. The nurse should encourage the client to cough because doing so clears this adventitious sound.

249: A nurse is caring for a client who is postoperative following vascular surgery on the left femoral artery. The nurse should identify that the surgical wound should be cleansed in which of the following directions?
A. From the middle of the thigh toward the wound
B. From the left lower abdominal quadrant toward the wound
C. From the left hip toward the wound
D. From the wound toward the surrounding skin
-The nurse should cleanse a surgical wound from the least contaminated location (the inside of the wound) toward the most contaminated location (the surrounding skin).

250. A nurse is caring for a client who is scheduled to receive transcutaneous electrical nerve stimulation (TENS) for pain management. The client asks the nurse how a TENS unit helps relieve pain. Which of the following responses should the nurse make?
A. “It provides a distraction from the pain.”
-incorrect: The nurse should inform the client that distraction is a method that can draw the client’s attention away from the pain and help decrease the perception of pain. Methods can include visual, auditory, tactile, and intellectual distraction. However, this is not the way that a TENS unit helps relieve pain.
B. “It modulates the transmission of the pain impulse.”
-The nurse should inform the client that a TENS unit applies low-voltage electrical stimulation directly over a location of pain at an acupressure point. It modulates the transmission of the pain impulse and can also cause a release of endorphins to assist with pain relief.
C. “It promotes increased circulation to the painful area.”
D. “It elicits a relaxation response.”
-incorrect C/D: The nurse should inform the client that massage can be applied to facilitate relaxation, which decreases muscle tension. It can also decrease pain intensity by increasing superficial circulation to an area of the body experiencing pain. However, this is not the way that a TENS unit helps to relieve pain.

251. As part of a neurological examination, a nurse instructs a client to keep his eyes closed, places an object in his hand, and asks him to identify the object. Which of the following abilities is the nurse evaluating with this technique?
A. Gustation
-incorrect: Gustation is the ability to taste.
B. Stereognosis
-Stereognosis is the ability to identify an object's size, shape and texture via tactile sensation.
C. Proprioception
-incorrect: Proprioception is the awareness of the position of the body.
D. Kinesthesia
-incorrect: Kinesthesia is the ability to sense the position and movement of the body parts without visualizing them.

252. A nurse is preparing to anchor the catheter tube with tape for a male client who has a newly inserted indwelling urinary catheter. At which of the following locations should the nurse tape the catheter?
A. Lateral thigh
-incorrect: Taping the indwelling urinary catheter to the client's lateral thigh or outside thigh can cause discomfort and tissue injury due to pressure on the urethra at the penoscrotal junction.
B. Lower abdomen
-The nurse should secure the client's indwelling urinary catheter with tape to the lower abdomen or the upper aspect of the thigh to eliminate the penoscrotal angle and prevent tissue injury.
C. Mid-abdominal region
-incorrect: Taping the indwelling urinary catheter to the client's mid-abdominal region can cause discomfort and does not allow the downward flow of urine via gravity into the drainage bag.
D. Medial thigh
-incorrect: Taping the indwelling urinary catheter to the client's medial or mid-thigh area can cause discomfort due to pressure on the urethra at the penoscrotal junction and can lead to tissue injury.

253. A nurse is caring for a client who has emphysema. The client has not stopped smoking cigarettes and states, "it's too late for me to quit." Which of the following actions should the nurse take?
A. Assist the client in finding local smoking-cessation assistance programs
-Smoking cessation slows the progression of chronic obstructive pulmonary disease (COPD). It is not "too late" for this client to stop smoking, and the nurse should encourage the client to do so.
B. Tell the client that she will be all right receiving medical care
-incorrect: This is an example of the nontherapeutic communication technique of giving false reassurance. Without smoking cessation, the client's condition will likely deteriorate further.
C. Inform the client that she must stop smoking or the provider will not be able to care for her

-incorrect: Threatening the client with potential harm due to lack of care is unethical and abusive. This action by the nurse will not help the client stop smoking. Also, in this context, the nurse's action violates the ethical principle of beneficence.
D. Advocate for the client by supporting her statement about not quitting
-incorrect: Advocacy aims to improve a client's health and safety. Rather than advocating for the client, the nurse is simply agreeing with the client, which is a nontherapeutic communication technique.

254. A nurse is providing teaching about crutches to a client who has a fracture of the right foot. Which of the following instructions should the nurse include?
A. "When you go up a flight of stairs, place your right foot on the first step."
-incorrect: The client should put his weight on the crutches, place his left foot on the first step, transfer his weight to the left foot, move the crutches to the step, and then bring up his right foot.
B. "Keep the rubber crutch tips securely in place."
-The client should never use crutches without the rubber crutch tips. The client should inspect the tips regularly, replace them when they show signs of wear, and remove and dry them thoroughly with paper towels if they become wet.
C. "When standing, keep the crutches 12 inches in front of you and 12 inches to the side."
-incorrect: The basic crutch stance should have the crutches 15 cm (6in) in front and 15 cm (6in) to the side of the client's feet, forming a tripod or triangular position.
D. "Place your weight on the crutch pads at your armpits."
-incorrect: The client should have his arms bear the weight of his body. Pressure on the axillae can damage the radial nerve and cause weakness and partial paralysis below his elbows.

255. A nurse is changing the dressings for a client who has 2 Penrose drains near an abdominal incision. Which of the following adhering devices is the best choice for the nurse to use to decrease skin irritation?
A. Abdominal binder
-incorrect: An abdominal binder can hold the dressings in place and decrease skin irritation while the client rests in bed; however, when the client ambulates, the dressings tend to slide out. Securing the dressings first is the preferred method when applying a binder. Therefore, the nurse should use a less-restrictive intervention first.
B. Montgomery straps
-The nurse should apply the least-restrictive priority-setting framework, which assigns priority to nursing interventions that are the least restrictive to the client, as long as those interventions do not jeopardize client safety. Least-restrictive interventions promote restraints when the safety of the client, staff members, or others is at risk. The nurse should plan to use Montgomery straps to minimize irritation of the skin near the incisional area. Montgomery straps are adhesive strips applied to the skin on either side of the surgical wound. The adhesive strips have holes for using gauze to tie the dressing securely. When the dressing is change, the ties are released, the dressing is replaced, and the ties are secured again without removing the adhesive strips.
C. Hypoallergenic tape

-incorrect: Hypoallergenic tape is used when a client is sensitive to adhesive material; however, hypoallergenic tape can cause skin sensitivity when frequently removed and reapplied. The nurse should use a less-restrictive intervention first.
D. Plastic tape
-incorrect: Plastic tape adheres well to skin and can cause skin sensitivity when frequently removed and reapplied. However, the nurse should use a less-restrictive intervention first.

256. A nurse is reviewing a client's laboratory results. The client's ABG levels are pH 7.5, PaCO2 32 mmHg and HCO3- 24 mEq/L. The nurse should determine that the client has which of the following acid-base imbalances.
A. Respiratory alkalosis
-This client's pH is elevated above the expected reference range of 7.35 to 7.45, indicating alkalosis. Additionally, the client's PaCO2 is below the expected reference range of 35 to 45 mmHg, which indicates a respiratory origin. Hence, the nurse should conclude that the client's elevated pH and decreased PaCO2 indicate respiratory alkalosis.
B. Metabolic acidosis
-incorrect: ABGs are drawn to determine the acid-base balance in the arterial blood. Acidosis is determined by measuring a pH lower than the expected reference range of 7.35-7.45. This client has a pH of 7.5 and therefore does not have acidosis.
C. Respiratory acidosis
-incorrect: This client's pH is elevated above the expected reference range of 7.35-7.45. Acidosis is presented by a lower pH, usually below 7.35.
D. Metabolic alkalosis
-incorrect: Metabolic origin is determined by examining the HCO3- levels. The client's bicarbonate is within the expected reference range of 22 to 26 mEq/L.
257. A nurse is caring for a client who has a hearing impairment. Which of the following interventions should the nurse use when speaking with the client?
A. Speak directly into the client's impaired ear
-incorrect: The nurse should speak toward the client's better ear. Moving closer to the better ear facilitates communication.
B. Exaggerate lip movements
-incorrect: The nurse should accentuate words, especially consonants, so the information does not sound like mumbling. The client's ability to read lips is inhibited when using exaggerated lip movements.
C. Speak loudly
-incorrect: Speaking loudly or shouting can cause distortion because sounds are at a higher pitch.
D. Face the client when speaking
-The nurse should directly face the client who has a hearing impairment and stand or sit at the same level to maximize communication. Many clients who are hearing-impaired combine lip reading with their residual hearing when communicating.

258. A nurse is caring for a client who has methicillin-resistant Staphylococcus aureus (MRSA). Which of the following precautions should the nurse implement?

A. Place the client in a semi-private room
-incorrect: The nurse should place the client in a private room when a wound is contaminated with a virulent or multi-drug resistant organism such as MRSA.
B. Wear a mask when providing care
-incorrect: The nurse should wear a mask when a client has an infection that can be transmitted via airborne or droplet routes. When splashing or spraying of body fluids is anticipated, the nurse will require full-face protection.
C. Wear a gown when in the client's room
-The nurse should apply a gown at all times when in the client's room to maintain contact precautions. This client who has MRSA should be placed in contact isolation, which includes the use of gloves and a gown when providing care.
D. Dispose of all bed linens used by the client
-incorrect: The nurse should use moisture-resistant single bags to collect linen. The nurse should not overfill and should tie the bag securely to prevent the transmission of microorganisms. The nurse should double bag the initial bag if the outside becomes contaminated. The linens should be properly sanitized and reused.

259. A nurse is measuring a client's vital signs and notices an irregularity in the pulse. Which of the following actions should the nurse take?
A. Measure the pulse using a Doppler ultrasound stethoscope
-incorrect: The nurse should use Doppler ultrasound stethoscope for a pulse that is nonpalpable or difficult to palpate.
B. Check the client's pedal pulses
-incorrect: The nurse should assess pedal pulses to determine circulation in the client's lower extremities.
C. Count the apical pulse rate for 1 full min and describe the rhythm in the chart
-If the peripheral pulse is irregular, the nurse should auscultate the apical pulse for 60 seconds to obtain an accurate rate. Then, the nurse should document the irregularity in the client's medical record.
D. Take the pulse at each peripheral site and count the rate for 30 sec
-incorrect: The nurse should assess all peripheral pulses to determine the equality of blood perfusion to the extremities.

260. A nurse is caring for a client who has a history of dysrhythmias. Upon entering the room, the nurse discovers the client is unresponsive to verbal or painful stimuli, has no respirations, and is pulseless. Which of the following actions should the nurse take first?
A. Start chest compressions
-The nurse should apply the safety and risk-reduction priority-setting framework, which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's hierarchy of needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client. The nurse should perform cardiopulmonary resuscitation, which starts with chest compressions followed by

opening the airway and breathing for adults and pediatric clients; evidence indicates a great survival rate when chest compressions are started before a breath is initiated.
B. Provide breaths with a manual resuscitation bag
-incorrect: The nurse should provide breaths with a manual resuscitation bag to oxygenate a client during cardiopulmonary resuscitation; however, there is another action the nurse should take first.
C. Administer oxygen
-incorrect: The nurse should administer oxygen to a client to ensure adequate oxygen is circulating during cardiopulmonary resuscitation; however, there is another action the nurse should take first.
D. Establish an airway
-incorrect: The nurse should establish an airway to perform ventilations and oxygenate the client during cardiopulmonary resuscitation; however, there is another action the nurse should perform first.

261. A nurse is admitting a client who has a hearing aid. Which of the following actions should the nurse take before beginning the interview process?
A. Sit beside the client during the interview
B. Make sure the device is functioning
-The nurse should ensure that all of the client's assistive devices are working before beginning the interview process
C. Make sure lighting in the room is soft
-incorrect: Room lighting should be bright enough to maximize the client's ability to see the nurse's mouth during the interview.
D. Provide a lengthy interview process to allow adequate time to answer questions
-incorrect: The interview process should be brief, so it does not tire the client. The nurse can gather additional data at a later time.

262. A nurse is teaching a group of unit nurses about the experiences of clients who are having surgery. In which phase of care is the client transferred to the surgical suite table before being transferred to the PACU?
A. Preoperative
-incorrect: Preoperative care begins when the client agrees to have surgery and ends when the client is transferred to the surgical suite.
B. Postoperative
-incorrect: Postoperative care begins when the client is admitted to the PACU and ends when healing is complete.
C. Intraoperative
-Intraoperative care begins when the client is transferred to the surgical suite table and ends when the client is admitted to the PACU.
D. Admission
-incorrect: The client's admission to the facility where the surgery is to take place is part of the preoperative phase and typically occurs outside of the surgical suite.

263. A nurse is preparing to insert an NG tube for a client who requires enteral feedings. Which of the following instructions should the nurse give the client before beginning the procedure?
A. “Inhale forcefully during insertion.”
B. “Raise your index finger if you need to pause during the insertion.”
-The nurse should instruct the client that the insertion of an NG tube is uncomfortable, and the gag reflex will be activated during the procedure. The nurse should establish a communication technique such as having the client raise a finger or hand to indicate distress and the need to pause the insertion process.
C. “Bear down during insertion.”
-incorrect A/C: The nurse should instruct the client to breathe through the mouth and swallow during the insertion of the tube.
D. “Avoid making any swallowing motions during the insertions.”
-incorrect: The nurse should instruct the client to swallow during the insertion of the tube to facilitate passage of the tube past the oropharynx.

264. A nurse is caring for a client who has chronic kidney disease. The kidneys regulate body fluids as well as assisting with which of the following functions?
A. Regulation of acid-base balance
-The nurse should identify that the kidneys assist with regulation of acid-base balance in the body by retaining bicarbonate as they excrete hydrogen ions.
B. Reabsorption of nutrients for cellular growth
-incorrect: The small intestines absorb nutrients for cellular growth, not the kidneys.
C. Regulation of body temperature
-incorrect: The integumentary system, not the kidneys, helps regulate body temperature.
D. Secretion of hormones needed for growth
-incorrect: The anterior pituitary gland secretes somatotropin (growth hormone), which is necessary for the growth of tissues and organs.

265. A nurse is teaching a client with lower extremity weakness how to use a 4-point crutch gait. Which of the following instructions should the nurse include in the teaching?
A. “Support the majority of your weight on the axillae.”
-incorrect: Pressure on the axillae increases the risk to underlying nerves, which could result in partial paralysis of the arms.
B. “Keep your elbows extended.”
-incorrect: The client should keep his elbows flexed about 30 degrees.
C. “Bear weight on both of your legs.”
-The client should keep 3 points on the ground at all times. Therefore, he must be able to bear weight on both legs.
D. “Move both crutches forward at the same time.”
-incorrect: The client should move each leg alternately with each opposite crutch so that 3 points of support are on the floor at all times.

266. A nurse is changing the dressings for a client who is 3 days postoperative following a cholecystectomy. The nurse observes yellow, thick drainage on the dressing. The nurse should document this finding as which of the following types of drainage?
A. Sanguineous exudate
-incorrect: Sanguineous exudate drainage on the client's dressings indicates an accumulation of RBCs from the plasma that appears bright red on the dressings.
B. Serous exudate
-incorrect: Serous exudate drainage on the client's dressings indicates plasma from the blood and appears watery and clear to light yellow in color.
C. Serosanguineous exudate
-incorrect: Serosanguineous exudate drainage on the client's dressings indicates plasma mixed with light bloody drainage, which is typically pale yellow to blood-tinged. Watery drainage may also be evident.
D. Purulent exudate
-Purulent exudate on the client's dressings includes thick yellow, green, or brown drainage and usually indicates wound sloughing or infection.

267. A nurse is caring for a client in a long-term care facility. Which of the following findings should alert the nurse to the possibility that the client has developed delirium?
A. Gradual memory loss
-incorrect: Gradual memory loss is a common finding in dementia, not delirium.
B. Reduced level of consciousness
-When a client has delirium, the nurse should expect a reduced level of consciousness, sudden memory impairment, illogical thinking, and sleep disturbances.
C. Difficulty with abstract thought
-incorrect: Difficulty with abstract thought is a common finding in dementia, not delirium.
D. Verbalized feelings of hopelessness
-incorrect: Verbalization of feelings of hopelessness is a common finding in depression, not delirium.

268. A nurse is reviewing a client's laboratory results and notes a WBC count of 3,600/ mm^3. The nurse should identify this result as which of the following conditions?
A. Leukoplakia
-incorrect: Leukoplakia involves thick white patches in the mucosa of the mouth. These lesions can be precancerous and are often seen in clients who smoke heavily.
B. Leukemia
-incorrect: Leukemia involves the uncontrolled production of blast cells or immature white blood cells in the bone marrow.
C. Leukocytosis
-incorrect: Leukocytosis is an increase in circulating white blood cells in response to white blood cells exiting from the blood vessels in response to inflammation.
D. Leukopenia
-Leukopenia occurs when there is a decrease in the production of WBCs. This alteration places the client at an increased risk of infection.

269. A nurse is preparing to perform mouth care for an unresponsive client. Which of the following actions should the nurse plan to take?
A. Place the client supine
-incorrect: To prevent the risk of aspiration, the nurse should raise the client's head to 30 degrees or turn the client to a side-lying position.
B. Keep both side rails up
-incorrect: To prevent straining reduce the risk of self-injury, the nurse should lower the near side rail before performing mouth care.
C. Raise the level of the bed
-The nurse should raise the bed to allow the use of proper body mechanics and reduce the risk of self-injury.
D. Inspect the client's mouth using a finger sweep
-incorrect: To reduce the risk of caregiver injury, the nurse should never insert fingers into the mouth of an unresponsive client.

270. A nurse is talking with the parent of a preschool-aged child who tells the nurse, "My child has suddenly become disinterested in certain foods." Which of the following statements should the nurse make?
A. "During this phase, feed your child anything that she will eat."
-incorrect: The nurse should inform the parent that children's dietary habits can change from day to day. It is important to feed the child healthy foods and focus on the quality of food rather than the quantity of food during this time.
B. "Increase the amount of calories and water your child consumes."
-incorrect: The nurse should inform the client that calorie and fluid requirements decrease slightly in preschool-aged children. The nurse should not promote an increase of calories and water in the child's diet.
C. "Keep a diary of the foods your child eats each day."
-The nurse should encourage the parent to keep a diary of the foods the child eats throughout the day for 1 week. This can help the parent realize that the child may be eating better than expected. Evidence suggests that children can self-regulate their caloric intake. When they eat less at a meal, they can compensate by eating more at another meal or by having a snack.
D. "Provide a large variety of fruit juices for your child to choose from."
-incorrect: The nurse should inform the parent that excessive consumption of sweetened beverages, including fruit juices, can be associated with adverse health effects such as dental caries, obesity, and metabolic syndrome.

271. A nurse is performing a mental-status examination on a client who has manifestations of dementia. Which of the following directions should the nurse give the client when evaluating the client's ability to think abstractly?
A. Subtract by 7 serially, starting at 100
-incorrect: This part of the mental-status exam evaluates the client's attention span.
B. Describe a previous illness
-incorrect: This part of the mental-status exam evaluates the client's remote memory.

C. Explain what to do if a fire happened in his bedroom
-incorrect: This part of the mental-status exam evaluates the client's judgment.
D. Discuss the meaning of a common proverb
-This part of the mental-status exam evaluates the client's ability to think abstractly.

272. A nurse is caring for a client who is receiving enteral feedings through an NG tube and develops diarrhea. Which of the following actions should the nurse take?
A. Change the tube feeding bag every 48 hours
-incorrect: The nurse should change the bag and tubing every 4 hours to decrease bacterial growth within the feeding tube system. The nurse should also employ aseptic technique.
B. Chill the formula prior to administration
-incorrect: The nurse should ensure the formula is at room temperature prior to administration. Cold formula can result in abdominal cramping and discomfort.
C. Increase the infusion rate
-incorrect: The nurse should decrease the infusion rate for a client who develops diarrhea while receiving feedings via NG tube. This can assist in reducing diarrhea as well as gastric intolerance to the formula.
D. Request a prescription for an isotonic enteral nutrition formula
-The nurse should assist a client who develops diarrhea while receiving NG tube feedings by consulting with the provider and the dietitian regarding changing the client's formula to an isotonic formula. This formulation can be easier for the client to digest and can decrease diarrhea.

273. A nurse is caring for a client who has a temperature of 38.7 C (101.7 F). Which of the following actions should the nurse take?
A. Apply an alcohol-water solution to the client's skin
-incorrect: This therapy is no longer recommended as an intervention for a fever because it can lead to shivering, which is counterproductive and can cause an increase in energy expenditure.
B. Keep the client's bed linens dry
-The nurse should maximize the client's heat loss by keeping the client's clothes and bed linens dry. The nurse should also reduce external coverings on the client's bed without causing shivering.
C. Apply ice packs to the groin
-incorrect: This therapy is no longer recommended as an intervention for a fever because it can lead to shivering, which is counterproductive and can cause an increase in energy expenditure.
D. Limit the client's fluid intake to 1183 mL (40oz) of fluid per day
-incorrect: The nurse should satisfy the client's increased metabolic needs by providing the client with at least 1893 mL (64 oz) of fluid per day.

274. A nurse is performing eye irrigation for a client who was exposed to smoke and ash. Which of the following actions should the nurse take?
A. Hold the irrigator 1.25 cm (0.5 in) above the eye
-incorrect: The nurse should hold the irrigator 2.5 cm (1 in) above the eye to keep the irrigator from touching the eye and to prevent the solution from damaging the eye tissue.

B. Direct the irrigation solution up toward the upper eyelid
-incorrect: The nurse should direct the irrigation solution onto the lower conjunctival sac to avoid injuring the cornea and having contaminated fluid flow down the nasolacrimal duct.
C. Exert pressure on the bony prominences when holding the eyelids open
-The nurse should hold the upper lid against the eyebrow and the lower lid against the cheekbone when irrigating the eye.
D. Direct the irrigation from the outer canthus to the inner canthus of the eye
-incorrect: The nurse should direct the irrigation solution from the inner canthus to the outer canthus of the eye to avoid injuring the cornea and having contaminated fluid flow down the nasolacrimal duct.

275. A nurse is planning to perform passive ROM exercises for a client. Which of the following actions should the nurse take?
A. Repeat each joint motion 5 times during each session
-To maintain the client's joint mobility, the nurse should repeat each motion 3 to 5 times.
B. Move the joint to the point of considerable resistance
-incorrect: The nurse should move the joint to the point of slight resistance.
C. Sit approximately 2 ft from the side of the bed closest to the joint being exercised
-incorrect: The nurse stand at the side of the bed closest to the joint being exercised
D. Exercise the smaller joints first
-incorrect: The nurse should exercise the large joints first

276. A nurse is called away for an emergency while conversing with a client who is corrected about his medical diagnosis. The nurse returns to the client promptly, as promised. Which of the following ethical principles is the nurse demonstrating?
A. Autonomy
-incorrect: The ethical principle of autonomy involves ensuring the client has the right to make personal decisions.
B. Fidelity
-The nurse is demonstrating the ethical principle of fidelity by keeping a promise that was made.
C. Nonmaleficence
-The ethical principle of nonmaleficence involves doing no harm.
D. Justice
-The ethical principle of justice involves treating everyone fairly.

277. A nurse is caring for a client who requires a chest x-ray. Prior to the client being transported for the procedure, which of the following actions should the nurse take first?
A. Explain the x-ray procedure to the client
-incorrect: The nurse should explain the x-ray procedure to the client. However, there is another action the nurse should take first.
B. Help the client into a wheelchair before the transporter arrives
-incorrect: The nurse should have the client ready for the procedure. However, there is another action the nurse should take first.
C. Ask if the client has any questions

-incorrect: The nurse should inquire if the client has any questions about the procedure. However, there is another action the nurse should take first.
D. Identify the client using 2 identifiers
-The nurse should apply the safety and risk-reduction-priority-setting framework, which assigns priority to the factor or situation posing the greatest safety risk to the client. When there are several risks to the client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's Hierarchy of needs, the ABC priority-setting framework, and/or nursing knowledge to identify which risk poses the greatest threat to the client.

-Once the client's identity is determined, the nurse can proceed with other options. This action is the priority because it provides for the safety of the client. The nurse must be certain that each client receives only what has been prescribed. Hence, the nurse must assure that the correct client is being transported for a chest x-ray.

278. A nurse is calculating a client's intake for a 12-hr shift. The client had dextrose 5% in 0.45% sodium chloride infusing at 125 mL/hr, gentamicin 150 mg in 100mL at 1400, ranitidine 50 mg in 50mL at 1000 and 1600, 250 mL of blood over 2 hr and a nasogastric flush of 30mL every 2 hr. What is the total intake in milliliters that the nurse should document for this client for this 12-hr period? (nearest whole number)

-2130 mL

279. A nurse is performing a neurological assessment of a client. To promote safety during the examination, the nurse stands nearby as the client follows the instructions for which of the following tests?
A. Romberg
-A Romberg test evaluates standing balance, first with the client's eyes open and then with them closed. The nurse should remain nearby because the client could fall during this test.
B. Kinesthetic sensation
-incorrect: Kinesthetic sensation tests the client's ability to identify the position in which the examiner is holding the client's middle finger or great toe. It is not likely to endanger the client's safety.
C. 2-point discrimination
-incorrect: When performing 2-point discrimination, the nurse touches various areas on the client's body with 1 and 2 pointed objects to see if the client can discriminate between 1 and 2 objects. It is unlikely to endanger the client's safety.
D. Weber
-incorrect: A Weber test is a hearing screening that uses a tuning fork. Following the instructions for this test is not likely to endanger the client's safety.

280. A nurse is initiating seizure precautions for a client who has a seizure disorder. Which of the following pieces of equipment should the nurse have readily available at the client's bedside?
A. Vest restraint

-incorrect: The nurse does not need to have a vest restraint at the client's bedside for seizure precautions. The nurse should not restrain a client during a seizure but should hold the client's flailing limbs loosely and loosen the client's clothing.
B. Tongue blade
-incorrect: The nurse does not need to have a tongue blade at the client's bedside for seizure precautions. The nurse should not place any objects into the client's mouth during a seizure, including a tongue blade or airway.
C. Oxygen equipment
-The nurse should have oxygen equipment at the bedside of a client who is on seizure precautions. The nurse should be able to apply oxygen via mask or nasal cannula to a client who experiences a seizure.
D. Neck brace
-incorrect: The nurse does not need to have a neck brace at the client's bedside for seizure precautions. The nurse should protect the client's head by holding it in the lap, placing the head on a pillow, or placing a pad under the client's head.

281. A nurse is planning to obtain the vital signs of a 2-year-old child who is experiencing diarrhea and may have a right ear infection. Which of the following routes should the nurse use to obtain the child's temperature?
A. Rectal
-incorrect: The rectal route is accurate for obtaining body temperature in young children; however, it should not be used for clients who have diarrhea.
B. Tympanic
-incorrect: The tympanic route can be used in young children but should be avoided in a child who has an active ear infection or who has tympanostomy tubes in place.
C. Oral
-incorrect: The oral route is not appropriate for use in children under the age of 3.
D. Temporal
-The temporal artery route, while not as accurate as the rectal route for obtaining a precise body temperature, is noninvasive and can be used to obtain a temperature in a toddler who might have an ear infection and who is having diarrhea. The nurse should place the probe behind the ear if the client is diaphoretic but should avoid placing it over an area covered with hair.

282. A nurse is performing a neurological assessment for a client. Which of the following examinations should the nurse use to check the client's balance?
A. 2-point discrimination test
-incorrect: Two-point discrimination is tested by touching the skin with 2 sharp, pointed objects. The purpose of the test if to determine when the client can differentiate between the points.
B. Glasgow coma scale
-incorrect: The Glasgow coma scale is used to measure a client's level of consciousness.
C. Babinski reflex
-incorrect: The Babinski reflex is tested by using an object to strike the sole of the foot. When the test is negative, all of the toes bend. The test is positive if the toes spread outward.

D. Romberg test
-When using the Romberg test, the nurse instructs the client to stand with the feet together and arms at the sides, first with the eyes open and then with the eyes closed. The inability to maintain balance is a positive Romberg test.

283. A nurse is caring for a client who has type 1 diabetes mellitus and is resistant to learning how to self-inject insulin. Which of the following statements should the nurse make?
A. "Tell me what I can do to help you overcome your fear of giving yourself injections."
-This response illustrates the therapeutic communication technique of clarifying and offering self. The nurse should allow the client to express feelings and fears and support the client in learning how to give the injections.
B. "Your provider will not be pleased that you refuse to give yourself insulin injections."
-incorrect: This response illustrates the nontherapeutic communication technique of challenging and ignores the client's concern.
C. "It's okay. I'm sure your partner will be able to learn how to give you the insulin injections."
-incorrect: This response illustrates the nontherapeutic communication technique of unwarranted reassurance and does not address the client's fears.
D. "You won't be able to go home unless you learn to give yourself insulin injections."
-incorrect: This response illustrates the nontherapeutic communication technique of threatening the client. This response will not help the client overcome these fears.

284. During a client care staff meeting, a nurse manager discusses potential problems with data security that affect confidential client information. Which of the following environments should the nurse manager identify as an acceptable place for discussing clients' information?
A. Areas with no public access
-Nurses should only discuss client's information in private arears where no one else can overhear. For example, a unit medication room is a non-public area where nurses can privately discuss information that pertains to the client's care.
B. Outside the door of a client's room
-incorrect: Discussing client information in a semi-public place risks other overhearing protected health information.
C. In the cafeteria during break
-incorrect: Discussing client information in a public place could allow others to overhear protected health information.
D. In the hallway near the nurse's station
-incorrect: Discussing client information in a semi-public place could allow others to overhear protected health information.

285. A nurse on an oncology unit receives report at the beginning of her shift about 4 clients who are postoperative. Which of the following clients should the nurse see first?
A. A client who is 1 day postoperative following a lobectomy for a small-cell carcinoma and has a chest tube with 35 mL/hr of bright red, bloody drainage.
-incorrect: Following a lobectomy, the client may need chest tubes for both pneumothorax and hemothorax (collapse of the lung with blood in the pleural space). Fully reinflating and removing

the remaining blood can take several days or more, depending on the severity of the trauma. Chest tube drainage of 35 mL is within the expected parameters for an adult client, especially on the first postoperative day. A client who has a draining chest tube after a lobectomy is stable.
B. A client who is 2 days postoperative following a colectomy due to colorectal cancer and has an ostomy bag full of bright red, bloody drainage.
-The nurse should apply the unstable vs stable priority-setting framework when caring for clients. Using this framework, unstable clients are prioritized due to needs that threaten survival. The nurse should first address problems involving the airway, breathing, or circulatory status that are life-threatening. Clients whose vital signs or laboratory values indicate a risk of becoming unstable are also a higher priority than clients who are stable. The nurse may need to use nursing knowledge to determine which option describes the most unstable client.

-An ostomy bag full of blood indicates that the client's bowel is hemorrhaging, and the nurse must report this finding to the surgeon immediately. The client may require fluid replacement, transfusion, and additionaly surgery to repair the bleeding vessel. This finding poses an immediate threat to the client's circulation.
C. A client who is 2 days postoperative following the excision of an abdominal mass and has a portable wound suction device with 20 mL/hr of serosanguineous drainage.
-incorrect: A portable suction device drains a surgical wound by gentle, continuous self-suction. Over time, the drainage will change from sanguineous to serosanguineous to serous. Serosanguineous drainage of 20 mL/hr on the second postoperative day is within the expected reference range for an adult client. A client who has a draining wound after abdominal surgery is stable.
D. A client who is 1 day postoperative following the excision of a bladder wall tumor and prostate and has continuous bladder irrigation with 300 mL/hr reddish-pink urine.
-incorrect: Continuous bladder irrigation (CBI) prevents clots from forming in the bladder. To keep the client's urine free of clots and mucous plugs, the nurse should irrigate the bladder with 0.9% sodium chloride. During the first few postoperative days, reddish-pink urine at an hourly output slightly greater than the amount of solution the nurse instills is expected. Consequently, drainage of 300 mL/hr on the first postoperative day is within expected reference range for this client.

286. A nurse in a provider's office is measuring a client and notes a loss in height from the previous year. The nurse should identify this finding as a manifestation of which of the following musculoskeletal system disorders?
A. Osteoporosis
-A loss of height is often and early indication of osteoporosis. This occurs due to loss of calcium in the vertebrae, which can cause them to fracture and collapse.
B. Scoliosis
-incorrect: Scoliosis does not precipitate a decrease in the height of a client. It is an abnormal lateral curve of the spine.
C. Kyphosis
-incorrect: Kyphosis does not precipitate a decrease in height of a client. It is an exaggerated posterior curvature of the thoracic spine. (ex: hunchback)

D. Lordosis
-incorrect: Lordosis does not precipitate a decrease in the height of a client. It is an exaggerated lumbar curvature. (ex: swayback)

287. A nurse is witnessing a client sign an informed consent form for surgery. What is the nurse affirming by this action?
A. The client fully understands the provider's explanation of the procedure
-incorrect: It is the responsibility of the provider who will perform the procedure to ensure that the client understands the explanation of the procedure.
B. The client has been informed about the risks and benefits of the procedure
-incorrect: It is the responsibility of the provider who will perform the procedure to inform the client about the risks and benefits and to obtain consent.
C. The nurse witnessed the provider's explanation of the procedure
-incorrect: It is not necessary for the nurse to witness the provider's explanation of the procedure.
D. The signature on the preoperative consent form is the client's
-The nurse acts as a witness to confirm that the client's signature is present on the preoperative consent form. It is the responsibility of the provider who will perform the procedure to obtain consent by explaining the procedure alone with the associated risks and benefits.

288. A nurse is assisting a client who has dysphagia at mealtimes. Which of the following actions should the nurse take?
A. Assist the client into a semi-sitting position
-incorrect: The nurse should assist the client to sit in an upright position when eating.
B. Have the client lean slightly backward
-incorrect: The nurse should have the client lean slightly forward when eating
C. Advise the client to tuck his chin downward
-To help the client swallow safely, the nurse should have the client sit upright, lean slightly forward, tilt his head forward, and tuck his chin. This position helps moves the food downward without lodging in the throat, where the client could aspirate it.
D. Instruct the client to tilt his head slightly backward
-incorrect: The nurse should instruct the client to tilt his head slightly forward when eating.

289. A nurse is assessing a client who is experiencing an obstruction of the flow of the vitreous humor in the eye. This manifestation is consistent with which of the following eye disorders?
A. Retinopathy
-incorrect: Manifestations of retinopathy include changes in the blood vessels of the retina that can lead to blindness.
B. Glaucoma
-The nurse should identify that an obstruction of the flow of the vitreous humor of the eye is a manifestation of glaucoma. This obstruction leads to an increase in intraocular pressure, resulting in damage to the eye.
C. Cataracts

-incorrect: Manifestations of cataracts include an increase in the opacity of the lens, blocking rays of light from entering the eye.
D. Macular degeneration
-incorrect: Manifestations of macular degeneration include changes in sharp and central vision and are often associated with aging.

290. A charge nurse is providing teaching to a newly licensed nurse about removing sutures from a client's laceration. Which of the following statements by the newly licensed nurse indicates an understanding of the teaching?
A. "I will use a staple remover and remove each suture individually."
-incorrect: A staple remover is used to remove staples, not sutures.
B. "Bandage scissors are used to cut the sutures."
-incorrect: Bandage scissors are ineffective in removing sutures, as the tips of the scissors are too large and blunt to capture the suture material. Special suture scissors with a short, curved tip are used to remove sutures.
C. "Tweezers are necessary only for removing retention sutures."
-incorrect: Retention sutures are placed more deeply within the body than regular sutures. Agency policy will determine if nurses are allowed to remove them. Tweezers, however, can be used to remove all types of sutures, not just retention ones.
D. "I will clip each suture close to the skin and pull it through from the other side."
-Clipping close to the skin and pulling the suture from the other side does not disrupt the wound-healing process.

291. A nurse is preparing to insert an indwelling urinary catheter for a female client. Which of the following actions should the nurse have the client perform just before inserting the catheter?
A. Swallow water
-incorrect: Swallowing eases the passage of a nasogastric tube past the client's oropharynx.
B. Prepare for painful sensation
-incorrect: The insertion of a catheter can feel uncomfortable but should not cause pain, and it can ease the discomfort of bladder distention.
C. Hold her breath
-incorrect: The nurse should ask the client to take a slow, deep breath just before insertion.
D. Bear down gently
-Bearing down helps the nurse visualize the urinary meatus and relaxes the external sphincter, which facilitates the insertion of the catheter.

292. A nurse is reviewing the use of side rails with an assistive personnel (AP). Which of the following statements by the AP indicates that further teaching is required?
A. "I should not leave all 4 side rails up unless there is a prescription for restraints."
-incorrect: Side rails are a form of restraint when all 4 rails are raised. This requires a prescription form the provider after less restrictive methods have been unsuccessful.
B. "An alert client will be safest if I raise the 2 upper side rails at the head of the bed."

-incorrect: Leaving the 2 upper side rails up improves the client's ability to turn and move around in bed. The client will also be able to use the rails when getting out of bed, which will help prevent falls.
C. "If the client seems confused, I'll raise all 4 side rails so that he doesn't hurt himself."
-Raising all 4 side rails can put the client at greater risk for injury. For example, the client might try to climb over the side rails, which could result in a fall.
D. "If a client is sedated, I should raise all 4 side rails to prevent a fall out of bed."
-incorrect: Raising all 4 side rails is not considered a restraint if the client is sedated. This action reduces the client's risk for injury due to falling out of bed.

293. A nurse is teaching a client how to use an albuterol metered-dose inhaler. After removing the cap form the inhaler and shaking the canister, what sequence of instructions should the nurse give the client?

-"Hold the mouthpiece 1 to 2 inches in front of your mouth."
-"Tilt your head slightly and open your mouth wide."
-"Depress the canister while taking a slow, deep breath."
-"Hold your breath for 10 seconds."

294. A nurse in an emergency department is caring for a client who reports developing severe right eye pain with a gritty sensation while sawing wood. Which of the following actions should the nurse take first?
A. Instill proparacaine hydrochloride eye drops
-incorrect: The nurse should instill proparacaine hydrochloride eyedrops, after assessing for client allergies, to promote relief of eye pain; however, there is another action the nurse should take first.
B. Perform ocular irrigation of the right eye
-incorrect: The nurse should prepare for and quickly perform ocular irrigation when a foreign body in the eye is suspected; however, there is another action the nurse should take first.
C. Place the client in a supine position with the head turned toward the affected side
-incorrect: The nurse should place the client in supine position with the head turned toward the affected eye to promote drainage of irrigation fluid during ocular irrigation; however, there is another action the nurse should take first.
D. Ask the client about first aid performed at the scene
-The nurse should apply the nursing process priority-setting framework to plan client care and prioritize nursing action. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection. Before the nurse can formulate a plan of action, implement a nursing intervention, or notify the provider of a change in the client's status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge to make an appropriate decision. Therefore, the first action the nurse should take is to assess the first aid that was performed at the scene to determine if eye irrigation was administered.

295. A nurse is performing a neurological assessment for a client. By asking the client to stick out his tongue, which of the following cranial nerves if the nurse testing?
A. Cranial nerve XII
-The nurse is checking the function of cranial nerve XII (hypoglossal), which innervates the tongue, by observing a range of tongue movements.
B. Cranial nerve X
-incorrect: The nurse checks for functioning of cranial nerve X (vagus) by asking the client to vocalize.
C. Cranial nerve VIII
-incorrect: The nurse checks the functioning of cranial nerve VIII (vestibulocochlear) through using the Rinne and Weber tests and asking the client if he can hear a whisper.
D. Cranial nerve V
-The nurse checks the functioning of cranial nerve V (trigeminal) by asking the client to clench his teeth and palpating the masseter muscles for contraction.

296. A nurse in an acute care facility is planning care for a client who is alert but temporarily immobile due to a total hip arthroplasty. Which of the following interventions should the nurse plan to take to prevent a complication of immobility?
A. Move the client from supine to a low Fowler's position every 2-3 hours to help prevent orthostatic hypotension.
-incorrect: Moving the client from supine to a low Fowler's position every 2-3 hours is not sufficient to help prevent orthostatic hypotension. Changing positions slowly helps prevent or minimize the effects of orthostatic hypotension.
B. Limit fluid intake to 1 L (33.8 oz) in 24 hr to help prevent dependent edema
-incorrect: Clients who are immobile should ingest at least 1.1-1.4 L (37.2-47.3 oz) of fluid in 24 hrs to help prevent bladder complications. Limiting fluid intake does not prevent dependent edema.
C. Encourage the client to turn from side to side every 3-4 hr to help prevent respiratory complications
-incorrect: The client should cough and breathe deeply every 1-2 hours to help prevent respiratory complications. Turning from side to side every 1-2 hours also helps prevent skin breakdown.
D. Instruct the client to perform foot and leg exercises every 1-2 hr while awake to help prevent thrombophlebitis.
-Antiembolic exercises (ex: flexion of the knees and rolls and pumps of the feet and ankles) every 1-2 hours help prevent thrombophlebitis, which is a complication of immobility.

297. A nurse is planning care for an adult client who has fluid volume excess. Which of the following intervention should the nurse plan to include to monitor the client's weight?
A. Calibrate the scales weekly
-incorrect: The nurse should calibrate the scales to 0 each day or before each use to provide accurate information.
B. Use a different scale each time

-incorrect: The nurse should weigh the client using the same scale each time because there generally is a slight difference between readings from each scale.
C. Weigh the client on arising
-The nurse should weigh the client on arising each day, after voiding, and before breakfast. An accurate weight requires the client to be weighed wearing the same garments and on the same carefully calibrated scale (balanced to 0 before each use). Accurate daily weights provide the easiest measurement of volume status. An increase of 1 kg (2.2 lbs) is equal to 1,000mL (1L) of retained fluid.
D. Weigh the client without clothing
-incorrect: The nurse should plan to have the client's weight taken wearing the same type of clothing each day to provide an accurate reading and to avoid embarrassment.

298. A nurse is caring for a client who is receiving mechanical ventilation via a tracheostomy tube and has a gastrostomy tube for enteral feedings. Which pieces of information are critical to communicate to the next nurse who will be caring for this client? (SATA)
A. Room temperature
-incorrect: Unless it is extreme, the room temperature should not affect the client's care and should not be included in a nursing handoff report.
B. New prescriptions
C. Number of visitors
-incorrect: Unless there is a specific concern about visitors, it is not necessary to report the number of visitors that the client had in the handoff report.
D. Arterial blood gas results
E. Tracheal secretion characteristics
-The nurse should report any changes in the client's treatment in the nursing handoff report. For a client who is receiving mechanical ventilation, the latest arterial blood gas results reflect the client's current respiratory and ventilatory status and are an essential part of the nursing handoff report. Additionally, tracheal secretion characteristics provide important information about the client's current respiratory and ventilatory status and are an essential part of the nursing handoff report.

299. A nurse is assessing a client who has a total calcium level of 12.7 mg/dL. Which of the following findings should the nurse expect?
A. Muscle tremors
-incorrect: Muscle tremors are manifestations of hypocalcemia, not hypercalcemia.
B. Positive Chvostek's sign
-incorrect: Positive Chvostek's sign and Trousseau's signs are manifestations of hypocalcemia, not hypercalcemia.
C. Depressed deep-tendon reflexes
-A total calcium level of 12.7 mg/dL is above the expected reference range. Manifestations of hypercalcemia include depressed deep-tendon reflexes, nausea, vomiting, bone pain, lethargy, and weakness.
D. Numbness around the mouth

-incorrect: Numbness and tingling around the mouth and in the extremities are manifestations of hypocalcemia, not hypercalcemia.

300. During the insertion of a urinary catheter for a client, the tip of the catheter brushes against the nurse's arm. Which of the following actions should the nurse take?
A. Wipe the catheter with povidone-iodine and continue the catheter insertion.
-incorrect: Antibacterial solutions do not guarantee sterility. This action could increase the client's risk for a catheter-associated urinary tract infection.
B. Soak the catheter in chlorhexidine for 15 mins and then reattempt insertion.
-incorrect: Antibacterial solutions do not guarantee sterility. This action could increase the client's risk for a catheter-associated urinary tract infection.
C. Continue with the catheter insertion.
-incorrect: Once the tip of the catheter touches a nonsterile surface, it is contaminated and should not be inserted.
D. Obtain a new catheter and reattempt insertion.
-The instruction of a urinary catheter is a sterile procedure. The only way to ensure sterility of the catheter the nurse plans to insert is by obtaining a new sterile catheter and following surgical asepsis throughout the insertion procedure.

301. A nurse is assessing a client's peripheral pulses. Which of the following descriptions should the nurse use to document the findings?
A. Peripheral pulses equal bilaterally at a rate of 60/min
-incorrect: The nurse measures the client's pulse rate at the apical and radial sites. Determination of rate is not a component of peripheral pulse evaluation.
B. Radial, brachial, and pedal pulses bilaterally weak
-incorrect: A full evaluation of peripheral pulses typically includes palpation of the radial, brachial, ulnae, femoral, popliteal, tibial, and dorsalis pedal pulses. It is not necessary to specify details about all pulse points, but the evaluation should indicate the upper portion of the lower extremities.
C. Peripheral pulses bilaterally symmetric, equal, and strong in all 4 extremities
-The nurse does not evaluate the peripheral pulses routinely when measuring vital signs. Peripheral pulse evaluation is for specific clinical indications such as circulatory impairment to an extremity or during a comprehensive physical examination. A full evaluation of peripheral pulses typically includes palpation of the radial, brachial, ulnar, femoral, popliteal, tibial, and dorsalis pedal pulses. Documentation of peripheral pulse evaluation should include the strength of pulsations as well as their equality and symmetry in all 4 extremities.
D. Brachial, radial, popliteal, and dorsalis pedis pulses regular, 58, and bilaterally palpable
-incorrect: The nurse measures the client's pulse rate at the apical and radial sites. Determination of rate is not a component of peripheral pulse evaluation.

302. A nurse is providing teaching to an older adult client who has constipation. Which of the following statements should the nurse include in the teaching?
A. "Drink a minimum of 1,000mL of fluid daily."

-incorrect: The nurse should instruct the client to consume a minimum of 1,500 mL of fluid to prevent constipation.
B. “Increase your intake of refined-fiber foods.”
-incorrect: The nurse should instruct the client to increase consumption of coarse fiber and whole grains, rather than refined-fiber foods.
C. “Sit on the toilet 30 mins after eating a meal.”
-Increased peristalsis occurs after food enters the stomach. Siting on the toilet 30 mins after eating a meal, regardless of feeling the urge to defecate, is a recommended method of bowel retraining to treat constipation.
D. “Take a laxative every day to maintain regularity.”
-incorrect: The nurse should not recommend intake of daily laxatives because consistent use hinders natural defecation habits and can cause constipation.

303. A nurse in the emergency department is caring for a client who has abdominal trauma. Which of the following assessment findings should the nurse identify as an indication of hypovolemic shock?
A. Warm, dry skin
-incorrect: Cool, clammy skin is an indication of hypovolemic shock.
B. Increased urinary output
-incorrect: Urine output of <30 mL/hr is an indication of hypovolemic shock.
C. Tachycardia
-Due to the decreased circulating blood volume that occurs with internal bleeding, the oxygen-carrying capacity of the blood is reduced. The body attempts to relieve the hypoxia by increasing the heart rate and cardiac output while increasing the respiratory rate.
D. Bradypnea
-incorrect: Tachypnea is an indication of hypovolemic shock.
304. A nurse is caring for an adult client who is grieving following the death of a loved one. Which of the following factors increases the client’s risk of developing complicated grief?
A. The deceased was a close friend
-incorrect: Loss of a close friend is only a risk factor for complicated grief if the grieving individual has had multiple recent losses, was strongly dependent on the friend, or is influenced by another compounding factor.
B. The client lived far from the deceased
-incorrect: Living far away from the deceased is only a risk factor for complicated grief if the grieving individual has had multiple recent losses, had unresolved issues with the deceased, or is influenced by another compounding factor.
C. The death was sudden
-Complicated grief can occur when the death of a loved one is sudden and unexpected.
D. The client has not visited the deceased in a long time
-incorrect: Not visiting the deceased in a long time is only a risk factor for complicated grief if the grieving individual has had multiple recent losses, had unresolved issues with the deceased, or is influenced by another compounding factor.

305. A nurse is communicating with a group of clients about what to expect during the postoperative phase of a total hip arthroplasty. Which of the following elements of the communication process should the nurse identify as an evaluation of effective communication?
A. The motivation for communication is evident
-incorrect: The element of "referent" motivates communication between people (ex: a sound of perception). This will not assist in determining whether the communication is effective.
B. Feedback is provided
-Feedback in verbal and/or nonverbal forms is evidence of successful communication. Feedback can indicate to the nurse whether the meaning of the message was understood by the recipient.
C. A message is communicated to the group of clients
-incorrect: The message is only the content of what the sender is trying to convey in the communication process. It can contain both verbal and nonverbal expression. Massages should be clear and concise. However, even though a message might be clearly delivered, this does not mean the communication if effective.
D. Multiple channels are used by the sender
-incorrect: Using multiple channels (ex: visual, auditory, and facial expressions) can improve the effectiveness of communication. However, this will not assist in determining if the communication is effective.

306. A nurse is caring for a client who has an NG tube for intermittent enteral feedings. Which of the following actions should the nurse take?
A. Auscultate bowel sounds after each feeding
-incorrect: The nurse should auscultate bowel sounds before each feeding to ensure the client has peristalsis bowel activity for the digestive system to digest or absorb the enteral nutrition.
B. Ensure the formula is cold before administering
-incorrect: The nurse should ensure the formula is at room temperature before administering because cold formula might cause intestinal cramping and discomfort.
C. Elevate the head of the client's bed to 45 degrees before the feeding
-The nurse should elevate the client's head of bed between 30-45 degrees to prevent aspiration.
D. Flush the tubing with 15mL of water after the enteral feeding
-incorrect: The nurse should flush the tubing with at least 30mL of water after the enteral feeding to maintain patency of the feeding tube.

307. A nurse is caring for a client who has a prescription for a vest restraint. Which of the following actions should the nurse take?
A. Fasten the ties on the restraints to the side rails of the bed
-incorrect: The nurse should not fasten the ties on the restraint to the side rails. If the side rails are lowered, the client could be injured.
B. Tie the restraint with a quick-release knot
-The nurse should use a quick-release knot that can be untied easily in case the client's well-being requires quickly removing the restraints.
C. Allow a fingerbreadth between the restraint and the client's chest
-incorrect: The nurse should allow two fingerbreadths between the restraint and the client's chest.

D. Place the restraint under the client's clothing
-incorrect: The nurse should apply the restraint over the client's clothing.

308. An assistive personnel (AP) is helping a nurse care for a female client who has an indwelling urinary catheter. Which of the following actions by the AP indicates a need for further teaching?
A. The AP uses soap and water to clean the perineal area
-incorrect: The AP should cleanse the client's perineal area with soap and water at least 3 times per day to reduce the risk of infection.
B. The AP tapes the catheter to the client's inner thigh
-incorrect: The AP should tape the catheter to the inner thigh of a female client to prevent pulling on the urethra as the client moves around. When the catheter tugs and pulls on the urethra, it increases the risk of infection and dislodging the catheter.
C. The AP hangs the collection bag at the level of the bladder
-The AP should place the drainage bag below the level of the bladder to ensure proper drainage by gravity.
D. The AP ensures there are no kinks in the drainage tube
-incorrect: The AP should make sure there are no kinks in the tubing to ensure proper drainage by gravity.

309. A nurse in a provider's office is collecting information from an older adult client who reports taking acetaminophen 500 mg/day for severe joint pain. The nurse should instruct the client that large doses of acetaminophen could cause which of the following adverse effects?
A. Constipation
-incorrect: Constipation is an adverse effect of opioid analgesics.
B. Gastric Ulcers
-incorrect: Gastric ulcers are an adverse effect of aspiring and other nonselective NSAIDs.
C. Respiratory depression
-incorrect: Respiratory depression is an adverse effect of opioid analgesics.
D. Liver damage
-Acetaminophen in large doses can be toxic to the liver. Daily intake should be limited to less than 3 to 4 grams per day for healthy individuals and 2.4 grams per day for older adults and those with a history of liver impairment.

310. A nurse is caring for a client who reports using several herbal medicines. Which of the following actions should the nurse take?
A. Discourage the use of unregulated medications and supplements
-incorrect: Although herbal products are not subject to the regulation and scrutiny of the U.S. Food and Drug Administration, many can be safe and effective for treating a variety of health concerns.
B. Verify the herbal supplements do not interact with medications the provider has prescribed
-Many herbal products interact with other prescription and nonprescription medications. Valerian, for example, interacts with antihistamines as well as barbiturates and other sleep-promoting medications. The nurse should report any potential interactions to the provider.
C. Tell the client to limit the number of herbal supplements to no more than 2

-incorrect: The nurse's responsibility is to obtain a list of all the medications and herbal products the client takes so that the provider can review them and make recommendations. The nurse should not set specific limits on how many herbals products the client uses.
D. Describe the dangers of taking plant-derived medications and supplements
-incorrect: Pharmaceutical companies make many prescription medications from plants (ex: digoxin, reserpine, aspirin, and morphine).

311. A nurse asks a client to explain the statement, "A bird in the hand is worth two in the bush." Through this question, the nurse is evaluating the client's ability in which of the following intellectual functions?
A. Judgment
-incorrect: To test judgment, the nurse could ask what decisions the client would make in response to a specific real-life challenge.
B. Short-term memory
-incorrect: To test short-term memory, the nurse could ask the client to recall something like a list of 3 words that was provided a few months earlier.
C. Attention span
-incorrect: To test attention span, the nurse could ask the client to count backward from 100 in intervals of 7.
D. Abstract reasoning
-This exercise evaluates higher- level thinking and the ability to understand and interpret abstract thoughts.

312. A nurse is planning care for a client who reports abdominal pain. An assessment by the nurse reveals the client has a temperature of 39.2 C (102.6 F), a heart rate of 105/min, a soft nontender abdomen, and menses overdue by 2 days. Which of the following findings should be the nurse's priority?
A. Heart rate of 105/min
-incorrect: This is an important assessment finding because the client's heart rate is elevated. However, a fever and pain can contribute to tachycardia. This is not the priority finding.
B. Soft nontender abdomen
-incorrect: This is an important assessment finding because of the client's report of pain. However, a soft non-tender abdomen is an expected finding and should not cause concern.
C. Temperature
-Elevated temperature is an emergent physiological need that requires priority intervention by the nurse. The nurse should consider Maslow's Hierarchy of Needs, which includes five levels of priority. The levels are as follows: physiological needs, safety, and security needs, love and belonging needs, personal achievement and self-esteem needs, and achievement of full potential and the ability to problem-solve and cope with life situations.

-When applying Maslow's Hierarchy of Needs, the nurse should review physiological needs first before following the remaining four levels. However, it is important for the nurse to consider all contributing client factors, as higher levels of the pyramid can compete with those at the lower levels, depending on the situation.

D. Overdue menses
-incorrect: This is an important assessment finding because of the client's report of pain. However, an irregularity in the menstrual cycle is a common finding when a client is stressed. This is not the priority finding.

313. A nurse is caring for a client who had a stroke and is at risk of falling. Which of the following actions should the nurse take?
A. Assign the client to a private room
-incorrect: The client does not need to have a private room sure to an increased risk of falls. Increased social interaction can decrease the client's fall risk. The nurse should place the client in a room near the nurse's station for improved visual contact of the client.
B. Keep 4 side rails up while the client is in bed
-incorrect: The use of 4 raised side rails on the client's bed is considered a physical restraint that the nurse cannot employ without a prescription from the provider. Bed rails can increase a client's fall risk if the client attempts to climb over the rails to get out of bed.
C. Monitor the client at least once every hour
-The nurse should monitor the client frequently as a means of reducing the client's fall risk. Other measures can include keeping the client's bed in a low position, creating elimination schedules, and using a gait belt when the client is ambulating.
D. Request a PRN prescription for restraints
-incorrect: The nurse should consider and attempt any potential alternatives prior to implementing restrains. The use of restraints can contribute to an increased risk of complications for a client such as incontinence and the development of pressure ulcers due to immobilization.

314. A nurse is caring for a middle-aged adult client. The nurse should evaluate the client for progress toward which of the following developmental tasks?
A. Managing a home
-incorrect: Young adults should focus on learning to manage a home.
B. Establishing a sense of self in the adult world
-incorrect: Young adults should focus on establishing themselves in the adult world.
C. Forming new friendships
-incorrect: Young adults should focus on forming new friendships.
D. Ceasing to compare personal identity with others
-Middle-aged adults usually feel more comfortable with themselves and cease to make comparisons with others.

315. A nurse is caring for an older adult client who has an in-the-canal hearing aid. The client states that the hearing aid is making a whistling sound. The nurse should identify which of the following factors as the source for this sound?
A. Low battery power
-incorrect: A hearing aid with low battery power will not work effectively, but it will not whistle. Removing the battery at night can help extend the life of the battery.
B. Excessive wax in the ear canal

-Factors that can make a hearing aid whistle include a poor seal with the ear mold, an ear infection, excessive wax in the ear canal, an improper fit, or a malfunction.
C. A volume setting that is too low
-incorrect: A hearing aid might whistle if the volume is too high, not too low.
D. A crack in the ear tube
-incorrect: A crack in the ear tube of an in-the-ear-canal hearing aid can impair the hearing aid's amplification of sound; however, it would not cause whistling.

316. A client who reports shortness of breath requests the nurse's help in changing positions. After repositioning the client, which of the following actions should the nurse take next?
A. Encourage the client to take deep breaths
-incorrect: Encouraging the client to take deep breaths can increase the intake of oxygen. However, there is another action the nurse should take first.
B. Observe the rate, depth, and character of the client's respirations
-The nurse should apply the nursing process priority-setting framework when caring for this client in order to plan client care and prioritize nursing actions. Each step of the nursing process builds on the previous step, beginning with an assessment or data collection.

-Before the nurse can formulate a plan of action, implement a nursing intervention, or notify a provider of a change in the client's status, the nurse must first collect adequate data from the client. Assessing or collecting additional data will provide the nurse with the knowledge needed to make an appropriate decision; therefore, the nurse should first assess the client's respiratory status.
C. Prepare to administer oxygen
-incorrect: Preparing to administer oxygen is important because oxygen is frequently administered when a client is experiencing dyspnea. However, there is another action the nurse should take first.
D. Give the client a back rub to promote relaxation
-incorrect: Giving the client a back rub is a relaxation technique that can reduce dyspnea. However, there is another action the nurse should take first.

317. A nurse in a provider's office is assessing a client who has heart failure. The client has gained weight since her last visit, and her ankles are edematous. Which of the following findings is another clinical manifestation of fluid volume excess?
A. Sunken eyeballs
-incorrect: Sunken eyeballs are a clinical manifestation of fluid volume deficit.
B. Hypotension
-incorrect: Hypotension is a clinical manifestation of fluid volume deficit.
C. Poor skin turgor
-incorrect: Poor skin turgor is a clinical manifestation of fluid volume deficit.
D. Bounding pulse
-A bounding pulse is an expected finding of fluid volume excess.

318. A nurse delegated the task of emptying an indwelling urinary catheter drainage bag to an assistive personnel (AP). The nurse later observes the AP emptying the bag without wearing gloves. Which of the following actions should the nurse take?
A. Notify the charge nurse about the incident
-incorrect: The nurse does not need to notify the charge nurse about the incident. The nurse who delegates a task transfers responsibility for the task but retains accountability for the task. The nurse should evaluate the AP's performance and provide feedback as needed.
B. Insist that the AP attend an in-service training about standard precautions
-incorrect: Although further training and education may be necessary, the nurse should discuss the situation with the AP and listen attentively to the reason for the AP's actions. If the cause of the error is a lack of understanding of the procedure, the nurse can conduct training for the AP and other staff who may need assistance. The nurse can also gain assistance from the education department.
C. Talk with the AP about the technique used
-The nurse who delegates a task is responsible for providing the right supervision and evaluation. The nurse is responsible for providing feedback to the AP and should reinforce the correct procedure for this task with the AP, which includes wearing gloves.
D. Observe the AP a second time and intervene if the technique remains the same
-incorrect: The nurse should not allow the AP an opportunity to make the same mistake twice. The nurse should discuss the situation with the AP to determine the cause of the incorrect procedure and intervene the first time it is observed.

319. A nurse is preparing to administer an intramuscular injection to a young adult client. Which of the following injection sites is the safest for this client?
A. Vastus lateralis
-incorrect: The vastus lateralis is safe for adults because it is thick and away from major blood vessels and nerves. However, according to evidence-based practice, it is not the safest injection site.
B. Dorsogluteal
-incorrect: The dorsogluteal site is close to the sciatic nerve, as well as the superior gluteal nerve and artery. Therefore, according to evidence-based practice, it is not the safest injection site.
C. Deltoid
-incorrect: The deltoid site is easy to access. However, according to evidence-based practice, it is not the safest site because the muscle is small and sometimes poorly developed. Additionally, it is close to numerous arteries and nerves.
D. Ventrogluteal
-According to evidence-based practice, the ventrogluteal site is the safest injection site for all adults because it contains thick gluteal muscles and does not contain major nerves or blood vessels.

320. A nurse is caring for a client who has a dysrhythmia. Which of the following techniques should the nurse use to assess for a pulse deficit?
A. Obtain the apical and radial rates simultaneously

-To assess for a pulse deficit, the nurse and a second person assess the client's radial and apical pulses simultaneously and then compare both rates. To calculate the pulse deficit, the nurse should subtract the difference between the apical and radial pulse rates.
B. Check the blood pressure in the left and right arms
-incorrect: It is important to check the blood pressure in both the left and right arms for a client who is experiencing a dysrhythmia. However, this is not the correct procedure for assessing a pulse deficit.
C. Compare the pulse strength in the upper extremities
-incorrect: Comparing the pulse strengths in the upper extremities will not assess a pulse deficit. The nurse must obtain pulse measurements in the upper extremities and subtract the difference.
D. Palpate the pulses in the lower extremities
-incorrect: The nurse does not need to palpate pulses in the lower extremities to assess a pulse deficit. The nurse must obtain pulse measurements in the upper extremities and subtract the difference.

321. A nurse is admitting a client who has tuberculosis. In addition to standard precautions, which of the following transmission-based precautions should the nurse add to the client's plan of care?
A. Protective
-incorrect: Protective environment precautions are for clients who are immunocompromised and are at high-risk for infection (ex: clients who had chemotherapy).
B. Airborne
-Tuberculosis requires airborne precautions, which are protocols that prevent the spread of infections via very small droplets (ex: measles and varicella).
C. Droplet
-incorrect: Droplet precautions prevent the spread of infections via larger droplets (ex: rubella, pertussis, and meningococcal pneumonia).
D. Contact
-incorrect: Contact precautions prevent the spread of infections via direct or indirect contact with contaminated blood or other body fluids (ex: Shigella, herpes simplex, and E. coli).

322. A nurse is planning to administer pain medication to a client following abdominal surgery. Which of the following actions should the nurse take first?
A. Use the pain scale to determine the client's pain level
-The nurse should consider Maslow's Hierarchy of Needs, which includes 5 levels of priority. The levels are as follows: physiological needs, safety and security needs, love and belonging needs, personal achievement and self-esteem needs, and achieving full potential and the ability to problem-solve and cope with life situations.

- When applying Maslow's hierarchy of needs priority-setting framework, the nurse should review physiological needs first and then address the client's needs by following the remaining hierarchal levels. The nurse should also consider all contributing client factors, as higher levels of the pyramid can compete with those at the lower levels, depending on the specific client

situation. To meet the client's physiological needs, the nurse should begin pain management by asking the client to describe her pain.
B. Discuss the adverse effects of pain medication with the client
-incorrect: The nurse should discuss the adverse effects of pain medication with the client and instruct the client to report any problems with the intervention chosen. However, there is another action the nurse should take first.
C. Obtain the client's vital signs
-incorrect: The nurse should obtain the client's vital signs before choosing an intervention to relieve the client's pain. Obtaining vital signs provides a baseline for the nurse to compare to when monitoring the client after treating the client's pain. Respiratory depression and decreased blood pressure are adverse effects of opioid pain medications. However, there is another action the nurse should take first.
D. Check the client's allergies
-incorrect: The nurse should check the client's allergies if a pain medication will be administered. However, there is another action the nurse should take first.

323. A nurse is preparing to administer medication to a client who has gout. The nurse discovers that an error was made during the previous shift in which the client received atenolol instead of allopurinol. Which of the following interventions is the nurse's priority?
A. Measure the client's apical pulse
-The first action the nurse should take using the nursing process is to assess the client by measuring the client's apical pulse. Atenolol is a beta blocker and can decrease the client's heart rate.
B. Administer the allopurinol to the client
-incorrect: The nurse should administer allopurinol to the client to ensure timely administration of medication. However, there is another action the nurse should take first.
C. Inform the nurse manager
-incorrect: The nurse should inform the nurse manager and report the error. However, there is another action the nurse should take first.
D. Complete an incident report
-incorrect: The nurse should complete an incident report to inform the risk manager of the medication error. However, there is another action the nurse should take first.

324. A nurse is assessing the pH of a client's gastric fluid to confirm the placement of an NG tube in the stomach. Which of the following pH values should the nurse expect?
A. 6
-incorrect: A pH of 6 can indicate the tube is in the lung. The expected reference range for lung secretions is >6.
B. 2
-A pH of 2 is within the expected reference range of 0-4 for gastric secretions.
C. 10
-incorrect: A pH of 10 can indicate a false reading, as an alkaline value is too high for intestinal or lung secretions.
D. 8

-incorrect: A pH of 8 can indicate the tube has migrated down into the intestines where the expected reference range is between 7 and 8.

325. A nurse is preparing to assist an older adult client with ambulation following bed rest for 3 days. Which of the following actions should the nurse take to decrease the risk of a fall?
A. Use a gait belt during ambulation
-The nurse should use a gait belt to keep the client's center of gravity midline and decrease the risk of a fall.
B. Ensure the client is wearing socks before ambulating
-incorrect: The nurse should ensure the client is wearing non-skid shoes or slippers when ambulating to decrease the risk of a fall from slipping.
C. Instruct the client to sit on the edge of the bed for 15 sec before ambulating
-incorrect: The nurse should encourage the client to dangle the legs on the edge of the bed for 60 seconds before attempting to ambulate to decrease the risk of a fall due to orthostatic hypotension.
D. Walk 2 ft behind the client during ambulation
-incorrect: The nurse should walk beside the client to provide physical support while ambulating and decrease the risk of a fall.

326. A nurse is planning care for a young adult client who has a terminal illness. Which of the following concepts of death should the nurse consider for this client?
A. Death is unacceptable under any circumstances
-incorrect: Adolescents tend to reject the end of life, especially their own.
B. Magical thinking helps avoid thoughts of death
-incorrect: Preschoolers tend to avoid thoughts of death by employing magical thinking.
C. Death is viewed as an interruption of what might have been
-Young adults tend to see a whole life ahead of them, so death is often seen as interrupting that life. Young adults do not typically welcome death at this time.
D. Death is a natural consequence of a deteriorating body
-incorrect: Accepting the deterioration of the body is more likely among older adults, some of whom might consider death a relief from chronic or terminal illness.

327. A nurse is caring for a client who has a prescription for acetaminophen 325 mg PO for an oral temperature above 38.4 C. Above what Fahrenheit temperature should the nurse administer acetaminophen to the client? (nearest tenth)

-101.1 F

328. A nurse is preparing to administer oral phenytoin to a client who has a seizure disorder. Before administering the medication, which of the following actions should the nurse take?
A. Document the administration of the medication
-incorrect: The nurse should document the administration of the medication after dispensing it to the client, not before.
B. Count the amount of available medication on hand and sign for it

-incorrect: Phenytoin is not a controlled substance, so narcotic counts do not apply.
C. Measure the client's respiratory rate
-incorrect: Phenytoin does not affect respiratory status, so it is not necessary for the nurse to measure the client's respiratory rate immediately prior to administering this medication.
D. Check the medication dose and the client's identification
-The "rights" of medication administration include verifying the right client and the right dose.

329. A nurse is reviewing the laboratory data of a client who has a fever and watery diarrhea. Which of the following results should the nurse report to the provider?
A. Calcium 9.5 mg/dL
-incorrect: A calcium level of 9.5 mg/dL is within the expected reference range of 9 to 10.5 mg/dL.
B. Sodium 150 mEq/L
-A sodium level of 150 mEq/L is greater than the expected reference range of 135 to 145 mEq/L. This client is at risk for dehydration due to diarrhea. Hypernatremia is a manifestation of dehydration, and the nurse should report this finding to the provider.
C. Potassium 4 mEq/L
-incorrect: A potassium level of 4 mEq/L is within the expected reference range of 3.5-5 mEq/L. However, this client is at risk for hypokalemia due to diarrhea, so the client's potassium level should be monitored.
D. Magnesium 1.5 mEq/L
-incorrect: A magnesium level of 1.5 mEq/L is within the expected reference range of 1.3 to 2.1 mEq/L.

330. A nurse is providing teaching about proper care to a client who has a new colostomy. Which of the following pieces of information should the nurse include in the teaching?
A. Change the colostomy bag following breakfast
-incorrect: The nurse should instruct the client to change the colostomy bag before a meal because drainage from the ostomy is less likely to occur.
B. Cleanse the skin around the stoma with warm water
-The nurse should instruct the client to cleanse the skin around the stoma with warm water, as using soap can leave a residue on the skin and cause poor adherence of the pouch.
C. Change the pouch every day
-incorrect: The nurse should instruct the client to change the pouch every 3 to 7 days to avoid skin breakdown around the stoma.
D. Place an aspirin in the ostomy pouch to decrease odor
-incorrect: The nurse should instruct the client not to place an aspirin in the ostomy pouch to decrease odor, as this can cause stoma bleeding.

331. A nurse is caring for a client who is exhibiting confusion. The nurse should identify that which of the following laboratory values can cause confusion?
A. Sodium 123 mEq/L
-A sodium level of 123 mEq/L is below the expected reference range of 136 to 145 mEq/L. Low sodium levels can cause confusion and lead to seizures, coma, and death.

B. Blood glucose 100 mg/dL
-incorrect: A blood glucose level of 100 mg/dL is within the expected reference range of 70-110 mg/dL for fasting and less than 200 mg/dL for a casual blood draw.
C. Potassium 3.5 mEq/L
-incorrect: A potassium level of 3.5 mEq/L is within the expected reference range of 3.5 to 5 mEq/L.
D. Hemoglobin 13 g/dL
-incorrect: A hemoglobin level of 13 g/dL is within expected reference range of 12 to 18 g/dL.

332. A nurse is caring for a client who has a gastric ulcer. The nurse should explain that prolonged exposure of the body to stress can also cause which of the following to occur?
A. Hyperglycemia
-Stress causes an increased secretion of cortisol, which can lead to hypertension and hyperglycemia.
B. Hypotension
-incorrect: Prolonged stress can lead to essential hypertension.
C. Heightened immune response
-incorrect: Prolonged stress weakens the immune response, placing the client at risk of various infections and worsening the severity of those infections.
D. Bleeding tendencies
-incorrect: Prolonged stress can lead to platelet aggregation and can increase the client's risk of myocardial infarction and stroke.

333. A nurse is assessing a client who is experiencing stress and anxiety regarding a recent diagnosis. Which of the following findings should the nurse expect?
A. Increased blood pressure
-The nurse should expect a client who is experiencing stress and anxiety to manifest an increase in blood pressure and heart rate as a result of sympathetic stimulation.
B. Decreased blood glucose level
-incorrect: The nurse should expect a client who is experiencing stress and anxiety to manifest an increase in blood glucose due to the release of glucocorticoids and gluconeogenesis.
C. Decreased oxygen use
-incorrect: The nurse should expect a client who is experiencing stress and anxiety to manifest an increase in oxygen use due to an increased metabolic rate and oxygen demands of the body.
D. Increased gastrointestinal motility
-incorrect: The nurse should expect a client who is experiencing stress and anxiety to manifest decreased gastrointestinal motility, which can result in constipation and flatus.

334. A nurse is planning to assess the abdomen of a client who reports feeling bloated for several weeks. Which of the following methods of assessment should the nurse use first?
A. Inspection
-According to evidence- based practice, the nurse should inspect the abdomen first by observing the contour of the abdomen, the condition of the skin, and the position of the umbilicus. Findings from the step of assessment are used by the nurse in the subsequent steps.

B. Auscultation
-incorrect: The nurse should auscultate the client's abdomen before percussion or palpation, both of which can stimulate peristalsis, yielding inaccurate results. This sequence is different from the assessment of other body systems.
C. Percussion
-incorrect: The nurse should not percuss the client's abdomen first because percussion can cause pain and stimulate peristalsis, yielding inaccurate results in auscultation.
D. Palpation
-incorrect: The nurse should not palpate the client's abdomen first because palpation can cause pain and stimulate peristalsis, yielding inaccurate results on auscultation.

335. A nurse is teaching the parent of a child who is to take 30mL of a liquid medication. The parent has a hollow medication spoon that has marks to indicate teaspoons and tablespoons. How many tablespoons of medication should the nurse instruct the parent to give to the child? (nearest whole number).

-2 tablespoons
336. A nurse is explaining Piaget's theory of cognitive development to a group of daycare providers for employees' children at an acute care facility. Which of the following activities should the nurse include as an example of concrete operational thinking?
A. Playing in the sand
-incorrect: Playing in the sand is an example of Piaget's sensorimotor stage, which characterizes children from birth to 2 years of age.
B. Playing dress-up with old clothes
-incorrect: Playing dress-up involves pretending, which reflects Piaget's preoperational thinking stage for ages 2 to 7 years.
C. Collecting and trading game cards
-Collecting and trading game cards require seriation of the cards, involving what to collect, what to trade, and what has value. This is a characteristic of Piaget's concrete operational stages for ages 7 to 11 years.
D. Describing interpersonal relationships
-incorrect: Describing interpersonal relationships requires abstract thought, which is part of Piaget's formal operational reasoning stage for ages 11 years and beyond.

337. A nurse is caring for a toddler at a well-child visit when the mother calls, "Help! My baby is choking on his food!" Which of the following findings indicates the toddler has an airway obstruction?
A. Flushing of the skin
-incorrect: Cyanosis is a finding with poor oxygenation, which could indicate an airway obstruction. The nurse should check the skin, nailbeds, and mucous membranes to identify the presence of cyanosis.
B. Inability to cry or speak

-When the client has no sound passing through the vocal cords, a complete airway obstruction is evident. The nurse should use the Heimlich maneuver to dislodge whatever is obstructing the trachea.
C. Presence of nausea and mild emesis
-incorrect: The presence of mild emesis does not indicate an airway obstruction. The nurse should monitor the client to ensure the client clears emesis from the oral cavity in order to prevent the airway from becoming obstructed.
D. Capillary refill time of 1.5 sec
-incorrect: The expected finding for capillary refill time or blanch testing of the nailbed is <2 seconds; therefore, the nurse should not identify this finding as an indication of airway obstruction. Delayed capillary refill time can indicate circulatory impairment.

338. A nurse is assessing the heart sounds of a client who has developed chest pain that worsens with inspiration. The nurse auscultates a high-pitched scratching sound during both systole and diastole with the diaphragm of the stethoscope positioned at the left sternal border. Which of the following heart sounds should the nurse document?
A. Audible click
-incorrect: An audible clicking sound occurs in clients who have undergone prosthetic valve replacement surgery.
B. Murmur
-incorrect: A heart murmur has a swishing or whistling sound. Heart murmurs are caused by turbulent blood flow through valves or ventricular outflow tracts. Low- and medium- frequency sounds are more easily heard with the bell of the stethoscope applied lightly to the skin; high-frequency sounds are more easily heard with a diaphragm. A murmur can be a manifestation of valvular disease.
C. Third heart sound
-incorrect: A third heart sound (S3) is a low-pitched noise after the second heart sound. An S3 is caused by rapid ventricular filling during diastole. It is best heard at the mitral area, with the client lying on the left side. An S3 is commonly heard in children and young adults. In older adults and clients who have heart disease, an S3 often indicates heart failure.
D. Pericardial friction rub
-A pericardial friction rub has a high-pitched scratching, grating, or squeaking leathery sound that is heard best with the diaphragm of the stethoscope at the left sternal border. A pericardial friction rub is a manifestation of pericardial inflammation and can be heard with infective pericarditis with myocardial infarction, following cardiac surgery or trauma, and with some autoimmune problems like rheumatic fever. A client who develops pericarditis typically has chest pain that becomes worse with inspiration or coughing and may be relieved by sitting up and leaning forward.

339. A nurse is assessing a client who is experiencing stress following a near fall out of bed. Which of the following physiological responses should the nurse expect due to the fight or flight response?
A. Decreased respiratory rate

-incorrect: The nurse should expect an increased respiratory rate in a client who is experiencing the fight or flight response.
B. Pinpoint pupils
-incorrect: The nurse should expect dilated pupils in a client who is experiencing the fight or flight response.
C. Increased blood pressure
-The nurse should expect a client who is experiencing the fight or flight response to manifest an increase in arterial blood pressure, heart rate, and cardiac output due to arousal of the central nervous system.
D. Bronchiolar construction
-incorrect: The nurse should expect bronchiolar dilation in a client who is experiencing the fight or flight response.

340. A nurse is assessing a client's incision and observes the drainage to be blood tinged. Which of the following terms should the nurse use to document this finding?
A. Sanguineous
-The nurse should document blood tinged drainage as sanguineous. This type of drainage contains large amounts of RBCs, indicating that damaged capillaries are allowing the escape of RBCs from the plasma.
B. Purulent
-incorrect: The nurse should identify that purulent drainage is exudate that is thicker than other drainages, indicating the presence of pus. This pus consists of leukocytes, liquefied dead tissue debris, and dead and living bacteria.
C. Serous
-incorrect: The nurse should identify serous drainage as exudate that is mostly serum, which is the clear portion of the blood. It appears watery and contains few cells.
D. Hyperemia
-incorrect: The nurse should identify hyperemia as a red coloration of the skin in clients who have light skin or as a blue coloration of the skin in clients who have dark skin. Hyperemia is not a type of drainage.

341. A nurse is providing discharge teaching to a client who has a prescription for daily wound care via home health services. Which of the following statements by the client indicates an understanding of the teaching?
A. "A nurse will show me how to care for my wound."
-The home health nurse will provide wound care as prescribed and educate the client about wound care and illness management."
B. "A nurse will stay with me at home during the day."
-incorrect: A client who will receive daily wound care will not require a nurse to stay throughout the day. The home health nurse can make a referral for a home health aide to stay with the client if needed.
C. "I will call the nurse to change my bed linens."
-incorrect: If needed, the home health nurse can make a referral to a home health aide to provide personal care, such as changing bed linens.

D. “I will call the nurse to help me bathe in the morning.”
-incorrect: If needed, the home health nurse can make a referral to a home health aide to provide personal care, such as bathing.

342. A nurse is removing protective personal equipment (PPE) after performing a procedure for a client who requires isolation precautions. Which of the following items of PPE should the nurse remove first?
A. Gloves
-According to evidence-based practice, the nurse should first remove the gloves because they are the most contaminated piece of PPE. Next, the nurse should remove the goggles or face shield and then the gown. Finally, the nurse should remove the respirator or mask because it is the least contaminated piece of PPE.
B. Gown
C. Eyewear
D. Mask
-incorrect B/C/D: According to evidence-based practice, nurses should remove the most contaminated piece of PPE first and the least contaminated piece of PPE last. The most contaminated piece of PPE are the gloves, and the least contaminated piece of PPE is the mask.

343. A nurse is measuring a client’s vital signs. The client’s resting radial pulse rate is 55/min. Which of the following actions should the nurse take next?
A. Document the finding
-incorrect: The nurse should document all findings in the client’s medical record to verify that this measurement was obtained. However, there is another action the nurse should take first.
B. Measure the client’s apical pulse rate
-The first action the nurse should take using the nursing process is to assess or collect data from the client. This pulse rate is below the expected reference range for an adult. The nurse and coworker should measure the apical and radial pulse rates simultaneously to determine if there is a pulse deficit. If the client’s radial pulse rate is lower than the apical rate, the client might have a cardiovascular disorder.
C. Talk with the client about factors that can affect the pulse rate
-incorrect: The nurse should inform the client about the low pulse rate and possible causes so that the client understands the reason for any additional actions the nurse might take. However, there is another action the nurse should take first.
D. Notify the provider about the client’s radial pulse rate
--incorrect: The nurse should inform the provider of the client’s low pulse rate to obtain additional diagnostic or treatment prescriptions. However, there is another action the nurse should take first.

344. A nurse is caring for a client who is unconscious. Which of the following actions should the nurse take when providing oral care for the client?
A. Test for the presence of the client’s gag reflex
-The nurse is responsible for checking for the presence of a gag reflex prior to performing oral care. This is done to determine the risk of aspiration and is especially important for clients who

are unconscious because many clients who have decreased level of consciousness often do not have a gag reflex.
B. Place the client in the supine position
-incorrect: The nurse should raise the bed to a semi-Fowler's position and turn the client's head toward the person who will be performing oral care.
C. Use a firm toothbrush for tooth and gum care
-incorrect: The nurse should use a soft-bristled toothbrush with nonabrasive fluoride toothpaste to perform oral care.
D. Use 2 gauze-wrapped fingers to hold the mouth open
-incorrect: The nurse should use a small oral airway or a padded tongue blade to hole the client's mouth open when cleansing the oral cavity. A bite from the client's mouth can contain multiple pathogenic microorganisms; therefore, the nurse should not place fingers inside the client's mouth.

345. A nurse is preparing to administer a partial dose of a prefilled opioid analgesic parenterally to a client. Which of the following actions should the nurse plan to take?
A. Return the unused portion of the medication to the pharmacy
-incorrect: The nurse should not return the unused portion of medication to the pharmacy. The medication should be wasted, and the amount wasted should be recorded on the controlled substance inventory.
B. Dispose of the wasted medication into a sharps container
-incorrect: The nurse should dispose of a controlled substance into a sharps container. Both the amount of the medication given, and the amount of medication wasted should be signed for.
C. Record the amount of medication wasted on the controlled substance inventory record
-Two nurses should sign the controlled substance inventory record to document the amount of medication wasted.
D. Ask an assistive personnel (AP) to witness the wasting of the controlled substance
-incorrect: A second nurse, not an AP, must serve as the witness to the wasting of the remaining controlled substance.

346. A nurse is monitoring a client's laboratory results. Which of the following results should the nurse report to the provider?
A. Sodium 140 mEq/L
-incorrect: This sodium value is within the expected reference range.
B. Potassium 3.0 mEq/L
-This potassium level is below the expected reference range, indicating hypokalemia. The nurse should report this finding to the provider for instructions about preventing muscle weakness that could affect respiration.
C. Chloride 100 mEq/L
-incorrect: This chloride value is within the expected reference range.
D. Magnesium 2.0 mEq/L
-incorrect: This magnesium value is within the expected reference range.

347. A nurse is caring for a client who has the head of the bed elevated to a 45-degree angle with his knees slightly flexed. Which of the following positions should the nurse document for the client?
A. Sims'
-incorrect: In this position, the client lies on a side with the leg on that side slightly flexed and the opposite leg more acutely flexed. The lower arm is behind, with the opposite arm flexed at the shoulder and the elbow.
B. Prone
-incorrect: In this position, the client is lying on the abdomen.
C. Supine
-incorrect: In this position, the client is lying flat on the back.
D.Fowler's
-This describes Fowler's position. Although various definitions exist for Fowler's position, generally a low Fowler's position means 30 degrees of elevation, semi-Fowler's is 45-60 degrees, and high Fowler's is 60-90 degrees of elevation.

348. A nurse is teaching a client who has asthma about the proper use of an albuterol inhaler. Which of the following client statements indicates an understanding of the teaching?
A. "I should rinse my mouth out right before I use the inhaler."
-incorrect: The nurse should instruct the client to rinse the mouth with water following the use of the inhaler to reduce irritation and infection, not before using the inhaler.
B. "After the first puff, I will wait 10 seconds before taking the second puff. "
-incorrect: The nurse should instruct the client to wait 20-30 seconds between inhalations of bronchodilator medications such as albuterol.
C. "I will shake the inhaler well right before I use it."
-The nurse should instruct the client to shake the inhaler vigorously for 3-5 seconds, which will mix the medication within the inhaler evenly.
D. "I will tilt my head forward while inhaling the medication."
-incorrect: The nurse should instruct the client to place the inhaler in the mouth and tightly close the lips around the mouthpiece to create a seal. The client should then depress the canister, take a deep breath, and hold it for at least 10 seconds.

349. A nurse is caring for a client who had a stroke and is at risk for falling. Which of the following actions should the nurse take?
A. Assign the client to a private room
B. Keep 4 side rails up while the client is in bed
C. Monitor the client at least once every hour
D. Request a PRN prescription for restraints

350. A nurse is caring for a group of clients. Which of the following tasks should the nurse assign to an assistive personnel (AP)?
A. Provide oral care to a client who cannot take oral fluids
-Providing oral care to a client who cannot take oral fluids is within the range of function for an AP. Therefore, the nurse can assign this task to the AP.

B. Check the client's IV insertion site for manifestations of infiltration
-incorrect: Checking the client's IV insertion site for manifestations of infiltration is not within the range of function for an AP. Therefore, the nurse should not assign this task to the AP.
C. Assess a client's ability to ambulate
-incorrect: Assessing a client's ability to ambulate is not within the range of function for an Ap. Therefore, the nurse should not assign the AP this task.
D. Demonstrate the use of a glucometer to a client who has diabetes mellitus
-incorrect: Demonstrating the use of a glucometer to a client who has DM is not within the range of function for an AP. Therefore, the nurse should not assign this task to the AP.

351. A nurse is teaching a group of young adults. Which of the following should the nurse identify as an expected developmental task for this age group?
A. Independent moral development
-According to Kohlberg's theory of moral development, making individual decisions about moral issues is a function of the highest level of moral development, the post-conventional level. Young adults who have reached this level separate themselves from the rules and tenets of others and make their own decisions according to personal beliefs and principles.
B. Acceptance of body changes
-incorrect: Acceptance of body changes should take place during adolescence
C. Strengthening ties with the family of origin
-incorrect: Young adults need to develop intimacy outside of the family.
D. Development of concrete reasoning
-incorrect: Concrete thinking develops during middle childhood. Abstract reasoning develops during adolescence.

352. A nurse in a provider's office is reviewing the laboratory findings of a client who reports chills and aching joints. The nurse should identify which of the following findings as an indication of an infection?
A. WBC 15,000 mm^3
-This finding is above the expected reference range and is an indication of infection.
B. Erythrocyte sedimentation rate (ESR) 15 mm/hr
-incorrect: Although an elevated ESR can indicate an infection, this finding is within the expected reference range.
C. Urine pH 7.2
-incorrect: A urine pH of 7.2 is within the expected reference range.
D. Urine specific gravity 1.0063
-incorrect: A urine specific gravity of 1.0063 is within the expected reference range.

353. A nurse is assessing a client's vascular system. Which of the following techniques should the nurse use when evaluating the carotid arteries?
A. Palpation of both carotid arteries simultaneously
-incorrect: Palpating the carotid arteries simultaneously can compromise the blood flow to the brain.
B. Auscultation of the arteries for bruits with the bell of the stethoscope

-The bell of the stethoscope is more effective than the diaphragm in transmitting blowing or swishing sounds, such as those from turbulence in blood vessels.
C. Palpation of the arteries for murmurs bilaterally
-incorrect: Murmurs are swishing or blowing sounds. Detecting them requires auscultation, not palpation.
D. Auscultation of the arteries for thrills with the diaphragm of the stethoscope
-incorrect: Thrills are palpable purring sensations. Detecting them requires palpation, not auscultation.

354. A nurse on a surgical unit is receiving a client who had abdominal surgery from the post anesthesia care unit. Which of the following assessments should the nurse make first?
A. Pain level
-incorrect: The nurse should assess the pain level of a client who is postoperative; however, another assessment should be made first.
B. Hydration status
-incorrect: The nurse should assess the hydration status of a client who is postoperative; however, another assessment should be made first.
C. Airway
-The nurse should apply the ABC priority-setting framework when caring for this client. This framework emphasizes the basic core of human functioning and prioritizes having an open airway, being able to breathe in adequate amounts of oxygen, and circulating oxygen to the body's organs via the blood. An alteration in any of these can indicate a threat to life. Therefore, this is the nurse's priority concern.

-When applying the ABC priority-setting framework, airway is always the highest priority because the airway must be clear for oxygen exchange to occur. Breathing is the second highest priority in the ABC priority-setting framework because adequate ventilatory effort is essential for oxygen exchange to occur. Circulation is the third highest priority in the ABC priority-setting framework because the delivery of oxygen to critical organs only occurs if the heart and blood vessels are capable of efficiently carrying oxygen to them.
D. Urinary output
-incorrect: The nurse should assess the urinary output of a client who is postoperative; however, another assessment should be made first.

355. A nurse is caring for a client who starts to experience a seizure while sitting in a chair. Which of the following actions should the nurse take?
A. Place a padded tongue blade in the client's mouth
-incorrect: The nurse should avoid placing a padded tongue blade in the client's mouth because this can cause injury (ex: broken teeth).
B. Lower the client to the floor and place a pad under the client's head
-To reduce the risk of injury to the client, the nurse should lower the client to the floor and place a pillow or another soft object under the client's head.
C. Seek the help of a coworker and lift the client back into bed
-incorrect: The nurse should not attempt to lift a client who is experiencing a seizure.

D. Use an oropharyngeal airway to keep the upper airway passages open
-incorrect: The nurse should avoid inserting an oropharyngeal airway because this can cause injury.

356. A nurse is preparing to change a dressing on a client who is receiving negative pressure wound therapy (NPWT). What sequence of actions should the nurse plan to take?
-Turn off the vacuum on the NPWT device and administer the prescribed analgesic.
-Remove the soiled dressing and perform hand hygiene
-Apply sterile or clean gloves and irrigate the wound
-Apply a skin protectant or barrier film to the skin around the wound
-Place prepared foam into the wound bed and cover with a transparent dressing
-Connect the tubing to transparent film and turn on the NPWT unit

357. A nurse is providing teaching to a client with heart failure about reducing his daily intake of sodium. Which of the following factors is the most important in determining the client's ability to learn new dietary habits?
A. The involvement of the client in planning the change
-According to evidence-based practice, client involvement in planning dietary changes is the most important factor in the client's ability to learn new habits.
B. The emphasis the provider places on the dietary changes
-incorrect: The emphasis the provider places on the dietary changes can influence the client's ability to learn new dietary habits; however, it is not the most important factor.
C. The learning theory the nurse uses to teach the dietary changes
-incorrect: The learning theory the nurse uses to teach dietary changes can influence the client's ability to learn new dietary habits; however, it is not the most important factor.
D. The extent of the dietary changes planned for the client
-incorrect: The extent of the changes planned can influence the client's ability to learn new dietary habits; however, it is not the most important factor.

358. While admitting a client to the medical unit, the nurse asks him if he has advanced directives. This client states "I have a document with me that names someone who can make health care decisions for me if I am not stable." The nurse should identify that the client is referring to which of the following documents?
A. Informed consent form
-incorrect: Prior to specific procedures, clients must sign an informed consent form to confirm that the provider has explained the risks and benefits and pertinent information about the procedure.
B. Living will document
-incorrect: A living will contain advance directives that inform medical personnel about the care to provide in case the individual is unable to make decisions.
C. Do-not-resuscitate (DNR) directive
-incorrect: A DNR directive is a prescription the provider writes on the client's request to instruct the staff to forego resuscitation efforts for the client.
D. Durable power of attorney document

-A durable power of attorney for health care document, or health care proxy, names a surrogate who can make health care decisions for the client if he is unable to do so.

359. A nurse is caring for a client who has a terminal illness. Which of the following findings indicates that the client's death is imminent?
A. Urinary retention
-incorrect: Urinary incontinence is a physical change that occurs when a client's death is imminent.
B. Cold extremities
-The presence of cold extremities, first in the feet and then in the hands, is a physical change that occurs when a client's death is imminent.
C. Hypertension
-incorrect: Hypotension is physical change that occurs when a client's death is imminent.
D. Tachycardia
-incorrect: A slow, weak pulse is a physical change that occurs when a client's death is imminent.

360. A nurse is using the I-SBAR communication tool to give a client's provider information about the client. The nurse should convey this client's pain status in which portion of the report?
A. Assessment
-The nurse provides information about the assessment findings in this portion of the report, including vital signs, pain assessment, and changes in assessment findings.
B. Background
-incorrect: The nurse provides information about pertinent medical history, laboratory findings, allergies, and code status in this portion of the report.
C. Situation
-incorrect: The nurse provides information about problems the client is experiencing in this portion of the report.
D. Recommendation
-incorrect: The nurse makes recommendations about treatment and asks the provider about additional treatment in this portion of the report.

361. A nurse is preparing to administer a tap water enema to a client. Which of the following actions should the nurse take?
A. Raise the enema bag if the client experiences cramping
-incorrect: The nurse should administer the fluids slowly and lower the container for a client who experiences fullness or pain during the administration of the enema.
B. Lubricate 2.54 cm (1in) of the tip of the rectal tube prior to insertion
-incorrect: The nurse should lubricate 5.08 cm (2in) of the tip rectal tube prior to insertion.
C. Place the client in a left Sims' position
-The nurse should place the client into a left Sims' position for the insertion of an enema. This left lateral position facilitates the flow of the enema solution into the sigmoid and descending colon. The anus is exposed by flexing the right leg.
D. Don sterile gloves prior to the procedure

-incorrect: The nurse should don clean gloves to perform an enema procedure for a client.

362. A nurse enters a client's room and finds the client sitting on the floor and leaning against the side of the bed. The client states she slipped while getting out of bed. Which of the following actions should the nurse take first?
A. Complete an incident report
-incorrect: Any accident or unusual occurrence, such as a fall or a medication error, requires the nurse to complete an incident report to document the event for the facility and to help the risk managers create strategies to prevent future occurrences; however, there is another action the nurse should take first.
B. Check the client for injuries
- Using the nursing process, the nurse should first evaluate the client for any injuries or physiological changes. The nurse should also notify the provider to determine the need for any further examination or intervention.
C. Make sure the client has skid-free footwear
-incorrect: The nurse should ensure the client has skid-free footwear that fits well that the client knows to wear this footwear any time she gets out of bed; however, there is another action the nurse should take first.
D. Remind the client to ask for help when getting out of bed
-incorrect: The nurse should seek to prevent future injuries, such as reminding the client to use the call light to ask for help when getting out of bed; however, there is another action the nurse should take first.

363. A nurse is preparing to administer a tuberculin skin test to a client. After performing hand hygiene, which of the following actions should the nurse take?
A. Select a 23-gauge needle
-incorrect: A 25-27-gauge needle is used for intradermal injections.
B. Insert the needle into the skin at a 25-degree angle
Incorrect: The needle should be inserted at an angle of 10-15 degrees. This ensures the solution will be injected into the intradermal area.
C. Massage the area of injection following removal of the needle
-incorrect: The area of injection should not be massaged because this can spread the medication into the tissue or out through the insertion site.
D. Circle the injection area with a pen
-Circling the area with a pen ensures the nurse will examine the correct site when reading the test 48-72 hours later.

364. A nurse is planning to document care provided for a client. Which of the following abbreviations should the nurse use?
A. BT for bedtime
-incorrect: The nurse should avoid using this abbreviation because it can be mistaken for BID, which means twice daily. Instead, the. nurse should use the word "bedtime".
B. SC for subcutaneously

-incorrect: The nurse should avoid using this abbreviation because it can be mistaken for sublingual. Instead, the nurse should use “subtcut” or “subcutaneously”.
C. PC for after meals
-The nurse can use this abbreviation because it is approved and not error-prone.
D. HS for half-strength
-incorrect: The nurse should avoid this abbreviation and use “Half-strength” instead.

365. A nurse is caring for a client who is having difficulty breathing. The nurse should assist the client into which of the following positions?
A. Supine
-incorrect: Although many clients find lying on their back comfortable, this position does not facilitate lung expansion for a client who has dyspnea.
B. Lateral
-incorrect: A side-lying position facilitates expansion of a single lung. However, a client who has dyspnea needs maximum expansion of both lungs.
C. Fowler’s
-Sitting upright promotes full expansion of both lungs and facilitates ventilation and perfusion.
D. Trendelenburg
-incorrect: Lowering the head of the bed with the foot of the bed raised in a straight incline can promote venous circulation and facilitate postural drainage. However, it will not improve lung expansion for a client who has dyspnea.

366. A nurse is caring for a client who is hospitalized and has a new tracheostomy. Which of the following actions should the nurse take when performing tracheostomy care for the client?
A. Perform tracheostomy care using medical asepsis
-incorrect: Tracheostomy care for a client with a new tracheostomy should be performed using surgical asepsis (sterile technique).
B. Allow enough slack under the tracheostomy ties to insert three fingers
-incorrect: The nurse should allow room to insert 1 to 2 fingers under the tracheostomy ties; this ensures they are not too restrictive.
C. Soak the inner cannula of the tracheostomy tube in normal saline
-The inner cannula of the tracheostomy tube should be soaked in normal saline or a mixture of normal saline and hydrogen peroxide to loosen secretions.
D. Cut a sterile gauze pad to place between the neck and tracheostomy tube
-incorrect: A cut gauze pad should not be used near a tracheostomy tube because the client can aspirate loose threads. The nurse should use a commercially prepared tracheostomy dressing under the tracheostomy tube.

367. A nurse is preparing to administer a bolus feeding to a client through an NG tube and observes that the exit mark on the tube has moved since the last feeding. Which of the following actions should the nurse plan to take?
A. Auscultate over the stomach while injecting air

-incorrect: The nurse should not verify the NG tube placement by auscultating over the stomach while injecting air because it is difficult to distinguish whether the sound is coming from the stomach, lung, or intestine.
B. Request an X-ray of the client's abdomen
-The nurse should request an x-ray to verify the placement of the NG tube both after to initial insertion of the tube and if displacement of the tube is suspected. The nurse should verify NG tube placement prior to administering a bolus feeding.
C. Place the head of the client's bed in a flat position
-incorrect: The nurse should verify NG tube placement and elevate the head of the client's bed before administering a bolus tube feeding to reduce the risk of aspiration.
D. Administer the feeding if the pH of the aspirated contents is >6
-incorrect: The pH of gastric contents should be <5. Aspirated contents that have a pH of >6 indicates that the NG tube is in the lungs or intestines. Therefore, the nurse should not administer the feeding.

368. A nurse is caring for a client who is having difficulty with muscle coordination following a head injury. The nurse should suspect injury to which of the following areas of the brain?
A. Hypothalamus
-incorrect: The nurse should suspect an injury to the hypothalamus if a client is experiencing difficulty with sleeping. This area of the brain serves as the sleep center in the body by secreting hypocretins that promote rapid eye movement (REM) sleep.
B. Cerebral cortex
-incorrect: The nurse should suspect an injury to the cerebral cortex if a client is experiencing difficulty with expression. This area of the brain contains the neural networks that facilitate complex behaviors like learning, memory, and language.
C. Pituitary
-incorrect: The pituitary gland secretes several hormones such as adrenocorticotropic hormone that produces cortisol. These hormones are necessary for stress adaptation.
D. Cerebellum
-The nurse should suspect an injury to the cerebellum if the client is experiencing difficulty controlling balance and coordination. A client's movements can become uncoordinated, unsure, and clumsy following an injury to this area of the brain.

369. A nurse is planning an in-service training session about nutrition. Which of the following pieces of information should the nurse take?
A. Fat breaks down into amino acids
-incorrect: Protein breaks down into amino acids.
B. Protein serves as an energy source when other sources are inadequate
-Protein is used as an energy source for the body when carbohydrates and fat stores are unavailable or depleted.
C. Glucose breaks down into ammonia
-incorrect: Protein breaks down into ammonia. Glucose does not produce any products of metabolism.
D. Carbohydrates provide 9 cal/g of energy

-incorrect: Carbohydrates provide 4 cal/g of energy. Fat provides 9 cal/g of energy.

370. A nurse is teaching a client who has urinary incontinence about bladder retraining. Which of the following instructions should the nurse include?
A. “Wake up every 2 hr to urinate during the night.”
-incorrect: The client should wake up every 4 hours to urinate during the night; for most clients, this occurs just once during sleeping hours.
B. “Drink citrus juices throughout the day.”
-incorrect: Citrus juices can irritate the bladder, increasing the likelihood of incontinence episodes.
C. “Try to block the urge to urinate until the next scheduled time.”
-When the client is following a schedule of voiding intervals and feels the urge to urinate before the next scheduled time, she should try slow, deep breathing to help reduce the urge. She can also try 5 or 6 strong and quick pelvic muscle exercises.
D. “Limit fluids to no more than 1 L (34 oz) during waking hours.”
-incorrect: The client should reduce her fluid intake during the 4 hours before bedtime; however, she should drink plenty of fluids during the rest of her waking hours and avoid drinking large amount all at once.

371. A nurse is collecting a specimen for culture from a client’s infected wound. Which of the following actions should the nurse perform?
A. Wear sterile gloves when collecting the specimen
-incorrect: The nurse should wear clean gloves to collect a wound culture specimen. The nurse’s hands will not touch the wound or the culture swab.
B. Cleanse the wound with 0.9% sodium chloride irrigation
-The nurse should cleanse the wound with sterile water or 0.9% sodium chloride irrigation to remove any surface debris or old exudate.
C. Allow the collection swab to absorb old exudate
--incorrect: Pooled drainage can collect microorganisms that are not the pathogens causing the wound infection.
D. Rotate the collection swab over the edges of the wound
-incorrect: The nurse should rotate the swab back and forth over the clean areas in the base of the wound to collect the pathogens causing the wound infection. The edges of the wound can harbor superficial microorganisms from the skin that are not infecting the wound.

372. A nurse is teaching a middle-aged adult client about health promotion and disease prevention. The nurse should inform the client that which of the following changes could occur?
A. Decreased estrogen and testosterone production
-Both estrogen and testosterone levels start to decrease in middle age.
B. Increased tone of the large intestines
-incorrect: The tone of the large intestines decreases during middle age, placing clients at risk for constipation.
C. Increased percentage of the body’s muscle mass

-incorrect: There is a decrease in the body's muscle mass as clients approach the latter portion of middle age.
D. Decreased incidence of chronic illnesses
-incorrect: The likelihood of developing a chronic illness increases during middle age.

373. A nurse is performing a physical examination for a client. To evaluate the client's skin moisture, the nurse should use which of the following techniques?
A. Percussion
-incorrect: Percussion is not an effective way to evaluate skin moisture. Percussion helps the nurse locate organs or masses and determine their dimensions.
B. Auscultation
-incorrect: Auscultation is not an effective way to evaluate skin moisture. Auscultation helps the nurse listen to lung, heart, and bowel sounds.
C. Inspection
-incorrect: Inspection is not an effective way to evaluate skin moisture. With inspection, the nurse observes visual variations from expected observational findings.
D. Palpation
-With palpation, the nurse uses touch to help detect unusual or expected sensations including texture, temperature, masses, or moisture.

374. A nurse is responding to a parent's question about his infant's expected physical development during the first year of life. Which of the following pieces of information should the nurse include?
A. A 2-month old infant can turn from his abdomen to his back
-incorrect: An infant cannot turn from his abdomen to his back until 5 months of age.
B. A 10-month old infant can pull up to a standing position
-An 8-10-month-old infant can pull up to a standing position.
C. A 4-month old infant can sit up without support
-incorrect: A 6 to 8-month old infant can sit up without support.
D. A 6-month old infant can crawl on his hands and knees
-incorrect: An 8 to 10-month old infant can crawl on hands and knees.

375. A nurse is planning care for a client who is postoperative and has a history of poor nutritional intake. Which of the following actions should the nurse include in the plan of care to promote wound healing?
A. Limit total caloric intake to 25 kcal/kg of body weight
-incorrect: A caloric intake of 35-40 kcal/kg of body weight per day is necessary to maintain a positive nitrogen balance, which promotes wound healing.
B. Provide an intake of 500 mg/day of vitamin E
-incorrect: Vitamin E is not essential for wound healing.
C. Limit fluid intake to 20 mL/kg of body weight per day
-incorrect: The nurse should encourage a fluid intake of 30-35 mL/kg of body weight per day, as water is essential to the wound- healing process.
D. Provide a protein intake of 1.5 g/kg of body weight per day

-A protein intake of 1 to 1.5 g/kg of body weight per day is necessary to maintain a positive nitrogen balance, which promotes wound healing.

376. A nurse is caring for a client who has Clostridium difficile infection and is in contact isolation. Which of the following actions should the nurse take?
A. Wear gloves when changing the client's gown.
-The nurse should wear gloves when handling articles that have the potential to contaminate the hands when caring for a client in contact isolation.
B. Use alcohol-based sanitizer to cleanse the hands
-incorrect: The nurse should use soap and water to cleanse the hands. Alcohol-based hand sanitizer is ineffective against the spores of C. difficile.
C. Wear a mask when assisting the client with his meal tray
-incorrect: The nurse should wear a mask when working within 3 feet of a client who has an infection, and droplet precautions are required.
D. Place the client on complete bed rest
-incorrect: The nurse should not place the client on complete bed rest because this places him at risk for the hazards of immobility, such as impaired skin integrity and retained respiratory secretions. The nurse should instruct the client to remain in his room but to move, cough, and deep breathe at least every 2 hours.

377. A home health nurse enters a client's home and finds a used insulin syringe without a cap on the table. Which of the following actions should the nurse take?
A. Recap the needle on the syringe
-incorrect: The nurse should not recap the needle because of the risk of a needlestick injury during this action.
B. Schedule a nurse to administer future injection for this client
-incorrect: The nurse should not schedule another nurse to administer future injections for this client. The nurse should teach the client about potential injuries and infections that can result from a needlestick injury. After exploring the client's reasons for nonadherence to safety measures, the nurse should review appropriate methods of disposal for used syringes.
C. Explain to the client that the syringe should be disposed of in the bathroom trash can
-incorrect: The nurse should not instruct the client to dispose of used syringes in a bathroom trash can due to the risk of a needlestick injury when handling the trash.
D. Place the syringe in a puncture-proof disposal container
-The nurse should place the uncapped syringe in a puncture-proof sharps disposal or rigid plastic container to prevent a needlestick injury. The nurse should keep the syringe uncapped to prevent a needlestick injury while placing the cap on the needle. Then, the nurse should provide client education on safety and proper disposal of syringes.

378. A nurse is performing an admission assessment for a client. Which of the following responses by the nurse reflects the communication technique of clarifying?
A. "Now that we have talked about your medications, let's talk about your pain."
-incorrect: This is an example of the communication technique of focusing. The nurse can use this technique to keep the conversation moving in an organized direction.

B. “Are you having other symptoms?”
-incorrect: This is an example of the communication technique of asking a relevant question. These kinds of questions are open-ended and allow the client to offer more information to the nurse.
C. “It sounds like your pain is intermittent.”
-This response by the nurse reflects communication technique of clarifying. The nurse should use this technique to ensure an understanding of the client’s message.
D. “It seems as though you have really had a rough time these past few weeks.”
-incorrect: This is an example of the communication technique of sharing empathy. With this technique, the nurse is able to convey understanding and acceptance of what the client is or has been experiencing.

379. A nurse is preparing to assess the function of the client’s trigeminal nerve (cranial nerve V). Which of the following items should the nurse gather for the test?
A. Sugar
-incorrect: The nurse should use sugar to test the function of the olfactory nerve (CN VII).
B. Coffee
-incorrect: The nurse should use coffee to test the function of the olfactory nerve (CN I).
C. Cotton wisps
-The trigeminal nerve has both sensory and motor capabilities. To assess its sensory function, the nurse uses a safety pin to assess for recognition of pain and a cotton wisp to evaluate recognition of touch sensations. To test motor abilities of cranial nerve (CN V), the nurse should ask the client to clench the teeth.
D. Snellen Chart
-incorrect: The nurse should use the Snellen chart to test the function of the optic nerve (CN II).

380. A nurse is caring for an adult client in the terminal stages of lung cancer who refuses any further treatment. The nurse should provide care that facilitates which of the following outcomes?
A. Allows minimal treatment
-incorrect: The client has the right to refuse all treatment, and the nurse has a duty to honor that right.
B. Benefits the client’s family
-incorrect: The nurse’s priority is to provide care that benefits the client, not necessarily the family.
C. Offers hope for a cure
-incorrect: Offering hope for a cure when lung cancer is advanced is a nontherapeutic response and provides false reassurance to the client.
D. Supports self-determination
-The nurse must honor the client’s autonomy and ability to make health care decisions. The client has the right to refuse treatment; as the client’s advocate, the nurse must support that right.

381. A nurse is preparing to administer medications to a client who is unconscious. The nurse should bring the medication administration record (MAR) to the client's bedside and perform which of the following verification procedures?
A. Check the client's name and medical record number on the MAR against the room and bed number
-incorrect: The client's room and bed numbers are not acceptable identifiers.
B. Call the client by name and check the name on her identification band against the MAR
-incorrect: This client cannot respond to her name.
C. Compare the medical record number and name on the MAR with the client's identification band
-The Joint Commission requires the use of 2 client identifiers when administering medications. The nurse should compare the medical record number and name on the MAR with the client's identification band.
D. Ask the client's visitor to identify the client by name and to state the client's date of birth
-incorrect: A visitor is not an acceptable source for identification.

382. A nurse is preparing to administer an intramuscular injection to a client who is overweight. Which of the following sites should the nurse select for the injection?
A. Lower medial quadrant of the buttock near the coccyx
-incorrect: To administer an intramuscular medication using the dorsogluteal site, the nurse should select the upper lateral quadrant of the buttock. However; this site can increase the risk of injury to the client because the medication is more likely to be injected into subcutaneous tissue, and there is an increased risk of piercing the sciatic nerve.
B. Side hip between the iliac crest and anterior iliac spine
-The side hip between the iliac crest and anterior iliac spine forms the boundaries for a ventrogluteal injection; therefore, this is an appropriate site for the nurse to select. This site is preferred for intramuscular injections for an adult client. The nurse should prepare for injection by placing a hand on the client's greater trochanter (ex: right hand on left hip) with the first 2 fingers touching the iliac crest and anterior superior iliac spine, forming a "V" shape.
C. Tissue of the posterior upper arm
-incorrect: The nurse should select the outer posterior tissue of the upper arm when preparing to administer a subcutaneous injection. For intramuscular injections that are <1 mL, the nurse may select the deltoid muscle by placing 4 fingers on the deltoid muscle with the top finger on the acromion process. The injection site then is three finger widths below the acromion process, or about 5 cm (2in).
D. Lower inner thigh 4 finger-widths above the patella
-incorrect: To administer intramuscular medication using the vastus lateralis site, the nurse should select the middle portion of the muscle from the midline of the thigh to the midline of the outer side of the thigh. The nurse can place a hand below the greater trochanter and the other hand just above the knee to locate the middle portion of the muscle for the injection site.

383. A nurse is preparing to perform postural drainage for a client. Which of the following actions should the nurse take?
A. Give the client a bronchodilator immediately after the procedure

-incorrect: The nurse does not administer a bronchodilator to a client who is receiving postural drainage.
B. Position the client for drainage of secretions by gravity
-Postural drainage consists of providing drainage, positioning, and turning the client. The positioning can help to drain secretions from the affected lung segments and bronchi into the trachea.
C. Schedule postural drainage following meals
-incorrect: Procedures such as postural drainage, chest physiotherapy, or vibration should be scheduled prior to the client eating a meal to decrease the risk of gastrointestinal discomfort.
D. Instruct the client regarding the importance of fluid restrictions

384. A nurse is applying antiembolitic stockings for a client who has a history of deep vein thrombosis. Which of the following actions should the nurse take when applying the stockings?
A. Roll the stocking partially down if too long
-incorrect: The nurse should apply another size stocking if the stocking is too long. Rolling the stocking partially down can decrease venous return and cause skin irritation.
B. Remove the stocking once per day
-incorrect: The nurse should remove the stockings once every shift to inspect the skin and check circulation.
C. Bunch and pull the stocking halfway up the calf
-incorrect: The nurse should slide the top of the stocking up over the client's calf all at once to lessen constrictive wrinkles, which can decrease venous return.
D. Turn the stocking inside out up to the heel before applying
-The nurse should turn the stocking inside out up to the client's heel to make the application of the stocking easier and cause fewer constrictive wrinkles.

385. A nurse is preparing to administer an afternoon dose of ampicillin to a client. The client appears upset and refuses to take the medication before throwing the pill on the floor. Which of the following entries should the nurse enter into the client's medical record?
A. The client refused to take medication today
B. The client states, "I will not take this pill. "
C. The client seemed angry and hostile
D. The client threw the medication on the floor

386. A nurse is preparing to administer eye drops for a client who has glaucoma. When instilling the medication, which of the following actions should the nurse take?
A. Instruct the client to blink several times after instilling the medication
-incorrect: The nurse should instruct the client to close the eyes gently and to avoid blinking after the instillation to prevent any loss of the medication out of the eye and promote absorption.
B. Ask the client to look straight ahead during instillation of the medication
-incorrect: The nurse should instruct the client to look upward toward the ceiling during instillation of the medication to allow proper placement of the medication and to suppress the client's blink reflex.

C. Apply pressure to the puncta after instilling the medication
-The nurse should instill the medication into the conjunctival sac and apply pressure to the puncta for 1-2 minutes afterward to prevent systemic absorption of the medication.
D. Place each drop of the medication directly onto the client's cornea
-incorrect: The nurse should instill the medication into the client's conjunctival sac and should take measures to protect the client's cornea during administration.

387. A newly licensed nurse is preparing to administer medications to a client. The nurse notes that the provider has prescribed a medication that is unfamiliar to him. Which of the following actions should the nurse take?
A. Consult the medication reference book available on the unit
-A nurse must have knowledge about medications to administer them safely. The nurse should become familiar with the medication by looking it up in the medication reference on the unit.
B. Ask a more experienced nurse for information about the medication
-incorrect: Even if the more experienced nurse has knowledge of the medication, information from this source is not sufficient to allow the nurse to administer the medication safely.
C. Call the client's provider and verify the prescription
-incorrect: There is no reason to believe that the medication prescription is in error; therefore, it is unnecessary for the nurse to confirm it with the provider.
D. Ask the client is she takes this medication at home
-incorrect: Even if the client has knowledge of the medication, information from the client is not sufficient to allow the nurse to administer the medication safely.

388. A nurse is changing the bed linens for a client who is on bed rest. Which of the following actions should the nurse perform?
A. Place the soiled linens on the chair while making the bed
-incorrect: The nurse should place the soiled linens in a linen bag immediately after removing the linen from the bed to prevent the spread of microorganisms on surfaces within the client's room and to minimize exposure to personnel.
B. Hold the linens away from the body and clothing
-The nurse should hold the linens away from the body and clothing to prevent soiling or the transfer of microorganisms. The microorganisms present on the nurse's clothing can expose other clients to microorganisms.
C. Place the linens on the floor until a linen bag is available
-incorrect: Soiled linen is contaminated with microorganisms and will further contaminate the floor and attract any microorganisms present on the floor, which places the nurse and the client at risk of infection.
D. Shake the clean linens to unfold
-incorrect: Opening linens by shaking them causes movement of air. Air currents can carry dust and spread microorganisms throughout the room, which places the client and the nurse at risk of infection.

389. A nurse is caring for a client who is receiving a fluid infusion through a peripheral IV catheter. The nurse notes that the area of the arm immediately surrounding the insertion site is red and feels warm. Which of the following actions should the nurse take?
A. Change the infusion tubing
-incorrect: These manifestations do not suggest that the infusion tube is punctured, contaminated, occluded, or expired.
B. Flush the IV catheter
-incorrect: This action could worsen the complication suggested by the client's manifestations.
C. Remove the IV catheter
-This client's manifestations suggest phlebitis. The nurse should stop the infusion and remove the IV catheter immediately. The nurse should then apply warm compresses to the site.
D. Apply a cool compress to the site
-incorrect: Warm moist heat is part of the treatment protocol for the complication suggested by the client's manifestations.

390. A nurse is caring for a client who is well-hydrated and has no visible evidence of nutritional deficiencies. A laboratory results within the expected reference range for which of the following substances indicates adequate protein uptake and synthesis?
A. Albumin
-The nurse should identify that an albumin level within the expected reference range is an indication that the client has adequate protein uptake and synthesis. Albumin levels measure protein status. They are useful for identifying long-term protein depletion rather than short-term or acute changes in nutritional status.
B. Calcium
-incorrect: Calcium levels do not reflect protein status. Calcium levels reflect the adequacy of bone and tooth formation, blood clotting, nerve impulse transmission, muscle contraction and relaxation, and various other essential processes.
C. Sodium
-incorrect: Sodium levels do not reflect protein status. Sodium levels indicate fluid balance, nerve impulse transmission, acid-base balance, and various other cellular activities.
D. Potassium
-incorrect: Potassium levels do not reflect protein status. Potassium levels reflect the status of many metabolic activities, including nerve impulse transmission, cardiac conduction, and skeletal and smooth muscle contraction.

391. A nurse is caring for a client who has a stage II pressure ulcer. Which of the following wound dressings should the nurse apply to the ulcer?
A. Hydrocolloid
-The nurse should apply a hydrocolloid dressing to a stage II pressure ulcer. This type of dressing is applied to absorb exudate and to produce a moist environment that will facilitate healing while preventing maceration of surrounding skin.
B. Collagen
-incorrect: The nurse should apply collagen to a clean, moist wound to stop bleeding, bring cells into the wound, and stimulate their proliferation to facilitate healing.

C. Calcium alginate
-incorrect: The nurse should apply calcium alginate to a stage IV pressure ulcer. This type of dressing is used for wounds with significant exudate and must be covered with a secondary dressing.
D. Proteolytic enzyme
-incorrect: The nurse should apply a proteolytic enzyme to an unstageable pressure ulcer. This type of dressing is applied to facilitate debridement and to soften eschar.

392. A nurse on a medical-surgical unit observes smoke billowing from a client's room. Which of the following actions should the nurse take first?
A. Close the door to the client's room
-incorrect: The nurse should close the doors and windows in the immediate vicinity to help contain the fire; however, this is not the first action the nurse should take.
B. Evacuate the client from the room
-The acronym RACE can help nurses remember the order of the actions to take in the event of a fire. The components of RACE are rescue, activate, confine, and extinguish. The first priority is rescuing or removing the client from immediate danger. The second action is activation of the fire alarm system. The third action is confining the fire by closing doors and windows. The final action is extinguishing the fire, if possible, using an available fire extinguisher. If attempts to extinguish a fire could compromise the safety of clients or staff members, the nurse should await the arrival of emergency fire personnel.
C. Sound the fire alarm
-incorrect: The nurse should sound the fire alarm to summon fire professionals to put out the fire and ensure safety in the facility; however, this is not the first action the nurse should take.
D. Activate the fire extinguisher
-incorrect: The nurse should attempt to extinguish the fire safely if possible; however, this is not the first action the nurse should take.

393. A. nurse is teaching a client who is recovering from gallbladder surgery how to use an incentive spirometer. Which of the following pieces of information should the nurse include in the teaching?
A. Exhale slowly to reach the goal volume
-incorrect: The nurse should instruct the client to inhale slowly to reach the goal volume and to decrease the collapse of alveoli in the client's lungs.
B. Hold the breath for 5 sec after goal volume is reached
-The nurse should instruct the client to hold the breath for 3 to 5 seconds after reaching maximal inspiratory volume. This decreases the collapse of alveoli, which helps prevent the risk of atelectasis and pneumonia.
C. Continue to breathe deeply between each cycle
-incorrect: The nurse should instruct the client to breathe normally for short periods of time between each cycle of breaths to reduce hyperventilation and fatigue.
D. Limit the repeat pattern of breathing to 5 breaths
-incorrect: The nurse should instruct the client to repeat the patterns for 10 to 20 breathes every hour while awake to prevent atelectasis and pneumonia.

394. A nurse is caring for a client who is postoperative and has paralytic ileus. Which of the following abdominal assessments should the nurse expect?
A. Frequent bowel sounds with flatus
B. Absent bowel sounds with distention
-Paralytic ileus is an immobile bowel. In this disorder, bowel sounds are absent, and the abdomen is distended.
C. Hyperactive bowel sounds with diarrhea
D. Normal bowel sounds with increased peristalsis
-incorrect A/C/D: With paralytic ileus, bowel sounds are absent, the abdomen is distended and there is no flatus or stool.

395. A nurse is caring for a client who has a fecal impaction. Before the digital removal of the mass, which of the following types of enemas should the nurse plan to administer to soften the feces?
A. Carminative
-incorrect: The nurse should administer a carminative enema to assist a client to expel flatus.
B. Hypertonic
-incorrect: The nurse should administer a hypertonic fluid solution to cleanse the client's bowels (ex: in preparation for surgery).
C. Oil retention
-The nurse should administer an oil retention enema prior to the removal of a fecal impaction to soften the stool. This makes the procedure less painful for the client.
D. Sodium polystyrene sulfate
-incorrect: The nurse should administer a sodium polystyrene sulfate enema to a client who has a high potassium level.

396. A nurse is teaching a client about how to remove a soiled dressing. Which of the following statements by the client indicates an understanding of the teaching?
A. 'I'll wear nonsterile gloves."
-Wearing gloves prevents the spread of microorganisms outside of the dressings and onto the client's hands. The gloves the client uses can be clean and do not need to be sterile unless the provider specifically prescribes sterile gloves for dressing changes.
B. "I'll use adhesive remover each time."
-incorrect: The client should use adhesive remover only if tape removal or residual adhesive creates significant problems on especially sensitive skin.
C. "I'll take my pain pill after I change the dressing."
-incorrect: If the client expects the dressing removal to hurt, the client should take an analgesic long enough before the dressing change for the medication to take effect.
D. "I'll fold the dressing with the soiled surface facing outward."
-incorrect: The client should remove the dressing by folding the soiled surfaces inward to prevent the transfer of microorganisms to the client's hands and other surfaces.

397. A nurse is caring for a child who is postoperative following a tonsillectomy. Which of the following actions should the nurse take?
A. Encourage the child to cough frequently to clear congestion from anesthesia
-incorrect: The child should be discouraged from coughing or clearing the throat following a tonsillectomy because these actions can contribute to bleeding.
B. Place a heating pad on the client's neck for comfort
-incorrect: The nurse should offer an ice collar, not a heating pad, to ease the child's pain.
C. Administer analgesics to the child on a routine schedule throughout the day and night
-To soothe the client's throat following a tonsillectomy, the nurse should administer pain medication routinely. The nurse can provide the medication rectally or intravenously to avoid the oral route.
D. Provide the child with ice cream when oral intake is initiated
-incorrect: Milk products, such as ice cream and pudding, are usually avoided because they coat the mouth and throat, causing the child to clear the throat and potentially leading to bleeding. Ice chips and ice pops are usually the first items offered following a tonsillectomy.

398. A nurse is collecting a urine specimen for culture and sensitivity for a client who has a urinary tract infection. The client has an indwelling urinary catheter in place. Which of the following actions should the nurse take?
A. Withdraw the specimen from the drainage bag
-incorrect: The nurse should use a fresh specimen obtained near the indwelling urinary catheter to prevent contamination.
B. Cleanse the collection port with soap and water
-incorrect: The nurse should cleanse the collection port with an antimicrobial swab to prevent contamination.
C. Place the specimen in a clean specimen cup
-incorrect: The nurse should place the specimen in a sterile specimen cup to prevent contamination.
D. Clamp the tubing below the collection port
-The nurse should clamp the tubing below the collection port to allow fresh, uncontaminated urine to collect before withdrawing the specimen through the port and placing it in a sterile cup.

399. A nurse is caring for a client who is receiving a blood transfusion. The client reports flank pain, and the nurse notes reddish-brown urine in the client's urinary catheter bag. The nurse recognizes these manifestations as which of the following types of transfusion reactions?
A. Hemolytic
-A hemolytic reaction occurs when the client's blood is incompatible with the donor's blood. Chills, low back pain, hypotension, and tachycardia are indications of a hemolytic transfusion reaction.
B. Febrile
-incorrect: A febrile reaction occurs when the client's blood is sensitive to the WBCs and platelets in the donor's blood. Fevers, chills, headaches, and flushing are indications of a febrile reaction.

C. Circulatory overload
-incorrect: Circulatory overload occurs when blood is administered too quickly for the client's circulatory system to handle. Dyspnea, coughing, headaches, and hypertension are indications of circulatory overload.
D. Sepsis
-incorrect: Sepsis occurs when the blood is contaminated with bacteria. High fevers, vomiting, and diarrhea are indications of sepsis.

400. A nurse is teaching the parent of a child who is to take 10 mL of a liquid medication. The parent has a hollow medication spoon with marks to indicate teaspoons and tablespoons. How many teaspoons should the nurse instruct the parent to give the child? (Nearest whole number).

-2 teaspoons

401. A nurse is implementing cold therapy for a client who has an ankle sprain. Which of the following actions should the nurse take?
A. Apply a cold pack to the edematous area
-incorrect: The nurse should avoid applying a cold pack to an area that displays edema because it can further decrease adequate circulation and prevent absorption of the edema.
B. Check capillary refill before applying an ice pack to the affected area
-The nurse should check the affected area for adequate circulation by assessing pulses and capillary refill because a cold pack applied to an area of impaired circulation can further decrease the blood supply to the area.
C. Half-fill an ice pack with crushed ice
-incorrect: The nurse should fill an ice pack two-thirds full of crushed ice to mold around the affected area.
D. Apply an ice pack for 60 min intervals
-incorrect: The nurse should apply an ice pack for 30-minute intervals to anesthetize and prevent further swelling of the affected area.

402. A nurse is demonstrating postoperative deep breathing and coughing exercises to a client who is scheduled for emergency surgery for appendicitis. Which of the following statements indicates a lack of readiness to learn by the client?
A. The client asks the nurse to repeat the instructions before attempting the exercises
-incorrect: By asking the nurse to repeat the instructions, the client is demonstrating a readiness to learn the activity, even though he might not understand the mechanics of performing the exercises.
B. The client reports severe pain
-A client who is experiencing severe pain is not able to concentrate and is not ready to learn a new activity.
C. The client asks the nurse how often deep breathing should be done after surgery
-incorrect: Asking about the frequency of the activity indicates a readiness to learn, as the client is motivated to perform the exercises and wants to know how often to do them.

D. The client tells the nurse that this exercise will probably be painful after surgery
-incorrect: This indicates a readiness to learn because the client is able to think about the possible effects of the exercise following surgery.