

Kevin's Review - 100 NCLEX Practice Questions

1. During a trichology seminar at a prestigious institution, Dr. Patel presented a curious case of a 28-year-old patient exhibiting sudden changes in hair texture and slowed hair growth after recovering from severe malnutrition. Drawing connections between nutrition, systemic health, and hair physiology, Dr. Patel then steers the discussion towards fundamental hair structures. He poses a pertinent question: In the vast realm of hair growth dynamics, which specific structure is instrumental in birthing new hair cells at the foundational level of the hair follicle and remains pivotal in determining both hair growth rate and its texture?

- A. Hair Bulb
- B. Papilla
- C. Shaft
- D. Arrector pili

Correct Answer: A. Hair Bulb

The hair bulb is the base of the hair follicle where active and rapid cell division occurs, leading to the production of new hair cells. As these cells push upwards, they keratinize and form the hair we see. The texture and growth of the hair are significantly influenced by the activity and health of the hair bulb. The presented case of altered hair growth and texture after malnutrition underscores the importance of nutrients in supporting the health and function of the hair bulb.

- **Option B:** Positioned at the base of the hair follicle, the papilla is rich in blood vessels that supply nutrients to the hair bulb. Though crucial for nourishing the hair follicle, the papilla itself does not produce hair cells.
- **Option C:** The shaft is the part of the hair that we see protruding from the skin's surface. It is composed of dead, keratinized cells and does not play a direct role in producing new hair cells.
- **Option D:** The arrector pili muscles (APM) are tiny muscles attached to hair follicles. When these muscles contract (usually in response to cold or emotional stimuli), it causes the hair to stand erect, commonly known as "goosebumps." They don't have a role in the direct production of hair cells.

2. During a mother's class, the nurse who is teaching the participants on stress management is questioned about the use of alternative treatments, such as herbal therapy and therapeutic touch. She explains that the advantage of these methods would include all of the following except:

- A. They are congruent with many cultural belief systems.
- B. They encourage the consumer to take an active role in health management.
- C. They promote interrelationships within the mind-body-spirit.
- D. They usually work better than traditional medical practice.

Correct Answer: D. They usually work better than traditional medical practice.

Complementary alternative medicine treatments are often used as adjuncts to traditional medical treatment. Although an individual may choose a particular alternative treatment method, there is really no current scientific proof that these methods will work better than traditional medicine. Stress can be effectively managed by Yoga, meditation, mindfulness, healthy eating, exercise, acupressure,

acupuncture, building relaxation rituals like massaging or drinking herbal teas such as rose, bamboo, chamomile, peppermint etc.

- **Option A:** Complementary therapies can be described as the health care techniques aimed at integrating physical, mental, and spiritual dimensions. The objective of complementary therapies differs from the allopathic care used in Western medicine, in which the cure of the disease is the result from direct interventions in injured organs. Different classifications have been proposed for complementary therapies. The National Center for Complementary and Alternative Medicine mainly categorizes them as biologically based therapies, mind-body interventions, and manipulative and body-based methods.
- **Option B:** Complementary therapies may help improve a patient's quality of life and the use of these therapies should be part of a further health care model established toward comprehensive care, offering therapeutic modalities that can strengthen the mind-body-spirit during a patients' treatment journey.
- **Option C:** Mind-body-based programs can also reduce stress and anxiety associated with the cancer experience. Data from breast cancer populations have suggested that mind-body based complementary therapies (eg, mindfulness, meditation, yoga, Tai Chi, Qigong, guided imagery, and affirmations) have the potential to influence the immune profile of breast cancer patients and survivors, along with decreasing stress levels by helping them in developing a greater sense of emotional balance and well-being.

3. Which of the following variables will he likely exclude in his study?

- A. Competence of nurses
- B. Caring attitude of nurses
- C. Salary of nurses
- D. Responsiveness of staff

Correct Answer: C. Salary of nurses

The salary of staff nurses is not an indicator of patient satisfaction, hence need not be included as a variable in the study. A variable in research simply refers to a person, place, thing, or phenomenon that the researcher is trying to measure in some way. The best way to understand the difference between a dependent and independent variable is that the meaning of each is implied by what the words tell us about the variable the researcher is using.

- **Option A:** The competence of nurses can affect the patient's satisfaction rate, therefore it is an independent variable. The variable that is stable and unaffected by the other variables the researcher is trying to measure. It refers to the condition of an experiment that is systematically manipulated by the investigator. It is the presumed cause.
- **Option B:** The caring attitude of the nurses can affect the patient's satisfaction rate, therefore it is an independent variable. An important distinction has to do with the term 'variable' is the distinction between an independent and dependent variable. This distinction is particularly relevant when the researcher is investigating cause-effect relationships.
- **Option D:** The responsiveness of the staff can affect the patient's satisfaction rate, therefore it is an independent variable. Anything that can vary can be considered a variable. For instance, age can be considered a variable because age can take different values for different people or for the same person at different times.

4. Tony with agoraphobia has been symptom-free for 4 months. Classic signs and symptoms of phobia include: Severe anxiety and fear.

- A. Severe anxiety and fear.
- B. Withdrawal and failure to distinguish reality from fantasy.
- C. Depression and weight loss.
- D. Insomnia and inability to concentrate.

Correct Answer: A. Severe anxiety and fear

Phobias cause severe anxiety (such as panic attacks) that is out of proportion to the threat of the feared object or situation. Physical signs and symptoms of phobias include profuse sweating, poor motor control, tachycardia, and elevated B.P. Patients with a specific phobia experience high levels of anxiety and panic attacks along with excessive and unreasonable fear due to either exposure or anticipation of exposure to a feared stimulus. As a result, these patients will try to avoid the anxiety-provoking stimulus to any extent possible.

- **Option B:** Schizophrenia is not, as commonly thought, solely about hearing voices or having multiple personalities. Instead, it is defined by a lack of ability to distinguish reality. Schizophrenia can cause paranoia and belief in elaborate conspiracies.
- **Option C:** Depression covers a wide range of conditions, typically defined by a persistent bad mood and lack of interest in pursuing daily life, as well as bouts of lethargy and fatigue. Dysthymia is a milder but longer-lasting form of depression.
- **Option D:** Concentration difficulties can be caused by medical, cognitive, or psychological problems or may be related to sleep disorders or medications, alcohol, or drugs. Psychological conditions that can interfere with concentration include anxiety, depression, bipolar disorder, emotional trauma, and stress.

5. The client with Crohn's disease has a nursing diagnosis of acute pain. The nurse would teach the client to avoid which of the following in managing this problem?

- A. Lying supine with the legs straight.
- B. Massaging the abdomen.
- C. Using antispasmodic medication.
- D. Using relaxation techniques.

Correct Answer: A. Lying supine with the legs straight.

Lying with the legs flexed is recommended. Lying with the legs extended is not useful because it increases the muscle tension in the abdomen, which could aggravate the inflamed intestinal tissues as the abdominal muscles are stretched. Encourage the patient to assume a position of comfort (knees flexed) to reduce abdominal tension and promote a sense of control.

- **Option B:** Applying local cold or heat to the abdomen or massaging the abdomen can help alleviate the pain in Crohn's disease. Provide comfort measures (back rub, reposition) and diversional activities. Promotes relaxation, refocuses attention, and may enhance coping abilities.
- **Option C:** The pain associated with Crohn's disease is alleviated by the use of analgesics and antispasmodics. Implement prescribed dietary modifications (commence with liquids and increase

to solid foods as tolerated). Complete bowel rest can reduce pain, cramping.

- **Option D:** The pain associated with Crohn's disease is reduced by having the client practice relaxation techniques. Provide sitz baths as appropriate. Enhances cleanliness and comfort in the presence of perianal irritation or fissures.

6. A 33-year-old patient with a history of seizures and medication compliance of phenytoin (Dilantin) and carbamazepine (Tegretol) is brought to the ED by the MS personnel for repetitive seizure activity that started 45 minutes prior to arrival. You anticipate that the physician will order which drug for status epilepticus?

- A. Phenytoin and Carbamazepine PO
- B. Carbamazepine (Tegretol) IV
- C. Magnesium sulfate IV
- D. Lorazepam (Ativan) IV

Correct Answer: D. Lorazepam (Ativan) IV.

IV Lorazepam (Ativan) is the drug of choice for status epilepticus. Benzodiazepines are the antiepileptic drug of choice for emergent control. Lorazepam is preferred because of its rapid onset of action and is dosed at 0.1 mg/kg IV. No more than 2 mg should be administered per minute.

- **Option A:** PO (per os) medications are inappropriate for this emergency situation. Intravenous administration is preferred, but benzodiazepines can be administered via the intramuscular, rectal, nasal, or buccal route if vascular access is not available.
- **Option B:** Tegretol is used in the management of generalized tonic-clonic, absence or mixed type seizures, but it does not come in an IV form. Carbamazepine is used to manage and treat epilepsy, trigeminal neuralgia, and acute manic and mixed episodes in bipolar I disorder. Indications for epilepsy are specifically for partial seizures with complex symptomatology (psychomotor, temporal lobe), generalized tonic seizures (grand mal), and mixed seizure patterns.
- **Option C:** Magnesium sulfate is given to control seizures in toxemia of pregnancy. If eclampsia is suspected, intravenous magnesium sulfate is the antiepileptic drug of choice. Delivery of the fetus is the definitive treatment of eclampsia.

7. Which of the following groups of antitubercular agents includes first-line agents?

- A. INH, PZA, RIF
- B. SM, PAS, INH
- C. EMB, PAS, INH
- D. INH, cycloserine, RIF

Correct Answer: A. INH, PZA, RIF

INH, PZA, and RIF are used as combination first-line agents. Antitubercular medications: rifampin, isoniazid, pyrazinamide, and ethambutol are FDA approved for the treatment of Mycobacterium tuberculosis infections. The combination and duration on which medications to use for therapy rely on

whether the patient has an active or latent disease.

- **Option B:** Rifampin exerts its effects by reversibly inhibiting DNA-dependent RNA polymerase, which further inhibits bacterial protein synthesis and transcription. Isoniazid is a pro-drug that is converted to its active form metabolite by catalase-peroxidase and exerts its action by further inhibiting the biosynthesis of mycolic acid. Pyrazinamide's mechanism of action remains unknown and not fully understood. Pyrazinamide is converted to its active form pyrazinoic acid and exerts its effect by inhibiting trans-translation and possibly coenzyme A synthesis needed for the bacteria to survive.
- **Option C:** Ethambutol inhibits the enzyme arabinosyl transferases and prevents the biosynthesis of the mycobacterial cell wall. Aminoglycosides exert their action by binding to the 30S subunit of ribosomes and inhibiting the protein synthesis of the mycobacteria. Fluoroquinolones exert their effects by inhibiting DNA gyrase and topoisomerase IV, further inhibiting DNA synthesis within the bacteria.
- **Option D:** During active disease, there are two phases for treatment: the initiation phase and the continuation phase. The initiation phase consists of two months of rifampin, isoniazid, pyrazinamide, and ethambutol therapy. This regimen is administered orally daily for eight weeks for a total of 56 doses. Once completed, isoniazid and rifampin are continued for an additional four-month for the continuation phase. This regimen is administered orally daily for 18 weeks for a total of 126 doses. For patients that cannot tolerate ethambutol, streptomycin can be substituted.

8. Which of the following symptoms is a client with colon cancer most likely to exhibit?

- A. A change in appetite.
- B. A change in bowel habits.
- C. An increase in body weight.
- D. An increase in body temperature.

Correct Answer: B. A change in bowel habits.

The most common complaint of the client with colon cancer is a change in bowel habits. Tumor location on the clinical presentation can be separated on left-sided with more changes in bowel habits and hematochezia, and right-sided with obscured anemia impacting on late-stage at diagnosis.

- **Option A:** The client may have anorexia, secondary abdominal distention. The provider should perform a thorough physical examination for signs of ascites, hepatomegaly, and lymphadenopathy. Comprehensive family history is of great relevance to identify familial clusters and inherent patterns that would alter surveillance and therapy on the high-risk patient.
- **Option C:** The client may have weight loss. Late presentation with metastatic disease at diagnosis will depend on the symptoms at the organ affected by the route of spread; to the liver via the portal system, to lungs via the inferior vena cava, to supraclavicular adenopathy via lymphatic or to neighbor structures by contiguous invasion.
- **Option D:** Fever isn't associated with colon cancer. Diagnostic colonoscopy's triggers are blood per rectum (37%), abdominal pain (34%), and anemia (23%). The most common indications of emergency surgery are obstruction (57%), peritonitis (25%), and perforation (18%).

9. A two-year-old child has sustained an injury to the leg and refuses to walk. The nurse in the emergency department documents swelling of the lower

affected leg. Which of the following does the nurse suspect is the cause of the child's symptoms?

- A. Possible fracture of the tibia.
- B. Bruising of the gastrocnemius muscle.
- C. Possible fracture of the radius.
- D. No anatomic injury, the child wants his mother to carry him.

Correct Answer: A. Possible fracture of the tibia.

The child's refusal to walk, combined with swelling of the limb is suspicious for fracture.

- **Option B:** Toddlers will often continue to walk on a muscle that is bruised or strained.
- **Option C:** The radius is found in the lower arm and is not relevant to this question.
- **Option D:** Toddlers rarely feign injury to be carried, and swelling indicates a physical injury.

10. The nurse should include which of the following instructions when developing a teaching plan for clients receiving INH and rifampin for treatment for TB?

- A. Take the medication with antacids.
- B. Double the dosage if a drug dose is forgotten.
- C. Increase intake of dairy products.
- D. Limit alcohol intake.

Correct Answer: D. Limit alcohol intake

INH and rifampin are hepatotoxic drugs. Clients should be warned to limit intake of alcohol during drug therapy. Liver function tests should be monitored routinely as rifampin, isoniazid, pyrazinamide, and ethambutol all may exert hepatotoxic effects. CBC also requires regular monitoring for patients taking rifampin, as it can cause thrombocytopenia and neutropenia.

- **Option A:** Both drugs should be taken on an empty stomach. If antacids are needed for GI distress, they should be taken 1 hour before or 2 hours after these drugs are administered. Rifampin also exerts its effects by inducing cytochrome P450(CYP450), which may cause unwanted drug interactions of medications that are metabolized by the CYP450 system and decrease their clinical efficacy.
- **Option B:** Clients should not double the dosage of these drugs because of their potential toxicity. Isoniazid can cause pyridoxine deficiency that may lead to peripheral neuropathy in patients. All first-line antitubercular medications, rifampin, isoniazid, pyrazinamide, and ethambutol can exert hepatotoxic effects. A continual rise in liver functions test should prompt discontinuation of treatment.
- **Option C:** Clients taking INH should avoid foods that are rich in tyramine, such as cheese and dairy products, or they may develop hypertension. All first-line antitubercular medications, rifampin, isoniazid, pyrazinamide, and ethambutol can exert hepatotoxic effects. A continual rise in liver functions test should prompt discontinuation of treatment.

11. A nurse assigned to the emergency department evaluates a patient who underwent fiberoptic colonoscopy 18 hours previously. The patient reports increasing abdominal pain, fever, and chills. Which of the following conditions poses the most immediate concern?

- A. Bowel perforation
- B. Viral gastroenteritis
- C. Colon cancer
- D. Diverticulitis

Correct Answer: A. Bowel perforation

Bowel perforation is the most serious complication of fiberoptic colonoscopy. Important signs include progressive abdominal pain, fever, chills, and tachycardia, which indicate advancing peritonitis. Bowel perforation results from insult or injury to the mucosa of the bowel wall resulting from a violation of the closed system. This exposes the structures within the peritoneal cavity to gastrointestinal contents. Patients presenting with abdominal pain and distension, especially in the appropriate historical setting, must be evaluated for this entity as delayed diagnosis can be life-threatening due to the risk of developing infections such as peritonitis.

- **Option B:** Several different viruses including rotavirus, norovirus, adenovirus, and astroviruses account for most cases of acute viral gastroenteritis. Most are transmitted via the fecal-oral route, including contaminated food and water. Transmission has also been shown to occur via fomites, vomitus, and possibly airborne methods. Norovirus is more resistant to chlorine and ethanol inactivation than other viruses. Acute gastroenteritis is defined by loose or watery diarrhea that consists of 3 or more bowel movements in a day. Other symptoms may include nausea, vomiting, fever, or abdominal pain
- **Option C:** Colon cancer does not cause these symptoms. Tumor location on clinical presentation can be separated on left-sided with more changes in bowel habits and hematochezia, and right-sided with obscured anemia impacting on late stage at diagnosis. The provider should perform a thorough physical examination for signs of ascites, hepatomegaly, and lymphadenopathy.
- **Option D:** Diverticulitis may cause pain, fever, and chills, but is far less serious than perforation and peritonitis. Acute diverticulitis is inflammation due to micro-perforation of a diverticulum. The diverticulum is a sac-like protrusion of the colon wall. Diverticulitis can present in about 10% to 25% of patients with diverticulosis. Diet appears to play a significant role. Low fiber, high fat, and red meat diets may increase the risk for development of diverticulosis and possible diverticulitis. Obesity and smoking are known to increase the potential for both diverticulitis and diverticular bleeding.

12. During the first 4 hours after a male circumcision, assessing for which of the following is the priority?

- A. Infection
- B. Hemorrhage
- C. Discomfort
- D. Dehydration

Correct Answer: B. Hemorrhage

Hemorrhage is a potential risk following any surgical procedure. Although the infant has been given vitamin K to facilitate clotting, the prophylactic dose is often not sufficient to prevent bleeding.

- **Option A:** Although infection is a possibility, signs will not appear within 4 hours after the surgical procedure.
- **Option C:** The primary discomfort of circumcision occurs during the surgical procedure, not afterward.
- **Option D:** Although feedings are withheld prior to the circumcision, the chances of dehydration are minimal.

13. A nurse is giving discharge instructions to a patient who is taking Synthroid (levothyroxine). The nurse instructs the client to notify the physician if which of the following occurs?

- A. Cold intolerance
- B. Tremors
- C. Coarse, dry hair
- D. Muscle cramps

Correct Answer: B. Tremors

Excessive doses of levothyroxine can produce signs and symptoms of hyperthyroidism which includes heat tolerance, tremors, nervousness, tachycardia, chest pain, hyperthermia, and insomnia.

- **Options A, C, & D:** These are signs of hypothyroidism.

14. The client newly diagnosed with chronic renal failure recently has begun hemodialysis. Knowing that the client is at risk for disequilibrium syndrome, the nurse assesses the client during dialysis for:

- A. Hypertension, tachycardia, and fever.
- B. Hypotension, bradycardia, and hypothermia.
- C. Restlessness, irritability, and generalized weakness.
- D. Headache, deteriorating level of consciousness, and twitching.

Correct Answer: D. Headache, deteriorating level of consciousness, and twitching.

Disequilibrium syndrome is characterized by headache, mental confusion, decreasing level of consciousness, nausea, and vomiting, twitching, and possible seizure activity. Disequilibrium syndrome is caused by the rapid removal of solutes from the body during hemodialysis. At the same time, the blood-brain barrier interferes with the efficient removal of wastes from brain tissue. As a result, water goes into cerebral cells because of the osmotic gradient, causing brain swelling and the onset of symptoms. The syndrome most often occurs in clients who are new to dialysis and is prevented by dialyzing for shorter times or at reduced blood flow rates.

- **Option A:** Symptoms are commonly seen in patients with high blood urea nitrogen levels, in patients with chronic kidney disease (CKD) versus acute kidney injury, and with aggressive urea removal after initial dialysis treatment. In severe cases, symptoms can progress to seizure, somnolence, stupor, or coma leading to mortality.

- **Option B:** Some symptoms, such as dizziness and muscle cramps that occur towards the latter part of dialysis, are also considered to be part of DDS. Rarely, DDS can present as increased intraocular pressure. Dialysis disequilibrium syndrome is usually self-limited, with symptoms resolving in a short interval. The prognosis is generally favorable, and dialysis does not need to be stopped in the majority of cases.
- **Option C:** Most cases of DDS can be mild and self-limited, with patients reporting headache, nausea, or blurred vision as well as other CNS symptoms such as restlessness and confusion. These symptoms usually begin soon after the initiation of dialysis and resolve within hours in most cases. The complications of dialysis disequilibrium syndrome include consequences from delay in recognition of the condition and delay in implementing prevention strategies.

15. When developing a plan of care for a female client with acute stress disorder who lost her sister in a car accident. Which of the following would the nurse expect to initiate?

- Facilitating progressive review of the accident and its consequences.
- Postponing discussion of the accident until the client brings it up.
- Telling the client to avoid details of the accident.
- Helping the client to evaluate her sister's behavior.

Correct Answer: A. Facilitating progressive review of the accident and its consequences

The nurse would facilitate progressive review of the accident and its consequence to help the client integrate feelings & memories and to begin the grieving process. Help patients reframe any destructive cognitions (eg, beliefs that they acted terribly and are terrible people or are weak for being so distraught, that life is hopeless or worthless, or that the world is totally unsafe).

- **Option B:** Support self-esteem; help patients understand that their reaction to the trauma is a normal reaction to an abnormal situation, not a sign of weakness or psychopathology. Reassure and help survivors concerning immediate needs, such as rest, food, shelter, social support, or a sense of belonging to a community (some feel cut off and detached).
- **Option C:** Promote coping mechanisms. Avoid prompting discussion of issues that cannot be resolved; avoid abreaction in groups and the resulting contagion effect; respect defenses, and do not force reality on people who cannot handle it yet; keep in mind that debriefing may be harmful. Discuss the experience with patients who want to talk about it, and avoid pressuring those who do not wish to discuss it.
- **Option D:** Check to see if children feel that they somehow caused the death or disaster or if they have other misunderstandings, and take pains to reassure them or correct any misunderstanding; do not assume children are fine just because they are not saying anything. Let them know it is all right to talk about unpleasant feelings (including sadness and anger) and listen to them; sharing personal feelings of sadness with them is all right as well.

16. A client who had cardiac surgery 24 hours ago has a urine output averaging 19 ml/hr for 2 hours. The client received a single bolus of 500 ml of IV fluid. Urine output for the subsequent hour was 25 ml. Daily laboratory results indicate the blood urea nitrogen is 45 mg/dL and the serum creatinine is 2.2 mg/dL. A nurse interprets the client is at risk for:

- A. Hypovolemia
- B. UTI
- C. Glomerulonephritis
- D. Acute renal failure

Correct Answer: D. Acute renal failure

The client who undergoes cardiac surgery is at risk for renal injury from poor perfusion, hemolysis, low cardiac output, or vasopressor medication therapy. Renal insult is signaled by decreased urine output and increased BUN and creatinine levels. The client may need medications such as dopamine (Intropin) to increase renal perfusion and possibly could need peritoneal dialysis or hemodialysis.

- **Option A:** Clinical signs, such as hypotension, tachycardia, and dry oral membranes, along with laboratory findings, such as blood urea nitrogen, serum and urine sodium, hematocrit, and blood gas measurements, help to elucidate the underlying etiology of hypovolemia. The simplest and fastest means of evaluating hypovolemia remains arterial blood pressure measuring.
- **Option B:** Remember that in patients with symptoms of UTI, a negative dipstick does not rule out UTI, but positive findings can help make the diagnosis. Look for the presence of bacteria and/or white blood cells (WBC) in the urine. A good urine sample with greater than 5 to 10 WBC/HPF is abnormal and highly suggestive of UTI in symptomatic patients.
- **Option C:** As the glomerular filtration rate (GFR) is decreased, symptoms like edema and hypertension occur, majorly due to the subsequent salt and water retention caused by the activation of the renin-angiotensin-aldosterone system.

17. Following the birth of her baby, a woman expresses concern about the weight she gained during pregnancy and how quickly she can lose it now that the baby is born. The nurse, in describing the expected pattern of weight loss, should begin by telling this woman that:

- A. Return to pre-pregnant weight is usually achieved by the end of the postpartum period.
- B. Fluid loss from diuresis, diaphoresis, and bleeding accounts for about a 3-pound weight loss.
- C. The expected weight loss immediately after birth averages about 11 to 13 pounds.
- D. Lactation will inhibit weight loss since caloric intake must increase to support milk production.

Correct Answer: C. The expected weight loss immediately after birth averages about 11 to 13 pounds.

The woman should plan to return to pre-pregnancy weight by 6 to 12 months after delivery. Most women lose half of their baby weight by 6 weeks after childbirth (postpartum). The rest most often comes off over the next several months. The body needs time to recover from childbirth. If the woman loses weight too soon after childbirth, it can take longer for her to recover. She should give herself until the 6-week checkup before trying to slim down.

- **Option A:** Prepregnant weight is usually achieved by 2 to 3 months after birth, not within the 6-week postpartum period. Through diet and regular exercise, it might be reasonable to lose up to 1 pound (0.5 kilogram) a week. It might take six months to one year to return to pre-pregnancy weight, whether breast-feeding or not.
- **Option B:** Weight loss from diuresis, diaphoresis, and bleeding is about 9 pounds. Most women lose about 13 pounds (5.9 kilograms) during childbirth, including the weight of the baby, placenta

and amniotic fluid. During the first week after delivery, the woman will lose additional weight as she sheds retained fluids — but the fat stored during pregnancy won't disappear on its own.

- **Option D:** Weight loss continues during breastfeeding since fat stores developed during pregnancy and extra calories consumed are used as part of the lactation process. If breastfeeding, wait until the baby is at least 2 months old and the milk supply has normalized before drastically cutting calories. Women who are exclusively breastfeeding need about 500 more calories per day than they did before pregnancy. Get these calories from healthy choices such as fruits, vegetables, whole grains, and lean protein. Breastfeeding makes the body burn calories which helps lose weight. If the woman is patient, she may be surprised at how much weight she may lose naturally while breastfeeding.

18. Julia is a mother who is receiving oxytocin therapy. The nurse must continuously evaluate:

- A. Membrane integrity
- B. Uterine contractions
- C. Cervical dilation
- D. Cervical effacement

Correct Answer: B. Uterine contractions

A client receiving oxytocin therapy requires continuous monitoring of maternal vital signs, fluid intake and output, electronic fetal monitoring, and uterine contractions. It is essential to monitor patient fluids (both intake and outtake) while administering oxytocin, as well as the frequency of uterine contractions, patient blood pressure, and heart rate of the unborn fetus. When oxytocin is released, it stimulates uterine contractions, and these uterine contractions, in turn, cause more oxytocin to be released; this is what causes the increase in both the intensity and frequency of contractions and enables a mother to carry out vaginal delivery completely.

- **Option A:** When oxytocin is given to women who are in the first or second stages of labor, or to women to cause induction of labor, uterine rupture, as well as maternal subarachnoid hemorrhages, maternal death, and even fetal death, can result. If oxytocin is given in doses too large or even slowly during 24 hours, the medication can exhibit an antidiuretic effect resulting in extreme water intoxication; this can result in coma, seizures, and even death in the mother.
- **Option C:** Oxytocin is the commonest induction agent used worldwide. It has been used alone, in combination with amniotomy or following cervical ripening with other pharmacological or non-pharmacological methods. Prior to the introduction of prostaglandin agents oxytocin was used as a cervical ripening agent as well.
- **Option D:** Comparison between the use of intravenous oxytocin alone with a combination of oxytocin and either vaginal or intracervical PGE2 demonstrate that prostaglandins result in a significantly lower cesarean delivery rate and an increased proportion of vaginal deliveries within 24 hours.

19. Which type of lochia should the nurse expect to find in a client 2 days PP?

- A. Foul-smelling
- B. Lochia serosa

- C. Lochia alba
- D. Lochia rubra

Correct Answer: D. Lochia rubra

Lochia, also known as postpartum bleeding, is a normal discharge of blood and mucus from the uterus after childbirth. It begins right after delivery and can continue for four to six weeks postpartum, with the heaviest flow occurring for the first 10 to 14 days. Some women may have a shorter period of discharge, while others may have lochia for slightly longer than four to six weeks. At first, lochia will look dark red and the flow may be heavy. This is called lochia rubra. The lochia is initially red and comprised of blood and fragments of decidua, endometrial tissues, and mucus and lasts 1 to 4 days.

- **Option A:** The presence of an offensive odor or large pieces of tissue or blood clots in lochia or the absence of lochia might be a sign of infection. The cervix and vagina may be edematous and bruised in the early postpartum period and gradually heal back to normal.
- **Option B:** The lochia then changes color to yellowish or pale brown, lasting 5 to 9 days, and is comprised mainly of blood, mucus, and leukocytes. This is called lochia serosa.
- **Option C:** Finally, the lochia is white and contains mostly mucus, lasting up to 10 to 14 days. This is lochia alba. The lochia can persist up to 5 weeks postpartum. The persistence of red lochia beyond one week might be an indicator of uterine subinvolution.

20. Jaime has a diagnosis of schizophrenia with negative symptoms. In planning care for the client, Nurse Brienne would anticipate a problem with:

- A. Auditory hallucinations
- B. Bizarre behaviors
- C. Ideas of reference
- D. Motivation for activities

Correct Answer: D. Motivation for activities.

In a client demonstrating negative symptoms of schizophrenia, avolition, or the lack of motivation for activities, is a common problem. These “negative” symptoms are so-called because they are an absence as much as a presence: inexpressive faces, blank looks, monotone, and monosyllabic speech, few gestures, seeming lack of interest in the world and other people, inability to feel pleasure or act spontaneously. It is important to distinguish between lack of expression and lack of feeling, between lack of will and lack of activity. When questioned, patients with schizophrenia often express a full range of feelings and desires.

- **Option A:** Schizophrenia causes a surplus of mental experiences (thoughts, feelings, behaviors). For example, hallucinations, which are not part of the normal, day-to-day experience for most people, are classified as a positive symptom for people with schizophrenia. The phrase “positive symptoms” refers to symptoms that are in excess or added to normal mental functioning.
- **Option B:** Another positive symptom of schizophrenia is disorganized or abnormal movements or motor behaviors. An example of this is catatonic behavior, which involves a decreased reactivity to the environment. Catatonia is marked by a significant decrease in someone’s reactivity to their environment. This can involve stupor, mutism, negativism or motor rigidity, and even purposeless excitement.
- **Option C:** A belief that gestures, comments, or other cues have special meaning directed at oneself. Delusions can be bizarre, such as the belief that one’s organs have been removed by

aliens, or non-bizarre, such as believing one is under surveillance by the police.

21. The student nurse is preparing a teaching care plan to help improve nutrition in a patient with achalasia. You include which of the following:

- A. Swallow foods while leaning forward.
- B. Omit fluids at mealtimes.
- C. Eat meals sitting upright.
- D. Avoid soft and semi soft foods.

Correct Answer: C. Eat meals sitting upright.

Eating in the upright position aids in emptying the esophagus. Doing the opposite of the other three also may be helpful. Achalasia is an esophageal smooth muscle motility disorder that occurs due to a failure of relaxation of the lower esophageal sphincter. This condition causes a functional obstruction at the gastroesophageal junction.

- **Option A:** The majority of patients with achalasia typically present with dysphagia, initially with solids than to liquids though 70-97% of patients will have dysphagia to both solids and liquids at presentation. Dysphagia and regurgitation are the most common presenting symptoms in achalasia.
- **Option B:** Instruct patient regarding eating small amounts of bland food followed by a small amount of water. Instruct to remain in an upright position at least 1–2 hours after meals, and to avoid eating within 2–4 hours of bedtime. Gravity helps control reflux and causes less irritation from reflux action into the esophagus.
- **Option D:** Patients need to understand necessary lifestyle changes following myotomy, such as the need to eat small food boluses in an upright position, which allows gravity to assist with food transit and never to lay flat but rather at 30 to 45 degrees due to increased risk for aspiration.

22. How can central venous access devices (CVADs) be of value in a patient receiving chemotherapy who has stomatitis and severe diarrhea?

- A. The chemotherapy can be rapidly completed allowing the stomatitis and diarrhea to resolve.
- B. Crystalloid can be administered to prevent dehydration.
- C. Concentrated hyperalimentation fluid can be administered through the CVAD.
- D. The chemotherapy dose can be reduced.

Correct Answer: C. Concentrated hyperalimentation fluid can be administered through the CVAD.

For patients who are unable to take oral nutrition, a parenteral hyperalimentation is an option for providing nutritional support. High concentrations of dextrose, protein, minerals, vitamins and trace elements can be provided. Dosing is not affected in options a and d. Hyperalimentation can provide free water and considerable nutritional benefits.

- **Option A:** The outcome and prognosis of patients with a CVAD directly depend on the complications. If complications are minimized, the outcome related to the placement of these lines is excellent. In addition, meticulous and sterile care of the CVAD can also prevent line infections.

- **Option B:** Crystalloid can provide free water but has very little nutritional benefits. Crystalloid fluids are a subset of intravenous solutions that find frequent use in the clinical setting. Crystalloid fluids are the first-line choice for fluid resuscitation in the presence of hypovolemia, hemorrhage, sepsis, and dehydration. Further clinical applications include acting as a solution for intravenous medication delivery, delivering maintenance fluid in patients with limited or no enteral nutrition, blood pressure management, and increasing diuresis to avoid nephrotoxic drug or toxin-mediated end-organ damage.
- **Option D:** There is a possibility that decreasing the dose would decrease the effectiveness of the drug, no matter what genotype a patient had. Chemotherapy is a type of treatment that targets and kills rapidly dividing cells, such as cancer, and is a hallmark of cancer treatment. Unfortunately, this type of medicine also kills rapidly dividing cells that are not cancerous, such as blood and skin cells and the lining of the intestine. This toxicity causes serious side effects, leaving patients ill and bedridden. Many patients are reluctant to start potent chemotherapy regimens, no matter how effective, because they are concerned about the toll the side effects will take on daily living.

23. Evaluating the apical pulse is the most reliable noninvasive way to assess cardiac function. Which is the best area for auscultating the apical pulse?

- A. Aortic arch
- B. Pulmonic area
- C. Tricuspid area
- D. Mitral area

Correct Answer: D. Mitral area

The mitral area (also known as the left ventricular area or the apical area), the fifth intercostal space (ICS) at the left midclavicular line, is the best area for auscultating the apical pulse. The apical pulse is auscultated with a stethoscope over the chest where the heart's mitral valve is best heard. In infants and young children, the apical pulse is located at the fourth intercostal space at the left midclavicular line. In adults, the apical pulse is located at the fifth intercostal space at the left midclavicular line.

- **Option A:** The aortic arch is the second ICS to the right of the sternum. Apical pulse rate is indicated during some assessments, such as when conducting a cardiovascular assessment and when a client is taking certain cardiac medications (e.g., digoxin). Sometimes the apical pulse is auscultated pre and post medication administration.
- **Option B:** The pulmonic area is the second intercostal space to the left of the sternum. It is also a best practice to assess apical pulse in infants and children up to five years of age because radial pulses are difficult to palpate and count in this population. It is typical to assess apical pulses in children younger than eighteen, particularly in hospital environments. Apical pulses may also be taken in obese people because their peripheral pulses are sometimes difficult to palpate.
- **Option C:** The tricuspid area is the fifth ICS to the left of the sternum. Position the client in a supine (lying flat) or in a seated position. Physically palpate the intercostal spaces to locate the landmark of the apical pulse. Ask the female client to re-position her own breast tissue to auscultate the apical pulse.

24. A client with burns covering 50% of their body was admitted 10 hours ago and now has a blood glucose level of 142 mg/dL. What should the nurse do first?

- A. Documents the finding
- B. Obtains a family history of diabetes
- C. Repeats the glucose measurement
- D. Stop IV fluids containing dextrose

Correct Answer: A. Documents the finding

Neural and hormonal compensation to the stress of the burn injury in the emergent phase increases liver glucose production and release. An acute rise in the blood glucose level is an expected client response and is helpful in the generation of energy needed for the increased metabolism that accompanies this trauma.

- **Option B:** A family history of diabetes could make her more of a risk for the disease, but this is not a priority at this time. The secondary assessment shouldn't begin until the primary assessment is complete; resuscitative efforts are underway; and lines, tubes, and catheters are placed.
- **Option C:** The glucose level is not high enough to warrant retesting. A variety of laboratory tests will be needed within the first 24 hours of a patient's admission (some during the initial resuscitative period and others after the patient is stabilized).
- **Option D:** The cause of her elevated blood glucose is not the IV fluid. Rapid and aggressive fluid resuscitation is needed to replace intravascular volume and maintain end-organ perfusion.

25. Referencing the image below, what is the name of the structure marked #4.

- A. Cortical blood vessels
- B. Portal artery
- C. Portal vein
- D. Renal pyramid
- E. Renal calyx
- G. Minor calyx
- H. Major calyx
- I. Renal artery
- J. Renal vein

Correct answer: #4 is Option J. Renal vein

The renal vein is a blood vessel that carries deoxygenated blood from the kidney to the inferior vena cava. There is one renal vein for each kidney. The renal veins are formed by the confluence of the interlobar veins of one kidney. They enter the kidney at the hilum, which is the indented area on the medial side of the kidney. The renal veins then drain into the inferior vena cava, which is a large vein that carries blood directly to the heart.

26. Nurse Louie is developing a teaching plan for a male client diagnosed with diabetes insipidus. The nurse should include information about which hormone lacking in clients with diabetes insipidus?

- A. Antidiuretic hormone (ADH).

- B. Thyroid-stimulating hormone (TSH).
- C. Follicle-stimulating hormone (FSH).
- D. Luteinizing hormone (LH).

Correct Answer: A. Antidiuretic hormone (ADH).

ADH is the hormone clients with diabetes insipidus lack. The client's TSH, FSH, and LH levels won't be affected. Diabetes insipidus (DI) is a disease process that results in either decreased release of antidiuretic hormone (ADH, also known as vasopressin or AVP) or decreased response to ADH, causing electrolyte imbalances. There are two types of diabetes insipidus, central and nephrogenic, and each has congenital and acquired causes. There is a passage of large volumes of dilute urine (less than 300m Osm/kg) in all cases.

- **Option B:** Hypothyroidism results from low levels of thyroid hormone with varied etiology and manifestations. Untreated hypothyroidism increases morbidity and mortality. In the United States, autoimmune thyroid disease (Hashimoto thyroiditis) is the most common cause of hypothyroidism, but globally lack of iodine in the diet is the most common cause.
- **Option C:** A low FSH result is generally associated with better ovarian function. Higher levels are associated with diminished ovarian reserve, which makes pregnancy difficult. Most women have low FSH in their 20s, and levels increase naturally as women age.
- **Option D:** Luteinizing hormone (LH) is a glycoprotein hormone secreted from the pituitary gland in response to the pulsatile release of gonadotropin-releasing hormone (GnRH) from the hypothalamus. Many conditions can cause its deficiency as a response to maintain homeostasis and as a response to hypothalamic-pituitary-gonadal feedback regulation.

27. Nurse Elijah has been teaching a client about a high-protein diet. The teaching is successful if the client identifies which meal as high in protein?

- A. Baked beans, hamburger, and milk
- B. Spaghetti with cream sauce, broccoli, and tea
- C. Bouillon, spinach, and soda
- D. Chicken cutlet, spinach, and soda

Correct Answer: A. Baked beans, hamburger, and milk

Baked beans, hamburger, and milk are all excellent sources of protein. Good choices include soy protein, beans, nuts, fish, skinless poultry, lean beef, pork, and low-fat dairy products. Avoid processed meats.

- **Option B:** The spaghetti-broccoli-tea choice is high in carbohydrates. The quality of the carbohydrates (carbs) one eats is important too. Cut processed carbs from the diet, and choose carbs that are high in fiber and nutrient-dense, such as whole grains and vegetables and fruit.
- **Option C:** The bouillon-spinach-soda choice provides liquid and sodium as well as some iron, vitamins, and carbohydrates.
- **Option D:** Chicken provides protein but the chicken-spinach-soda combination provides less protein than the baked beans-hamburger-milk selection.

28. A client is at risk for pulmonary embolism and is on anticoagulant therapy with warfarin (Coumadin). The client's prothrombin time is 20 seconds, with a control of 11 seconds. The nurse assesses that this result is:

- A. The same as the client's own baseline level.
- B. Lower than the needed therapeutic level.
- C. Within the therapeutic range.
- D. Higher than the therapeutic range.

Correct Answer: C. Within the therapeutic range.

The therapeutic range for prothrombin time is 1.5 to 2 times the control for clients at risk for thrombus. Based on the client's control value, the therapeutic range for this individual would be 16.5 to 22 seconds. Therefore the result is within the therapeutic range. PT measures the time, in seconds, for plasma to clot after adding thromboplastin, (a mixture of tissue factor, calcium, and phospholipid) to a patient's plasma sample.

- **Option A:** Many different preparations of thromboplastin reagents are available which can give different PT results even when using the same plasma. Due to this variability, the World Health Organization (WHO) introduced the international normalized ratio (INR) and has become the standard reporting format for PT results.
- **Option B:** The reference ranges for PT vary by laboratory since different facilities use reagents or instruments. However, in most laboratories, the normal range for PT is 10 to 13 seconds. The normal INR for a healthy individual is 1.1 or below, and the therapeutic range for most patients on VKAs is an INR of 2.0 to 3.0.
- **Option D:** An increased PT/INR for patients on VKAs may suggest a super-therapeutic level and will require medication dose adjustments to prevent bleeding. As the use of VKAs increases, it is vital to educate patients on the importance of routine monitoring of PT/INR. Proper monitoring will allow for medication adjustments and prevention of adverse events.

29. The client who is human immunodeficiency virus seropositive has been taking saquinavir (Invirase). The nurse provides medication instructions and advises the client to:

- A. Take the medication in the morning before meals.
- B. Include a low-fat diet.
- C. Weight gain is expected.
- D. Avoid being exposed to sunlight.

Correct Answer: D. Avoid being exposed to sunlight.

Saquinavir (Invirase) is an antiviral medicine that prevents human immunodeficiency virus (HIV) from multiplying in the body. This can cause photosensitivity so the nurse should instruct the client to avoid sun exposure.

- **Option A:** The medicine is taken with food or within 2 hours after eating a full meal.
- **Option B:** The medicine is best absorbed with a high-fat meal.
- **Option C:** Weight loss instead is expected.

30. Transcultural nursing implies:

- A. Using a comparative study of cultures to understand similarities and differences across human groups to provide specific individualized care that is culturally appropriate.
- B. Working in another culture to practice nursing within their limitations.
- C. Combining all cultural beliefs into a practice that is a non-threatening approach to minimize cultural barriers for all clients' equality of care.
- D. Ignoring all cultural differences to provide the best-generalized care to all clients.

Correct Answer: A. Using a comparative study of cultures to understand similarities and differences across human groups to provide specific individualized care that is culturally appropriate

Transcultural care means that by understanding and learning about specific cultural practices the nurse can integrate these practices into the plan of care for a specific individual client who has the same beliefs or practices to meet the client's needs in a holistic manner of care.

- **Option B:** Nurses should explore new ways of providing cultural care in multicultural societies, understand how culture affects health-illness definitions, and build a bridge for the gap between the caring process and the individuals in different cultures.
- **Option C:** The individuals' beliefs about health, attitudes, and behaviors, past experiences, treatment practices, in short, their culture, play a vital role in improving health, preventing and treating diseases. Health workers must collect cultural data to understand the attitudes of coping with illness, health promotion, and protection.
- **Option D:** Nurses should offer acceptable and affordable care for the individuals under the conditions of the day. Knowing what cultural practices are done in the target communities and identifying the cultural barriers to offering quality health care positively affects the caring process.

31. A 50-year-old male client with a history of colorectal cancer has recently undergone a colon resection. Postoperatively, while assisting the client to turn in bed for routine care, the nurse notices the surgical wound site has suddenly dehiscd, and there is evisceration of abdominal contents. In prioritizing the immediate actions to take, which step should the nurse perform first to address this acute complication?

- A. Promptly notify the surgeon to report the critical incident and seek further orders.
- B. Immediately cover the eviscerated tissue with a dressing moistened with sterile normal saline.
- C. Check the client's vital signs to assess for shock or other immediate life-threatening conditions.
- D. Attempt to gently approximate the wound edges without applying pressure to the eviscerated organs.
- E. Prepare the client for emergency surgery while ensuring the preservation of the exposed tissues.
- F. Administer prescribed analgesia to manage the client's pain due to the dehiscence.

Correct Answer: B. Immediately cover the eviscerated tissue with a dressing moistened with sterile normal saline.

This action is critical to maintain the viability of the exposed organs and prevent further contamination and infection. It is the most immediate and appropriate first step in the event of evisceration. Once this is done, the nurse should then perform other actions, such as notifying the surgeon (A), assessing vital signs (C), and preparing the client for emergency intervention (E). Attempting to close the wound (D) or administering pain medication (F) should only be done under the direct instruction of a physician, as they are not initial emergency measures.

32. After surgery for an ileal conduit, the nurse should closely evaluate the client for the occurrence of which of the following complications related to pelvic surgery?

- A. Peritonitis
- B. Thrombophlebitis
- C. Ascites
- D. Inguinal hernia

Correct Answer: B. Thrombophlebitis

After pelvic surgery, there is an increased chance of thrombophlebitis owing to the pelvic manipulation that can interfere with circulation and promote venous stasis. The pathogenesis is thought to include injury to the intima of the pelvic vein caused by a spreading uterine infection, bacteremia, and endotoxins, which can also occur secondary to the trauma of delivery or surgery.

- **Option A:** Peritonitis is a potential complication of any abdominal surgery, not just pelvic surgery. Typically, patients who experience spontaneous bacterial peritonitis have chronic liver disease with a Child-Pugh classification, which assesses the prognosis of liver disease, of C. This ranking involves a high to a maximum score of 10 to 15 points (on the Child-Pugh scale), and measures 1-year patient survival at 45% and 2-year survival at 35%.
- **Option C:** Ascites is most frequently an indication of liver disease. In the United States, the most common disease that causes patients to get ascites is cirrhosis, which accounts for approximately 80% of cases. Other causes of ascites include cancer, 10%; heart failure, 3%; tuberculosis, 2%; dialysis, 1%; pancreatic disease, 1%; and others, 2%.
- **Option D:** Inguinal hernia may be caused by an increase in abdominal pressure or congenital weakness of the abdominal wall; a ventral hernia occurs at the site of previous abdominal surgery. Inguinal hernias are considered to have both a congenital and acquired component. Most adult hernias are considered acquired. However, there is evidence to suggest genetics also play a role. Patients with a known family history of a hernia are at least 4 times more likely to have an inguinal hernia than patients with no known family history.

33. A 68-year-old woman with a recent diagnosis of osteoporosis is admitted to the geriatric care unit. Given her heightened risk for fractures, the nurse is keen on implementing preventive measures to minimize the chances of falls. As part of the comprehensive plan of care, which nursing intervention is most appropriate to safeguard the patient against potential falls? Select all that apply.

- A. Encouraging the use of assistive devices for mobility.
- B. Administering calcium supplements as ordered.

- C. Teaching relaxation techniques to manage pain.
 - D. Applying heat packs to alleviate discomfort.
 - E. Encouraging the patient to walk barefoot for better grip.
 - F. Placing the patient's personal items on the floor for easy access.
 - G. Installing grab bars in the bathroom and ensuring well-lit hallways.
 - H. Recommending the patient to use high-heeled shoes for better posture.
- **Option A. Encouraging the use of assistive devices for mobility.** Using assistive devices such as canes or walkers can improve stability and prevent falls in patients with osteoporosis.
 - **Option G. Installing grab bars in the bathroom and ensuring well-lit hallways.** This intervention helps provide stability and support for the patient, especially in areas where falls are common, like the bathroom. Additionally, well-lit hallways help the patient see clearly and navigate safely, reducing the risk of tripping or falling.
 - **Option B:** Administering calcium supplements is important for bone health but does not directly prevent falls.
 - **Options C & D:** Teaching relaxation techniques and applying heat packs address pain management but not fall prevention.
 - **Option E:** Walking without shoes elevates the likelihood of experiencing a fall. Furthermore, individuals who fall either while shoeless or when donning slippers demonstrate a heightened probability of incurring a severe injury.
 - **Option H:** High-heeled shoes can actually increase the risk of falls as they can be unstable and alter the wearer's center of gravity. While they might offer a temporary boost in height and posture, they are not recommended for elderly patients or those with conditions like osteoporosis due to the increased risk of imbalance and falls.

34. Patient S is a sexually active adolescent. Which of the following instructions would be included in the preventive teaching plan about urinary tract infections?

- A. Drinking acidic juices
- B. Avoiding urinating before intercourse
- C. Wearing nylon underwear
- D. Wiping back to front

Correct Answer: A. Drinking acidic juices

Drinking acidic juices, such as cranberry juice, helps keep the urine at its desired pH and reduces the chance of infection. Pure cranberry juice, cranberry extract, or cranberry supplements may help prevent repeated UTIs in women, but the benefit is small. It helps about as much as taking antibiotics to prevent another UTI.

- **Option B:** Many health authorities, including the Centers for Disease Control and Prevention (CDC), recommend urinating after sex to prevent UTIs. Doing so may help flush away bacteria that are close to the urethra and prevent them from entering the urinary tract.
- **Option C:** Synthetic fabrics trap moisture and create the perfect breeding ground for infection. If the patient is prone to UTIs, she should wear loose-fitting bottoms that allow air to circulate around

the vagina. At night, the patient can wear loose-fitting boxers or shorts.

- **Option D:** After urinating, tilt the body forward and, reaching between the buttocks, start wiping from the front of the vagina to the back. Doing so prevents the introduction of bacteria from the anus to the vagina.

35. A nurse is working with a client who has schizophrenia, paranoid type. Which of the following outcomes related to the client's delusional perceptions would the nurse establish?

- A. The client will demonstrate realistic interpretation of daily events in the unit.
- B. The client will perform daily hygiene and grooming without assistance.
- C. The client will take prescribed medications without difficulty.
- D. The client will participate in unit activities.

Correct Answer: A. The client will demonstrate realistic interpretation of daily events in the unit.

A client with schizophrenia, paranoid type, has distorted perceptions and views people, institutions, and aspects of the environment as plotting against him. The desired outcome for someone with delusional perceptions would be to have a realistic interpretation of daily events. Unlike DSM-5, ICD-10 further subcategories schizophrenia based on the key presenting symptoms as either paranoid schizophrenia, hebephrenic schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia, post-schizophrenic depression, residual schizophrenia, and simple schizophrenia.

- **Option B:** The client with a distorted perception of the environment would not necessarily have impairments affecting hygiene and grooming skills. A thorough risk assessment must also be undertaken to determine the risk of harm to self and others. The first schizophrenic episode usually occurs during early adulthood or late adolescence. Individuals often lack insight at this stage; therefore few will present directly to seek help for their psychotic symptoms.
- **Option C:** For the initial treatment of acute psychosis, it is recommended to commence an oral second-generation antipsychotic (SGA) such as aripiprazole, olanzapine, risperidone, quetiapine, asenapine, lurasidone, sertindole, ziprasidone, brexpiprazole, molindone, iloperidone, etc. Sometimes, if clinically needed, alongside a benzodiazepine such as diazepam, clonazepam or lorazepam to control behavioral disturbances and non-acute anxiety. First generation antipsychotic (FGA) like trifluoperazine, Fluphenazine, haloperidol, pimozide, sulpiride, flupentixol, chlorpromazine, etc. are not commonly used as the first line but can be used.
- **Option D:** Although taking medications and participating in unit activities may be appropriate outcomes for nursing intervention; these responses are not related to client perceptions. Cognitive-behavioral therapy (CBT) and the use of art and drama therapies help counteract the negative symptoms of the disease, improve insight, and assist relapse prevention.

36. For Jayvin who is taking antacids, which instruction would be included in the teaching plan?

- A. "Take the antacids with 8 oz of water."
- B. "Avoid taking other medications within 2 hours of this one."
- C. "Continue taking antacids even when pain subsides."
- D. "Weigh yourself daily when taking this medication."

Correct Answer: B. “Avoid taking other medications within 2 hours of this one.”

Antacids neutralize gastric acid and decrease the absorption of other medications. The client should be instructed to avoid taking other medications within 2 hours of the antacid. The antacids act by neutralizing the acid in the stomach and by inhibiting pepsin, which is a proteolytic enzyme. Each of these cationic salts has a characteristic pharmacological property that determines its clinical use.

- **Option A:** Water, which dilutes the antacid, should not be taken with an antacid. The dose for antacids depends upon the age of the patient, the purpose of administration (neutralization of acid or off-label use), and the presence of other comorbidities like renal or hepatic impairment.
- **Option C:** A histamine receptor antagonist should be taken even when the pain subsides. Calcium salts neutralize gastric acidity resulting in increased gastric and duodenal bulb pH; they additionally inhibit the proteolytic activity of pepsin if the pH is greater than 4 and increase lower esophageal sphincter tone.
- **Option D:** Daily weights are indicated if the client is taking a diuretic, not an antacid. The average therapeutic dose of antacid is 10 to 15 mL (1 tablespoon or one package content) of liquid or 1 to 2 tablets 3 to 4 times a day. Periodic monitoring of calcium and phosphorus plasma concentrations is a suggested practice in patients on chronic therapy.

37. The nurse is caring for a client following enucleation. The nurse notes the presence of bright red blood drainage on the dressing. Which nursing action is appropriate?

- A. Notify the physician.
- B. Continue to monitor the drainage.
- C. Document the finding.
- D. Mark the drainage on the dressing and monitor for any increase in bleeding.

Correct Answer: A. Notify the physician.

If the nurse notes the presence of bright red drainage on the dressing, it must be reported to the physician because this indicated hemorrhage. Enucleation is the removal of the eye from the orbit and involves the separation of all tissue connections between the globe and the orbit. The main indications for enucleation are trauma, painful eye, a blind eye, which is unsightly, intraocular malignancy, and as part of eye donation.

- **Option B:** Postoperative orbital hemorrhage after enucleation is rare with the use of compression bandages, and the precautions discussed earlier. If severe hemorrhage occurs, surgical exploration may be necessary, and separate incisions can decrease wound dehiscence and fat atrophy.
- **Option C:** This is not a normal finding. Edema of the orbit after enucleation is common and usually settles down with time. Orbital infection is a rare complication but can lead to wound dehiscence, implant exposure, and extrusion. Symptoms can be increased chemosis and persistent pain in the socket.
- **Option D:** The pressure patch can remain in place up to a week to reduce postoperative edema, although it is generally removed in 24 hours because of the inevitable oozing and soaking of the dressing that occurs. It will need to be removed to allow the application of topical antibiotics and corticosteroid ointment onto the conformer.

38. You are a pediatric nurse at a community health clinic, providing prenatal and postnatal education to families. Today, you are facilitating a parent group focusing on infant care. During the session, you are discussing various aspects including sleep safety, feeding, and developmental stimulation. You present several actions and ask the group to identify which action is NOT appropriate for a 2-month-old infant. Given the following options, select the action that is NOT appropriate for the care of a 2-month-old infant:

- A. Place the infant on her back for naps and bedtime.
- B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.
- C. Talk to the infant frequently and make eye contact to encourage language development.
- D. Wait until at least 4 months to add infant cereals and strained fruits to the diet.
- E. Offer the infant cow's milk as a supplement to breastmilk or formula.
- F. Place a soft blanket and several plush toys in the crib for comfort.

Correct Answer: E. Offer the infant cow's milk as a supplement to breastmilk or formula.

Cow's milk should not be given to infants under 1 year of age as it lacks essential nutrients present in breastmilk or infant formula, and can irritate the infant's immature gastrointestinal system.

- **Option A:** This action aligns with safe sleep recommendations to reduce the risk of sudden infant death syndrome (SIDS). Placing infants on their backs to sleep is the correct position for infants up to 1 year of age.
- **Option B:** While it may be challenging for parents to hear their infant cry, a short waiting period before responding may allow the infant to self-soothe and fall back asleep. It's a common method used in some sleep training approaches. However, at 2 months of age, immediate response to crying is often recommended to build trust and security.
- **Option C:** Talking to the infant and making eye contact are crucial for socio-emotional and language development. This interaction helps in forming a secure attachment and stimulating brain development.
- **Option D:** It is recommended to wait until around 6 months before introducing solid foods, though some pediatricians may suggest starting as early as 4 months if the infant is showing readiness signs. Hence, waiting until at least 4 months to add cereals and strained fruits is appropriate.
- **Option F:** Placing a soft blanket and plush toys in the crib can be dangerous and is not recommended as it increases the risk of suffocation and SIDS. Safe sleep guidelines recommend keeping the crib free of soft bedding, bumpers, and toys.

39. A nurse is administering an IV bolus of cimetidine (Tagamet). Which of the following should the nurse monitor closely follow the administration?

- A. Respiratory rate
- B. Skin turgor
- C. Blood pressure
- D. Temperature

Correct Answer: C. Blood pressure

Rapid intravenous administration of Cimetidine causes hypotension due to arterial vasodilation. It is recommended to be injected slowly over a period of not less than 5 minutes.

- **Options A, B, & D:** These are not related to this medication.

40. Nurse Len should expect to administer which medication to a client with gout?

- A. Aspirin
- B. Furosemide (Lasix)
- C. Colchicines
- D. Calcium gluconate (Kalcinate)

Correct Answer: C. Colchicines

A disease characterized by joint inflammation (especially in the great toe), gout is caused by urate crystal deposits in the joints. The physician prescribes colchicine to reduce these deposits and thus ease joint inflammation.

- **Option A:** Although aspirin is used to reduce joint inflammation and pain in clients with osteoarthritis and rheumatoid arthritis, it isn't indicated for gout because it has no effect on urate crystal formation.
- **Option B:** Furosemide, a diuretic, doesn't relieve gout. It is a loop diuretic that prevents the body from absorbing too much salt. This allows the salt to be passed in the urine.
- **Option D:** Calcium gluconate is used to reverse a negative calcium balance and relieve muscle cramps, not to treat gout.

41. A client with depression who has been taking amitriptyline for three months returns to the clinic for a follow-up. The nurse observes the client in which of the following symptoms?

- A. Lack of energy
- B. Suicidal thoughts
- C. Loss of interest in personal appearance
- D. Neglect of responsibilities

Correct Answer: B. Suicidal thoughts

Clients may have thoughts about suicide when taking an antidepressant such as amitriptyline especially during the beginning of the treatment and any time during dosage adjustment.

- **Options A, C, and D:** These are signs and symptoms of depression but are most likely improved as the treatment goes on.

43. Toxicity from which of the following medications may cause a client to see a green halo around lights?

- A. Digoxin
- B. Furosemide
- C. Metoprolol
- D. Enalapril

Correct Answer: A. Digoxin

One of the most common signs of digoxin toxicity is the visual disturbance known as the green halo sign.

- **Option B:** Furosemide does not cause this kind of toxicity. The principal signs and symptoms of overdose with furosemide are dehydration, blood volume reduction, hypotension, electrolyte imbalance, hypokalemia, and hypochloremic alkalosis, and are extensions of its diuretic action.
- **Option C:** Metoprolol is not associated with this effect. Poisoning due to an overdose of metoprolol may lead to severe hypotension, sinus bradycardia, atrioventricular block, heart failure, cardiogenic shock, cardiac arrest, bronchospasm, impairment of consciousness, coma, nausea, vomiting, cyanosis, hypoglycemia, and, occasionally, hyperkalemia.
- **Option D:** This medication isn't associated with such an effect. While there is limited data about enalapril overdose in humans, overdosage may result in marked hypotension and stupor based on the pharmacological properties of the drug. The most common adverse effects of enalapril include cough, hypotension, stupor, headache, dizziness, and fatigue.

44. A nurse has a four-patient assignment in the medical step-down unit. When planning care for the clients, which client would have the following treatment goals: fluid replacement, vasopressin replacement, and correction of underlying intracranial pathology?

- A. The client with diabetes mellitus.
- B. The client with diabetes insipidus.
- C. The client with diabetic ketoacidosis.
- D. The client with syndrome of inappropriate antidiuretic hormone (SIADH) secretion.

Correct Answer: B. The client with diabetes insipidus.

Maintaining adequate fluid, replacing vasopressin, and correcting underlying intracranial problems (typically lesions, tumors, or trauma affecting the hypothalamus or pituitary gland) are the main objectives in treating diabetes insipidus. Diabetes insipidus (DI) is a disease process that results in either decreased release of or response to antidiuretic hormone (ADH, also known as vasopressin or AVP), which can cause electrolyte imbalances.

- **Option A:** Diabetes mellitus does not involve vasopressin deficiencies or an intracranial disorder, but rather a disturbance in the production or use of insulin. The physiology and treatment of diabetes are complex and require a multitude of interventions for successful disease management. Diabetic education and patient engagement are critical in management.
- **Option C:** Diabetic ketoacidosis results from severe insulin insufficiency. Fluid resuscitation and maintenance, insulin therapy, electrolyte replacement, and supportive care are the mainstays of management in diabetic ketoacidosis.

- **Option D:** An excess of vasopressin leads to SIADH, causing the client to retain fluid. The patients with SIADH have a combination of ADH-induced water retention and secondary solute loss. The overall solute loss is more prominent than water retention in patients with chronic SIADH. SIADH treatment involves correction and maintenance of corrected sodium levels and correction of underlying abnormalities such as hypothyroidism or pulmonary or CNS infection.

45. Which nursing intervention takes the highest priority when caring for a newly admitted client who's receiving a blood transfusion?

- A. Warming the blood prior to transfusion.
- B. Informing the client that the transfusion usually takes 4 to 6 hours.
- C. Documenting blood administration in the client chart.
- D. Instructing the client to report any itching, chest pain, or dyspnea.

Correct Answer: D. Instructing the client to report any itching, headache, or dyspnea.

This will help the nurse take immediate action in case a reaction happens during a transfusion. There are multiple complications of blood transfusions, including infections, hemolytic reactions, allergic reactions, transfusion-related lung injury (TRALI), transfusion-associated circulatory overload, and electrolyte imbalance.

- **Option A:** There is no evidence that warming blood is beneficial to the patient when transfusion is slow. At transfusion rates of greater than 100 mL/minute, cold blood may be a contributing factor in cardiac arrest. However, keeping the patient warm is probably more important than warming the blood.
- **Option B:** Transfusion of a unit of blood should be completed within a maximum period of four hours after removal from the blood fridge: discard the unit if this period is exceeded. If blood has been out of the blood bank refrigerator for more than 30 minutes and is not transfused, then the unit must be returned to the laboratory, where it will be disposed of.
- **Option C:** Documentation related to transfusion therapy should include verification of the prescribed blood product and blood product compatibility; verification of appropriate clinical indication for the transfusion; the date and time of transfusion, type of blood product administered, in addition to the volume, infusion rate, and time of initiation and completion of transfusion; any medication administered, including premedication (if I.V. drugs are required during transfusion, another I.V. site is required); the patient's clinical status throughout the transfusion therapy, including patient assessment data such as vital signs and lung sounds; the patient's response to therapy including any complications or adverse reactions, treatment required, and response to that treatment; and the amount of blood transfused and the return of the unused portion to the blood bank.

46. A 42-year-old patient with no significant medical history presents to the clinic with a recent positive Mantoux tuberculin skin test. The patient reports a productive cough and night sweats that have persisted for the past three weeks. The nurse understands that a chest X-ray has been ordered. The nurse considers that this diagnostic test is most crucial for which of the following reasons?

- A. To confirm the presence of active pulmonary tuberculosis.

- B. To determine if there is a need for a repeat Mantoux test due to potential false-positive results.
- C. To assess the size and spread of any lesions within the lung tissue.
- D. To differentiate between a primary TB infection or a reactivation of a latent TB infection.

Correct Answer: C. To determine the extent of lesions

If the lesions are large enough, the chest X-ray will show their presence in the lungs.

- **Option A:** Sputum culture confirms the diagnosis. It is a test to detect and identify bacteria or fungi that infect the lungs or breathing passages.
- **Option B:** There can be false-positive and false-negative skin test results. False-positive results happen with the skin test because the person has been infected with a different type of bacteria, rather than the one that causes TB. It can also happen because the person has been vaccinated with the BCG vaccine. A false-negative result may happen if the immune function is compromised by chronic medical conditions, cancer chemotherapy, or AIDS.
- **Option D:** A chest X-ray can't determine if this is a primary or secondary infection. In active pulmonary TB, infiltrates or consolidations and/or cavities are often seen in the upper lungs with or without mediastinal or hilar lymphadenopathy.

47. A 2-year-old is admitted for repair of a fractured femur and is placed in Bryant's traction. Which finding by the nurse indicates that the traction is working properly?

- A. The infant no longer complains of pain.
- B. The buttocks are 15° off the bed.
- C. The legs are suspended in the traction.
- D. The pins are secured within the pulley.

Correct Answer: B. The buttocks are 15° off the bed.

The infant's hips should be off the bed approximately 15° in Bryant's traction. Bryant's traction is a form of orthopedic traction. It is mainly used in young children who have fractures of the femur or congenital abnormalities of the hip. Both the patient's limbs are suspended in the air vertically at a ninety-degree angle from the hips and knees slightly flexed. Over a period of days, the hips are gradually moved outward from the body using a pulley system. The patient's body provides the counter-traction.

- **Option A:** Absence of pain is not an indication that the traction is working properly. The child's toes and feet should be warm and pink and the toes should move when touched. Check for these signs of good circulation every four hours the first few days, every four hours after rewrapping the legs, and then whenever the child is fed, changed, or played with.
- **Option C:** The child's body and the weights are used as tension to keep the end of the femur in the hip socket. The legs are wrapped in adhesive tape attached to a gauze adhesive elastic bandage, then connected to ropes and weights.
- **Option D:** Bryant's traction is a skin traction, not a skeletal traction. Take the ace wraps (the outer elastic bandage) off the legs. Inspect any skin for redness or irritation. Rewrap the legs with the ace bandages. Start at the feet. Overlap each loop of the wrap halfway. Do not stretch it tight. Stretch with mild tension only (1/3 tight).

48. A 50-year-old female patient is admitted to the hospital with recurrent episodes of upper abdominal pain and nausea. Upon evaluation, the gastroenterologist finds out that the pain is localized to the epigastric region and suspects gastritis or a peptic ulcer. To get a clearer picture, an endoscopic examination of the stomach is scheduled. The patient inquires about the areas of the stomach that will be inspected, and the medical team discusses the different regions of the stomach. Seizing this as an instructive moment, the nursing instructor asks the students a related question. In light of the patient's upcoming endoscopic evaluation and the discussion of stomach anatomy, which of the following options should the instructor ask students to identify as NOT correctly matched with its description regarding stomach structures?

- A. Cardiac region: the area closest to the small intestine
- B. Fundus: the most superior portion of the stomach
- C. Pyloric opening: opening from the stomach into the small intestine
- D. Body: the largest portion of the stomach

Correct Answer: A. Cardiac region: the area closest to the small intestine

This is incorrect. The cardiac region, or cardia, is the area surrounding the entrance of the esophagus into the stomach. It is not the area closest to the small intestine; that description would apply to the pyloric region.

- **Option B:** This is correct. The fundus is the dome-shaped uppermost part of the stomach. It lies superior to the cardiac region and the body of the stomach.
- **Option C:** This is correct. The pyloric opening is the exit from the stomach, leading into the small intestine (specifically, the duodenum). The pyloric sphincter controls the passage of stomach contents into the small intestine.
- **Option D:** This is correct. The body is the central and largest part of the stomach. It lies between the fundus and the pyloric region.

49. Nicolas is experiencing hallucinations and tells the nurse, "The voices are telling me I'm no good." The client asks if the nurse hears the voices. The most appropriate response by the nurse would be:

- A. "It is the voice of your conscience, which only you can control."
- B. "No, I do not hear your voices, but I believe you can hear them".
- C. "The voices are coming from within you and only you can hear them."
- D. "Oh, the voices are a symptom of your illness; don't pay any attention to them."

Correct Answer: B. "No, I do not hear your voices, but I believe you can hear them".

The nurse, demonstrating knowledge and understanding, accepts the client's perceptions even though they are hallucinatory. Accept the fact that the voices are real to the client, but explain that you do not hear the voices. Refer to the voices as "your voices" or "voices that you hear". Validating that your reality does not include voices can help the client cast "doubt" on the validity of their voices.

- **Option A:** Help the client to identify the needs that might underlie the hallucination. What other ways can these needs be met? Hallucinations might reflect needs for anger, power, self-esteem, and sexuality. Explore how the hallucinations are experienced by the client. Exploring the hallucinations and sharing the experience can help give the person a sense of power that he or she might be able to manage the hallucinatory voices.
- **Option C:** Help the client to identify times that the hallucinations are most prevalent and frightening. Helps both nurse and client identify situations and times that might be most anxiety-producing and threatening to the client. Stay with clients when they are starting to hallucinate, and direct them to tell the “voices they hear” to go away. Repeat often in a matter-of-fact manner. The client can sometimes learn to push voices aside when given repeated instructions. especially within the framework of a trusting relationship.
- **Option D:** Decrease environmental stimuli when possible (low noise, minimal activity). Decrease the potential for anxiety that might trigger hallucinations. Helps calm the client. Keep to simple, basic, reality-based topics of conversation. Help the client focus on one idea at a time. The client’s thinking might be confused and disorganized; this intervention helps the client focus and comprehend reality-based issues.

50. Mr. Bartowski who is newly diagnosed with rheumatoid arthritis asks the community nurse how stress can affect his disease. The nurse would explain that:

- A. The psychological experience of stress will not affect symptoms of physical disease.
- B. Psychological stress can cause painful emotions, which are harmful to a person with an illness.
- C. Stress can overburden the body’s immune system, and therefore one can experience increased symptoms.
- D. The body’s stress response is stimulated when there are major disruptions in one’s life.

Correct Answer: C. Stress can overburden the body’s immune system, and therefore one can experience increased symptoms.

The stress response causes stimulation of the hypothalamic-pituitary-adrenal axis, which can further compromise an immune system that has been activated by the autoimmune disorder of rheumatoid arthritis. Consequently, the client can expect disease symptoms to exacerbate when under stress.

- **Option A:** Research says that rheumatoid arthritis can be caused by stress. Stress triggers rheumatoid arthritis by setting off the immune system’s inflammatory response in which cytokines are released. Cytokines are chemicals that play an important role in inflammation and can increase the severity of rheumatoid arthritis in some patients. The greater the exposure to stress, the greater the inflammation becomes. This triggers a rheumatoid arthritis flare.
- **Option B:** Around one out of five patients with rheumatoid arthritis has depression due to the illness. Depression, in turn, further aggravates rheumatoid arthritis and leads to a greater number of painful joints, reduced functioning (higher number of days in bed), and increased visits to the doctor’s clinic. All these further affect the patient’s mental health and cause more stress and depression.
- **Option D:** Stress can cause rheumatoid arthritis and rheumatoid arthritis itself can also cause stress. Treatments that don’t work or their side effects might affect the patient’s mind. Joint pain and swelling can make routine activities difficult for the patient. All these things that come with rheumatoid arthritis can make the patient stressed, which can further trigger joint inflammation.

51. Tom is ready to be discharged from the medical-surgical unit after 5 days of hospitalization. Which client statement indicates to the nurse that Tom understands the discharge teaching about cellular injury?

- A. "I do not have to see my doctor unless I have problems."
- B. "I can stop taking my antibiotics once I am feeling better."
- C. "If I have redness, drainage, or fever, I should call my healthcare provider."
- D. "I can return to my normal activities as soon as I go home."

Correct Answer: C. "If I have redness, drainage, or fever, I should call my healthcare provider."

The knowledge that redness, drainage, or fever — signs of infection associated with cellular injury — require reporting indicates that the client has understood the nurse's discharge teaching. If a cell is unable to adapt to increased stress, injury results. Cell injury is reversible until a certain threshold where it progresses to cell death. Historically, cell death has been designated into two classes: necrosis and apoptosis. Necrosis is often coined as accidental death as it is generally seen as not controlled by the cell. Apoptosis, on the other hand, is typically viewed as programmed cell death, regulated and controlled.

- **Option A:** Follow-up checkups should be encouraged. Cell growth, division, and death are all important parts of this regulation, and each is highly regulated. Loss of this balance is seen in tumor cells where mechanisms of cell death are avoided, resulting in uncontrolled cell growth. Conversely, conditions where extensive cell death is seen also result in loss of homeostasis, such as in the case of neuronal loss in Alzheimer's disease.
- **Option B:** The nurse should place an emphasis on antibiotic compliance even if the client feels better. The understanding of cell death and the players involved is a subject of constant research. The better one understands the mechanism of cell death, the more likely it is that knowledge can be integrated into clinical medicine.
- **Option D:** There are usually activity limitations after cellular injury. Chemotherapy treatments with radiation can manipulate these pathways more directly by causing DNA damage that drives the cell to apoptosis. Understanding the basics of cell death allows for a better understanding of how tumor cells may evade death and counter-evade clinically.

52. A client taking lithium carbonate (Lithobid) started complaining of nausea, vomiting, diarrhea, drowsiness, muscle weakness, tremor, blurred vision, and ringing in the ears. The lithium level is 2 mEq/L. The nurse interprets this value as:

- A. Normal level
- B. Toxic level
- C. Below normal level
- D. Above normal level

Correct Answer: B. Toxic level

The therapeutic drug serum level of lithium is 0.6 to 1.2 mEq/L. Toxicity can happen when the level of lithium reaches 1.5 mEq/L or higher.

53. On the first postpartum (PP) night, a client requests that her baby be sent back to the nursery so she can get some sleep. The client is most likely in which of the following phases?

- A. Depression phase
- B. Letting-go phase
- C. Taking-hold phase
- D. Taking-in phase

Correct Answer: D. Taking-in phase

The taking-in phase occurs in the first 24 hours after birth. The mother is concerned with her own needs and requires support from staff and relatives. The woman becomes dependent on her healthcare provider or support person with some of the daily tasks and decision-making. The woman prefers to talk about her experiences during labor and birth and also her pregnancy. Encouraging the woman to talk about her experiences during labor and birth would greatly help her adjust and let her incorporate it into her new life.

- **Option A:** Depression is not one of the phases of postpartum psychological changes. The changes that the woman undergoes are crucial within the first 24 hours of postpartum, especially the psychological changes. These changes might affect the woman permanently if not given the appropriate attention and care.
- **Option B:** The letting-go phase begins several weeks later when the mother incorporates the new infant into the family unit. During the letting go phase, the woman finally accepts her new role and gives up her old roles like being a childless woman or just a mother of one child. Readjustment of relationships is needed for an easy transition to this phase.
- **Option C:** The taking-hold phase occurs when the mother is ready to take responsibility for her care as well as the infant's care. The taking hold phase starts 2 to 4 days after delivery. The woman starts to initiate actions on her own and makes decisions without relying on others. She starts to focus on the newborn instead of herself and begins to actively participate in newborn care.

54. Katherine is a young Unit Manager of the Pediatric Ward. Most of her staff nurses are senior to her, very articulate, confident, and sometimes aggressive. Katherine feels uncomfortable believing that she is the scapegoat of everything that goes wrong in her department. Which of the following is the best action that she must take?

- A. Identify the source of the conflict and understand the points of friction.
- B. Disregard what she feels and continues to work independently.
- C. Seek help from the Director of Nursing.
- D. Quit her job and look for another employment.

Correct Answer: A. Identify the source of the conflict and understand the points of friction

This involves a problem-solving approach, which addresses the root cause of the problem. Seek to understand the underlying emotions of the employees in conflict. Employers can manage workplace conflict by creating an organizational culture designed to preclude conflict as much as possible and by dealing promptly and equitably with conflicts that employees cannot resolve among themselves.

- **Option B:** Do not ignore conflict, and do not avoid taking steps to prevent it. Unresolved issues of interpersonal tension and conflict can create emotional stress for employees, politicize the workplace and divert attention from the organization's mission.
- **Option C:** Before escalating the conflict to the Director of Nursing, the unit manager should first try to deescalate the problem. If a manager has mechanisms in place to resolve conflict at its early stages, employees will generally see their employer as fair in their dealings with them and will likely be more satisfied with their jobs.
- **Option D:** If the manager does not act, conflicts will escalate into larger problems, discrimination and harassment complaints may increase, and the employer's reputation could be damaged. When employees mistrust management or perceive the organization as acting unfairly, turnover may increase. This can lead to recruiting and training expenses for new hires and the costs attributable to slippage of performance until new employees become fully proficient in their jobs.

55. A nurse is caring for an elderly Vietnamese patient in the terminal stages of lung cancer. Many family members are in the room around the clock performing unusual rituals and bringing ethnic foods. Which of the following actions should the nurse take?

- A. Restrict visiting hours and ask the family to limit visitors to two at a time.
- B. Notify visitors with a sign on the door that the patient is limited to clear fluids only with no solid food allowed.
- C. If possible, keep the other bed in the room unassigned to provide privacy and comfort to the family.
- D. Contact the physician to report the unusual rituals and activities.

Correct Answer: C. If possible, keep the other bed in the room unassigned to provide privacy and comfort to the family.

When a family member is dying, it is most helpful for nursing staff to provide a culturally sensitive environment to the degree possible within the hospital routine. In the Vietnamese culture, it is important that the dying be surrounded by loved ones and not left alone. Traditional rituals and foods are thought to ease the transition to the next life. When possible, allowing the family privacy for this traditional behavior is best for them and the patient.

- **Option A:** Know the availability of support systems for the patient. If the patient's main support is the object of perceived loss, the patient may need help in naming other sources of support. Communicate therapeutically with patient and family members and allow them to verbalize feelings.
- **Option B:** Support the patient and significant others share mutual fears, concerns, plans, and hopes for each other. Keeping secrets won't do any help during this time. These times of stress can be used as an opportunity for growth and family development.
- **Option D:** Initiate a process that provides additional support and resources. The patient and family may benefit from spiritual support resources. Strengthen the patient's efforts to go on with his or her life and normal routine. Allow the patient and family to feel that they are enabled to do this by supporting them.

56. A nurse is assessing the neurovascular status of a client who returned to the surgical nursing unit 4 hours ago after undergoing an aortoiliac bypass graft. The affected leg is warm, and the nurse notes redness and edema. The

pedal pulse is palpable and unchanged from admission. The nurse interprets that the neurovascular status is:

- A. Normal because of the increased blood flow through the leg.
- B. Slightly deteriorating and should be monitored for another hour.
- C. Moderately impaired, and the surgeon should be called.
- D. Adequate from the arterial approach, but venous complications are arising.

Correct Answer: A. Normal because of the increased blood flow through the leg.

An expected outcome of surgery is warmth, redness, and edema in the surgical extremity because of increased blood flow. Aortofemoral bypass surgery is a procedure utilized commonly for the treatment of aortoiliac occlusive disease, sometimes referred to as Leriche syndrome. Aortoiliac occlusive disease can contribute to lower extremity ischemic symptoms necessitating intervention.

- **Option B:** A common complication following surgery is renal insufficiency. This condition is typically a result of prolonged ischemia after clamping suprarenal, embolization secondary to clamping, hypoperfusion, hypovolemia or intrinsic renal artery disease.
- **Option C:** Often, this post-operative complication directly relates to the patient's preoperative cardiac and renal function. Knowing your patient's anatomy and having a precise plan preoperatively for clamping help reduce the incidence of renal insufficiency in the perioperative period.
- **Option D:** Eighty percent of aortobifemoral bypass surgeries are successful and open the artery and relieve symptoms for approximately 10 years after the procedure. Pain is usually relieved when the patient is resting and greatly reduced when walking.

57. Nurse Bella is aware that assessment finding is most consistent with early alcohol withdrawal?

- A. Heart rate of 120 to 140 beats/minute
- B. Heart rate of 50 to 60 beats/minute
- C. Blood pressure of 100/70 mmHg
- D. Blood pressure of 140/80 mmHg

Correct Answer: A. Heart rate of 120 to 140 beats/minute

Tachycardia, a heart rate of 120 to 140 beats/minute, is a common sign of alcohol withdrawal. Blood pressure may be labile throughout withdrawal, fluctuating at different stages. Hypertension typically occurs in early withdrawal. Hypotension, although rare during the early withdrawal stages, may occur in later stages. Hypotension is associated with cardiovascular collapse and most commonly occurs in clients who don't receive treatment. The nurse should monitor the client's vital signs carefully throughout the entire alcohol withdrawal process.

- **Option B:** Delirium tremens is the most severe form of alcohol withdrawal, and its hallmark is that of an altered sensorium with significant autonomic dysfunction and vital sign abnormalities. It includes visual hallucinations, tachycardia, hypertension, hyperthermia, agitation, and diaphoresis. Symptoms of delirium tremens can last up to seven days after alcohol cessation and may last even longer.

- **Option C:** Alcohol withdrawal can range from very mild symptoms to the severe form, which is named delirium tremens. The hallmark is autonomic dysfunction resulting from the excitation of the central nervous system. Mild signs/symptoms can arise within six hours of alcohol cessation. If symptoms do not progress to more severe symptoms within 24 to 48 hours, the patient will likely recover.
- **Option D:** Patients should be kept calm in a controlled environment to try to reduce the risks of progression from mild symptoms to hallucinations. With mild to moderate symptoms, patients should receive supportive therapy in the form of intravenous rehydration, correction of electrolyte abnormalities, and have comorbid conditions as listed above ruled out.

58. The statement, “The Holy Spirit Medical Center aims to provide patient-centered care in a total healing environment” refers to which of the following?

- A. Vision
- B. Goal
- C. Philosophy
- D. Mission

Correct Answer: B. Goal

Goals define the general intentions and ambitions of the business but can be difficult to measure. Setting goals is an important step of business planning, as a well-defined broad primary outcome will have an impact on areas including your mission statement, financial objectives, corporate culture, and marketing strategy.

- **Option A:** A vision refers to what the institution wants to become within a particular period of time. A vision statement looks forward and creates a mental image of the ideal state that the organization wishes to achieve. It is inspirational and aspirational and should challenge employees.
- **Option C:** In a conventional sense, company philosophy stands for the basic beliefs that people in the business are expected to hold and be guided by – informal unwritten guidelines on how people should perform and conduct themselves.
- **Option D:** A mission statement is a concise explanation of the organization’s reason for existence. It describes the organization’s purpose and its overall intention. The mission statement supports the vision and serves to communicate purpose and direction to employees, customers, vendors, and other stakeholders.

59. Teaching for a client with chronic obstructive pulmonary disease (COPD) should include which of the following topics?

- A. How to have his wife learn to listen to his lungs with a stethoscope from Wal-Mart.
- B. How to increase his oxygen therapy.
- C. How to treat respiratory infections without going to the physician.
- D. How to recognize the signs of an impending respiratory infection.

Correct Answer: D. How to recognize the signs of an impending respiratory infection.

Respiratory infection in clients with a respiratory disorder can be fatal. It's important that the client understands how to recognize the signs and symptoms of an impending respiratory infection. Acute exacerbation of COPD is an acute worsening of respiratory symptoms. Assessing severity is often based on the model developed by Anthonisen and colleagues which classifies severity by the presence of worsening dyspnea, sputum volume, and purulence. Mild exacerbations are defined by the presence of 1 of these symptoms in addition to one of the following: increased wheezing, increased cough, fever without another cause, upper respiratory infection within 5 days, or an increase in heart rate or respiratory rate from the patient's baseline.

- **Option A:** It isn't appropriate for the wife to listen to his lung sounds, besides, you can't purchase stethoscopes from Wal-Mart. COPD will typically present in adulthood and often during the winter months. Patients usually present with complaints of chronic and progressive dyspnea, cough, and sputum production. Patients may also have wheezing and chest tightness.
- **Option B:** Hospitalized patients often require oxygen and bronchodilator therapy in the form of a SABA with or without a SAMA. Oxygen therapy can range from a nasal cannula to mechanical ventilation depending on the severity of the exacerbation. Pulmonary rehabilitation plays a large role in improving outcomes. Rehabilitation has been shown to improve the quality of life, dyspnea, and exercise capacity in patients with COPD.
- **Option C:** If the client has signs and symptoms of an infection, he should contact his physician at once. Moderate and severe exacerbations are defined by the presence of 2 or all 3 of the symptoms respectively. Patients may have acute respiratory failure and physical findings of hypoxemia and hypercapnia. Arterial blood gas analysis, chest imaging, and pulse oximetry are indicated.

60. A client with myocardial infarction has been transferred from a coronary care unit to a general medical unit with cardiac monitoring via telemetry. A nurse plans to allow for which of the following client activities?

- A. Strict bed rest for 24 hours after transfer.
- B. Bathroom privileges and self-care activities.
- C. Unsupervised hallway ambulation with distances under 200 feet.
- D. Ad lib activities because the client is monitored.

Correct Answer: B. Bathroom privileges and self-care activities

On transfer from the CCU, the client is allowed self-care activities and bathroom privileges. Supervised ambulation for brief distances is encouraged, with distances gradually increased (50, 100, 200 feet). A patient on telemetry should be visualized hourly. With every ECG alarm, the patient should be visualized and assessed (refer to Nursing Assessment Clinical Guideline). It is the responsibility of nursing staff to know the whereabouts of their patient at all times – toilet doors should not be locked – however, laminated signs may be used on doors instead

- **Option A:** Patients should be assessed daily for the appropriateness of cardiac telemetry. Acutely unwell patients at risk of life-threatening arrhythmias should be on strict bed rest and continuously monitored on the bedside monitor and close to emergency equipment. The AUM will be involved in all aspects of care, from patient assessment and daily reviews for appropriateness of telemetry.
- **Option C:** All health professionals involved in the patient's care will know how far the patient is allowed to mobilize while on telemetry. The patient is required to remain within the boundaries of the hospital telemetry signal. If the patient requires a procedure or treatment outside the telemetry boundary, the patient will require a suitable portable cardiac monitoring device.

- **Option D:** The patient will be supervised by a parent or nurse at all times when mobilizing, this is to ensure patient safety. The primary nurse will be aware of the patient's location at all times. The ANUM should be consulted if the patient needs to cease telemetry monitoring for personal hygiene. In this case, the patient should be supervised at all times, and the medical team made aware.

61. A client's younger daughter is ignoring curfew. The client states, "I'm afraid she will get pregnant." The nurse responds, "Hang in there. Don't you think she has a lot to learn about life?" This is an example of which communication block?

- A. Requesting an explanation
- B. Belittling the client
- C. Making stereotyped comments
- D. Probing

Correct Answer: C. Making stereotyped comments

This is an example of the nontherapeutic communication block of making stereotyped comments. Clichés and trite expressions are meaningless in a therapeutic nurse-client relationship. Such comments are of no value in the nurse-client relationship. Any automatic responses will lack the nurse's consideration or thoughtfulness.

- **Option A:** Requesting an explanation or asking the client to provide reasons for thoughts, feelings, behaviors or events is nontherapeutic. There is a difference between asking the client to describe what is occurring or has taken place and asking him to explain why. Usually, a "why" question is intimidating.
- **Option B:** Belittling the client refers to misjudging the degree of the client's discomfort. When the nurse tries to equate the intense and overwhelming feelings the client has expressed to "everybody" or to the nurse's own feelings, the nurse implies that the discomfort is temporary, mild, self-limiting, or not very important. The client is focused on his or her own worries and feelings' hearing the problems or feelings of others is not helpful.
- **Option D:** Probing is the persistent questioning of the client. Probing tends to make the client feel used or invaded. Clients have the right not to talk about issues or concerns if they choose. Pushing and probing by the nurse will not encourage the client to talk.

62. A nurse is giving instructions to a client receiving lithium citrate. The nurse tells the client to do which of the following to prevent lithium toxicity:

- A. Avoid becoming dehydrated during exercise.
- B. Instruct the client to change positions slowly.
- C. Restrict salt intake in the diet.
- D. Limit fluid intake.

Correct Answer: A. Avoid becoming dehydrated during exercise

Lithium toxicity usually occurs during chronic treatment because of reduced drug excretion (dehydration, worsening renal function, concurrent infections, and drug interactions).

- **Option B:** Changes in position is not a related intervention to prevent lithium toxicity.
- **Options C and D:** The client should maintain a fluid intake of 6-8 glasses of water a day and an adequate salt intake to prevent lithium toxicity.

63. Which of the following represents a significant risk immediately after surgery for repair of aortic aneurysm?

- A. Potential wound infection
- B. Potential ineffective coping
- C. Potential electrolyte imbalance
- D. Potential alteration in renal perfusion

Correct Answer: D. Potential alteration in renal perfusion

There is a potential alteration in renal perfusion manifested by decreased urine output. The altered renal perfusion may be related to renal artery embolism, prolonged hypotension, or prolonged aortic cross-clamping during the surgery. Intervention or surgical treatment risks versus benefits of repair in patients at increased risk for open surgery should be considered, and no intervention may be appropriate in some cases. Patients should be well informed regarding their options, risks of repair, and potential postoperative complications.

- **Option A:** Wound infection may occur with a poorly dressed postoperative site, but it is not a priority after surgery. During postoperative care, the nurse has to be familiar with potential complications of the surgery and notify the interprofessional team if the patient has abdominal or back pain, wound discharge, fever, oliguria, or hypotension.
- **Option B:** Ineffective coping can be a possible diagnosis after a surgery, however, it is not considered as an immediate risk. The nurse should also ensure that the appropriate consulting physician/dietitian/social workers have seen the patient and the surgeon notified prior to discharge. Open communication between the interprofessional team is vital to ensure good outcomes.
- **Option C:** Electrolyte imbalance cannot be considered a potential diagnosis for a client who just had a surgery for repair of aortic aneurysm since there are no GI complications associated with this surgery. The nurse should also auscultate for bowel sounds and convey the results to the interprofessional team so that feeding can be initiated. Prior to discharge, the pharmacist and nurse should educate the patient on the importance of medication compliance, the need to control blood pressure, and avoiding tobacco.

64. The emergency room is flooded with clients injured in a tornado. Which clients can be assigned to share a room in the emergency department during the disaster?

- A. A schizophrenic client having visual and auditory hallucinations and the client with ulcerative colitis
- B. The client who is 6 months pregnant with abdominal pain and the client with facial lacerations and a broken arm
- C. A child whose pupils are fixed and dilated and his parents, and a client with a frontal head injury
- D. The client who arrives with a large puncture wound to the abdomen and the client with chest pain

Correct Answer: B. The client who is 6 months pregnant with abdominal pain and the client with facial lacerations and a broken arm

The pregnant client and the client with a broken arm and facial lacerations are the best choices for placing in the same room. Cohorting of patients according to the presence or absence of specific pathogens coupled with conventional hygienic precautions can lead to a decrease in incidence and prevalence of chronic infections with these two species, wherefore patient cohorting is now an integral component of infection control in patients.

- **Option A:** Schizophrenia is a brain disorder that probably comprises multiple etiologies. The hallmark symptom of schizophrenia is psychosis, such as experiencing auditory hallucinations (voices) and delusions (fixed false beliefs). Impaired cognition or a disturbance in information processing is an underappreciated symptom that interferes with day-to-day life. Hospitalizations are usually brief and are typically oriented towards crisis management or symptom stabilization.
- **Option C:** The goals of care are for the child and their loved ones are to be free of complicated grieving and to have access to adequate resources to allow for the natural grieving process. It is important for them to verbalize and express their true feelings and seek the help and support of others. Having privacy from other patients would be most appropriate.
- **Option D:** This group of clients needs to be placed in separate rooms due to the serious nature of their injuries. The client with chest pain should be placed in a private room to allow him to rest. Promote expression of feelings and fears. Let the patient/SO know these are normal reactions. Verbalization of concerns reduces tension, verifies the level of coping, and facilitates dealing with feelings. The presence of negative self-talk can increase the level of anxiety and may contribute to the exacerbation of angina attacks.

65. When a client is confused, left alone with the side rails down, and the bed in a high position, the client falls and breaks a hip. What law has been broken?

- A. Assault
- B. Battery
- C. Negligence
- D. Civil tort

Correct Answer: C. Negligence

Knowing what to do to prevent injury is a part of the standards of care for nurses to follow. Safety guidelines dictate raising the side rails, staying with the client, lowering the bed, and observing the client until the environment is safe. As a nurse, these activities are known as basic safety measures that prevent injuries, and to not perform them is not acting in a safe manner. Negligence is conduct that falls below the standard of care that protects others against unreasonable risk of harm.

- **Option A:** Assault is the intentional act of making someone fear that the nurse will cause them harm. One does not have to actually harm them to commit assault. Threatening them verbally or pretending to hit them are both examples of assault.
- **Option B:** Battery is the intentional act of causing physical harm to someone. Unlike assault, one doesn't have to warn the victim or make him fearful before they hurt them for it to count as a battery. If a nursing home attendant surprises the patient and pushes the patient from behind, that would qualify as a battery.
- **Option D:** Torts are civil laws that address the legal rights of patients and the responsibilities of the nurse in the nurse-patient relationship. Some torts specific to nursing and nursing practice include

things like malpractice, negligence, and violations relating to patient confidentiality.

66. A nurse is making initial rounds at the beginning of the shift and notices that the parenteral nutrition (PN) bag of an assigned client is empty. Which of the following solutions readily available on the nursing unit should the nurse hang until another PN solution is mixed and delivered to the nursing unit?

- A. 10% dextrose in water.
- B. 5% dextrose in water.
- C. 5% dextrose in normal saline.
- D. 5% dextrose in lactated Ringer solution.

Correct Answer: A. 10% dextrose in water.

The client is at risk of hypoglycemia. Hence the nurse will hang a solution that has the highest amount of glucose until the new parenteral nutrition solution becomes readily available. Crystalloid fluids are a subset of intravenous solutions that are frequently used in the clinical setting. Crystalloid fluids are the first choice for fluid resuscitation in the presence of hypovolemia, hemorrhage, sepsis, and dehydration.

- **Option B:** Option B is also a crystalloid fluid, but contains less glucose than option A. Other clinical applications include acting as a solution for intravenous medication delivery, to deliver maintenance fluid in patients with limited or no enteral nutrition, blood pressure management, and to increase diuresis to avoid nephrotoxic drug or toxin-mediated end-organ damage.
- **Option C:** Dextrose 5 in .9 Sodium Chloride is a prescription medicine used to treat the symptoms of hypoglycemia. Dextrose 5 in .9 Sodium Chloride may be used alone or with other medications. Dextrose 5 in .9 Sodium Chloride belongs to a class of drugs called Glucose-Elevating Agents; Metabolic and Endocrine, Other.
- **Option D:** 5% Dextrose in Lactated Ringer's Injection provides electrolytes and calories, and is a source of water for hydration. It is capable of inducing diuresis depending on the clinical condition of the patient. This solution also contains lactate which produces a metabolic alkalizing effect.

67. During an outbreak of a novel respiratory virus, a community health clinic organizes informational sessions to educate the public about the infection, prevention measures, and the immune response. At one such session, a patient who recently recovered from a mild form of the viral infection is curious about the type of immunity he has acquired against the pathogen. He asks the physician speaker about the immunity that arises when one naturally encounters and recovers from a specific infectious disease, leading the body to generate a tailored antibody response. In the context of this clinical and community health scenario, which term best describes the form of immunity acquired by the patient?

- A. Active Natural Immunity
- B. Active Artificial Immunity
- C. Passive Natural Immunity
- D. Passive Artificial Immunity

Correct Answer: A. Active Natural Immunity

Active natural immunity is acquired when an individual is exposed to a live pathogen, develops the disease, and becomes immune due to the primary immune response. In this case, the patient's immune system has encountered the natural infection, responded to it by generating specific antibodies, and thereby developed immunity to this particular respiratory virus.

- **Option B:** Active artificial immunity involves exposure to a weakened or inactivated form of the pathogen or to a recombinant antigen, such as a vaccine. This form of immunity also results from the body's own immune response, but the initial exposure is controlled and administered intentionally via vaccination, unlike the natural exposure in the scenario described.
- **Option C:** Passive natural immunity refers to the transmission of antibodies from mother to infant, either through the placenta during pregnancy or through breast milk postnatally. It does not result from the individual's own immune system responding to a pathogen, and therefore does not apply to the described scenario of a patient recovering from a natural infection.
- **Option D:** Passive artificial immunity is acquired through the administration of pre-formed antibodies, such as immunoglobulin therapy. This form of immunity provides immediate but temporary protection, without engaging the host's own immune system in an active response to the pathogen.

68. A nurse caring for a patient receiving oxytocin therapy suddenly is experiencing hypertonic contractions. Which of the following priority nursing actions should the nurse do? Select all that apply.

- A. The nurse leaves the client to ask for help.
- B. Administer oxygen at 8 to 10 liters per minute.
- C. Stop the oxytocin infusion.
- D. Place the client in the supine position.
- E. Increase the flow rate of the intravenous additive solution.

Correct Answer: B, C, & E.

The presence of hypertonic contractions indicates the need to initiate emergency measures. The oxytocin infusion must be stopped to reduce uterine stimulation, administering oxygen will promote increased fetal and maternal oxygenation.

- **Option A:** The nurse should stay with the client.
- **Option D:** Placing the client in a supine position will not promote an increase in placental oxygenation.

69. An adult client with a borderline personality disorder become nauseated and vomits immediately after drinking 2 ounces of shampoo as a suicide gesture. The most appropriate initial response by the nurse would be to:

- A. Promptly notify the attending physician.
- B. Immediately initiate suicide precautions.
- C. Sit quietly with the client until nausea and vomiting subsides.

D. Assess the client's vital signs and administer syrup of ipecac.

Correct Answer: C. Sit quietly with the client until nausea and vomiting subside.

This intervention demonstrates the nurse's caring presence which is vital for this client. Identify feelings experienced before and around the act of self-mutilation. Feelings are a guideline for future intervention (e.g., rage at feeling left out or abandoned).

- **Option A:** Although the treatment team does need to know about the event, notification is not the immediate concern. Set and maintain limits on acceptable behavior and make clear client's responsibilities. If the client is hospitalized at the time, be clear regarding the unit rules. Clear and non punitive limit setting is essential for decreasing negative behaviors.
- **Option B:** This is premature and it reinforces the client's predisposition to manipulative behavior. Secure a written or verbal no-harm contract with the client. Identify specific steps (e.g., persons to call upon when prompted to self-mutilate). The client is encouraged to take responsibility for healthier behavior. Talking to others and learning alternative coping skills can reduce frequency and severity until such behavior ceases.
- **Option D:** This medication is inappropriate in this situation; vomiting would be expected after the ingestion of shampoo. After the treatment, discuss what happened right before, and the thoughts and feelings that the client had immediately before self-mutilating. identify dynamics for both client and clinician. Allows the identification of less harmful responses to help relieve intense tensions.

70. A client with tonic-clonic seizure is receiving phenobarbital (Luminal) and valproic acid (Depakene). The nurse tells the client that:

- A. Valproic acid decreases phenobarbital metabolism.
- B. Valproic acid increases phenobarbital metabolism.
- C. There is no interaction between the two.
- D. Increase the dosage of the two medications.

Correct Answer: A. Valproic acid decreases phenobarbital metabolism.

Valproic acid appears to decrease phenobarbital metabolism, thus there is increased levels of phenobarbital in the body. Therefore, phenobarbital blood levels should be monitored and appropriate dosage adjustments made as indicated.

71. Hormonal effects of the antipsychotic medications include which of the following?

- A. Polydipsia and dysmenorrhea
- B. Dysmenorrhea and increased vaginal bleeding
- C. Retrograde ejaculation and gynecomastia
- D. Akinesia and dysphasia

Correct Answer: C. Retrograde ejaculation and gynecomastia

Decreased libido, retrograde ejaculation, and gynecomastia are all hormonal effects that can occur with antipsychotic medications. Reassure the client that the effects can be reversed or that changing medication may be possible. Among women taking conventional antipsychotics, 26% to 78%

experienced amenorrhea; some had galactorrhea. There was some evidence that hyperprolactinemia decreases libido, an effect that could cause nonadherence to treatment. In addition, bone loss appeared to be a secondary drug side effect in some studies. Finally, physician surveys indicated that the prevalence and severity of hyperprolactinemia are underestimated.

- **Option A:** Polydipsia is not a hormonal effect. Patients whose signs and symptoms are typical of hyperprolactinemia should be queried closely about their use of antipsychotic medications, and those with long-standing hyperprolactinemia should undergo bone density testing. Hyperprolactinemic effects should be a major consideration in assessing new antipsychotics as they appear on the market.
- **Option B:** Antipsychotic medications are being used increasingly for an expanding array of diagnoses. The stigma associated with antipsychotic medications and the diseases they treat may deter patients from informing healthcare professionals that they are receiving such treatment. Even when clinicians are aware that patients are taking antipsychotics, they may be unaware of the drugs' effects on prolactin levels and, in turn, prolactin's effects on ovarian function.
- **Option D:** Akinesia and dysphasia aren't hormonal effects. Akinesia refers to decreased or absent movement. The term akinesia refers to the inability to perform a clinically perceivable movement. It can present as a delayed response, freezing mid-action, or even total abolition of movement. Akinesia occurs when movement is not perceived either because the amplitude of the movement is small or because the time taken to initiate the reaction is significantly increased. Dysphasia is a condition that affects the ability to produce and understand spoken language. Dysphasia can also cause reading, writing, and gesturing impairments. Dysphasia is caused by brain damage.

72. A hospitalized client, diagnosed with a borderline personality disorder, consistently breaks the unit's rules. This behavior should be confronted because it will help the client:

- A. Control anger
- B. Reduce anxiety
- C. Set realistic goals
- D. Become more self-aware

Correct Answer: D. Become more self-aware.

Client's must first become aware of their behavior before they can change it. Occurs after the client is aware of the behavior and has a desire to change the behavior. Review with the client the types of cognitive distortions that affect self-esteem (e.g., self-blame, mind reading, overgeneralization, selective inattention, all-or-none thinking). These are the most common cognitive distortions people use. Identifying them is the first step to correcting distortions that form one's self-view.

- **Option A:** Maintain a neutral, calm, and respectful manner, although with some clients this is easier said than done. Helps the client see himself or herself as respected as a person even when behavior might not be appropriate. Keep in mind clients with personality disorders might defend against feelings of low-self-esteem through blaming, projection, anger, passivity, and demanding behaviors. Many behaviors seen in PD clients cover a fragile sense of self. Often these behaviors are the crux of clients' interpersonal difficulties in all their relationships.
- **Option B:** Focus questions in a positive and active light; helps client refocus on the present and look to the future. For example, "What can you do differently now?" or "What have you learned from that experience?". Allows the client to look at past behaviors differently, and gives the client a sense that he or she has choices in the future.

- **Option C:** Set goals realistically, and renegotiate goals frequently. Remember that a client's negative self-view and distrust of the world took years to develop. Unrealistic goals can set up hopelessness in clients and frustrations in nurse clinicians. Clients might blame the nurse for not "helping them," and nurses might blame the client for not "getting better".

73. A client with a total hip replacement requires special equipment. Which equipment would assist the client with a total hip replacement with activities of daily living?

- A. High-seat commode
- B. Recliner
- C. TENS unit
- D. Abduction pillow

Correct Answer: A. High-seat commode

The equipment that can help with activities of daily living is the high-seat commode. The hip should be kept higher than the knee. There is also equipment available for patients to help them follow their newly prescribed hip precautions. Some patients purchase raised toilet seats and chairs to prevent them from bending at the hip more than 90 degrees.

- **Option B:** The recliner is good because it prevents 90° flexion but not daily activities. Sock aids and dressing sticks are often used to make dressing and changing clothing easier for the patient. Reachers or "pinchers" can also be used by a patient following a total hip arthroplasty to help them grab items from the ground and other areas without breaking the hip precautions.
- **Option C:** A TENS (Transcutaneous Electrical Nerve Stimulation) unit helps with pain management. Compliance with hip precautions can be challenging for patients to follow. Many activities that were once simple to perform are instantly complicated. Activities of daily living can be significantly affected. Examples of activities of daily living include bathing, grooming, dressing, toileting, and transferring. Lack of independence can leave patients very upset and disheartened further affecting the rate of compliance.
- **Option D:** An abduction pillow is used to prevent adduction of the hip and possibly dislocation of the prosthesis. There are also environmental modifications that can help prevent hip dislocations; these include removing all tripping hazards from home, moving around the layout of home furniture so that there are fewer turns, and installing grab rails around the house.

74. The nurse in charge is assessing a patient's abdomen. Which examination technique should the nurse use first?

- A. Auscultation
- B. Inspection
- C. Percussion
- D. Palpation

Correct Answer: B. Inspection

Inspection always comes first when performing a physical examination. It is important to begin with the general examination of the abdomen with the patient in a completely supine position. The presence of

any of the following signs may indicate specific disorders. Percussion and palpation of the abdomen may affect bowel motility and therefore should follow auscultation.

- **Option A:** The last step of the abdominal examination is auscultation with a stethoscope. The diaphragm of the stethoscope should be placed on the right side of the umbilicus to listen to the bowel sounds, and their rate should be calculated after listening for at least two minutes. Normal bowel sounds are low-pitched and gurgling, and the rate is normally 2-5/min. Absent bowel sounds may indicate paralytic ileus and hyperactive rushes (borborygmi) are usually present in small bowel obstruction and sometimes may be auscultated in lactose intolerance.
- **Option C:** A proper technique of percussion is necessary to gain maximum information regarding the abdominal pathology. While percussing, it is important to appreciate tympany over air-filled structures such as the stomach and dullness to percussion which may be present due to an underlying mass or organomegaly (for example, hepatomegaly or splenomegaly).
- **Option D:** The ideal position for abdominal examination is to sit or kneel on the right side of the patient with the hand and forearm in the same horizontal plane as the patient's abdomen. There are three stages of palpation that include the superficial or light palpation, deep palpation, and organ palpation and should be performed in the same order. Maneuvers specific to certain diseases are also a part of abdominal palpation.

75. Nurse Gina understands that her client Glenda who is bulimic feels shame and guilt over binge eating and purging. This disorder is therefore considered:

- A. Ego-distorting
- B. Ego-dystonic
- C. Ego-enhancing
- D. Ego-syntonic

Correct Answer: B. Ego-dystonic

An ego-dystonic disorder is one in which the client views behaviors or symptoms as incongruent with self-image and therefore feels guilt, shame, and distress about the symptoms. Ego-dystonic refers to thoughts, impulses, and behaviors that are felt to be repugnant, distressing, unacceptable or inconsistent with one's self-concept.

- **Option A:** To say that the ego is distorted is simply to say that the mental apparatus is in a state of disordered function, and we cannot pursue this matter fruitfully unless we know exactly what part or layer of the ego is distorted and how and when and why, and with what other psychic reactions the ego-distortion is associated.
- **Option C:** Ego enhancement has been offered as the psychological mechanism that drives differences in judgments about effects on self and others. Findings indicate that although ego enhancement does not appear to directly influence either third-person perception or its relationship to support for government control, it does play a moderating role in regulating the relationship between perceived effects and support for controls, especially in the case of perceived effects on others.
- **Option D:** An ego-syntonic disorder is one which the client views behaviors as congruent with her self-image (as in anorexia nervosa). Ego-syntonic refers to instincts or ideas that are acceptable to the self; that are compatible with one's values and ways of thinking. They are consistent with one's fundamental personality and beliefs.

76. In a dermatology seminar, Dr. Rivera presented a case of a patient with a rare genetic disorder affecting the skin's structural integrity. The patient's stratum corneum lacks the typical strength and resilience observed in healthy individuals. Drawing upon this case, Dr. Rivera quizzes the participants about the structural component responsible for providing the stratum corneum with its exceptional structural strength within the epidermis. Which of the following is the correct component?

- A. Melanocytes
- B. Merkel cells
- C. Keratinocytes
- D. Langerhans cells

Correct Answer: C. Keratinocytes

Keratinocytes produce keratin, a type of protein that provides strength and protection to the epidermis. As keratinocytes move up from the lower layers of the epidermis to the stratum corneum, they become filled with keratin, die, and form a tough, protective layer, giving the stratum corneum its structural strength.

- **Option A:** Melanocytes are primarily responsible for producing melanin, the pigment that gives color to the skin, hair, and eyes. Melanin also plays a protective role against UV radiation, but it does not contribute to the structural strength of the stratum corneum.
- **Option B:** Merkel cells are tactile cells primarily found in the stratum basale of the epidermis. They are associated with nerve endings and play a role in the sensation of touch, but they are not involved in providing structural strength to the stratum corneum.
- **Option D:** Langerhans cells are immune cells found in the epidermis. They play a crucial role in the skin's immune response by capturing foreign substances and presenting them to T-cells in the immune system. While important for the immune function of the skin, they don't contribute to the structural strength of the stratum corneum.

77. As soon as the placenta is delivered, the nurse must do which of the following actions?

- A. Inspect the placenta for completeness including the membranes.
- B. Place the placenta in a receptacle for disposal.
- C. Label the placenta properly.
- D. Leave the placenta in the kidney basin for the nursing aide to dispose properly.

Correct Answer: A. Inspect the placenta for completeness including the membranes.

The placenta must be inspected for completeness to include the membranes because an incomplete placenta could mean that there is retention of placental fragments which can lead to uterine atony. If the uterus does not contract adequately, hemorrhage can occur.

- **Option B:** During the examination, the size, shape, consistency and completeness of the placenta should be determined, and the presence of accessory lobes, placental infarcts, hemorrhage, tumors and nodules should be noted. Once deemed complete, it may be disposed of properly.

- **Option C:** The placenta is not necessarily labeled. For inspection, keep in mind that the maternal surface of the placenta should be dark maroon in color and should be divided into lobules or cotyledons. The structure should appear complete, with no missing cotyledons. The fetal surface of the placenta should be shiny, gray, and translucent enough that the color of the underlying maroon villous tissue may be seen.
- **Option D:** Before the proper disposal of the placenta, it should be assessed properly. Evaluating placental completeness is of critical, immediate importance in the delivery room. Retained placental tissue is associated with postpartum hemorrhage and infection.

78. The intrauterine device prevents pregnancy by the ffg mechanism, except:

- A. Endometrium inflames.
- B. Fundus contracts to expel uterine contents.
- C. Copper embedded in the IUD can kill the sperms.
- D. Sperms will be barred from entering the fallopian tubes.

Correct Answer: D. Sperms will be barred from entering the fallopian tubes.

An Intrauterine device is a T-shaped piece of plastic placed inside the uterus. The piece of plastic contains copper or a synthetic progesterone hormone that prevents pregnancy. The device releases a constant low dose of a synthetic hormone continually throughout the day. Usually, IUDs are coated with copper to serve as spermicide killing the sperms deposited into the female reproductive tract. But the IUD does not completely fill up the uterine cavity thus sperms which are microscopic in size can still pass through.

- **Option A:** An intrauterine device is a foreign body so that if it is inserted into the uterine cavity, the initial reaction is to produce an inflammatory process and the uterus will contract in order to try to expel the foreign body.
- **Option B:** The IUD changes the lining of the uterus, preventing implantation should fertilization occur. It is important to consider the ethical implications of this third method.
- **Option C:** The released progesterone or copper creates changes in the cervical mucus and inside the uterus that kills sperm or makes them immobile.

79. The nurse is caring for a client who is receiving a chemotherapy. Which of the following would be expected as a result of the massive cell destruction that occurred from the chemotherapy?

- A. Leukopenia
- B. Anemia
- C. Thrombocytopenia
- D. Hyperuricemia

Correct Answer: D. Hyperuricemia.

Increased levels of uric acid (Hyperuricemia) in the body is common following the treatment for leukemias and lymphomas because chemotherapy results in massive cell destruction.

- **Options A, B, & C:** These are usually noted, but an increased uric acid level is specifically related to massive cell destruction.

80. During a neurology clinical rotation, a nursing student encounters a 45-year-old patient who recently sustained a traumatic brain injury following a motor vehicle accident. The patient's initial CT scan reveals localized contusions in the left parietal lobe. Upon assessment, the patient exhibits various cognitive and sensorimotor symptoms, prompting a more focused evaluation of the left parietal lobe involvement. The attending neurologist quizzes the student about the functional deficits specifically associated with a traumatic left parietal lobe injury. Which of the following manifestations presented by the patient is most consistent with the findings of a traumatic left parietal lobe injury?

- A. Difficulty with calculations and mathematical tasks
- B. Short term memory, blurred vision
- C. Altered personality and affective behavior
- D. Loss of fine movements and strength of the arms, hands, and fingers

Correct Answer: A. Difficulty with calculations and mathematical tasks

The left parietal lobe, particularly the angular gyrus, is associated with various aspects of language and mathematical processing. Injury in this area can lead to difficulties with calculations, writing, and even language comprehension, encompassed in the syndrome called Gerstmann's syndrome.

- **Option B:** Short term memory is primarily associated with the function of the hippocampus and surrounding medial temporal lobe structures, while vision and visual processing are mainly associated with the occipital lobe and to some extent, the temporal lobe. Therefore, these manifestations are not directly related to left parietal lobe injury.
- **Option C:** These changes are more typically associated with frontal lobe dysfunction or injury, especially to the prefrontal cortex, and not with the parietal lobe.
- **Option D:** Motor function and strength are primarily governed by the primary motor cortex located in the precentral gyrus of the frontal lobe. While the parietal lobe does contribute to sensorimotor integration, a loss of strength or fine motor control would more directly implicate the frontal lobe or other motor pathways rather than the parietal lobe.

81. For a client in hepatic coma, which outcome would be the most appropriate?

- A. The client is oriented to time, place, and person.
- B. The client exhibits no ecchymotic areas.
- C. The client increases oral intake to 2,000 calories/day.
- D. The client exhibits increased serum albumin level.

Correct Answer: A. The client is oriented to time, place, and person.

Hepatic coma is the most advanced stage of hepatic encephalopathy. As hepatic coma resolves, improvement in the client's level of consciousness occurs. The client should be able to express

orientation to time, place, and person. Throughout the intermediate stages, patients tend to experience worsening levels of confusion, lethargy, and personality changes.

- **Option B:** Ecchymotic areas are related to decreased synthesis of clotting factors. In order to make a diagnosis of hepatic encephalopathy, there must be confirmed the presence of liver disease (e.g., abnormal liver function tests, ultrasound or liver biopsy demonstrating liver disease) or a portosystemic shunt, and exclusion of other potential etiologies (e.g., intracranial lesions, masses, hemorrhage or stroke; seizure activity; post-seizure encephalopathy; intracranial infections; or toxic encephalopathy from other causes).
- **Option C:** Although oral intake may be related to the level of consciousness, it is more closely related to anorexia. Triggers of hepatic encephalopathy include renal failure, gastrointestinal bleeding (e.g., esophageal varices), constipation, infection, medication non-compliance, excessive dietary protein intake, dehydration (e.g., fluid restriction, diuretics, diarrhea, vomiting, excessive paracentesis), electrolyte imbalance, consumption of alcohol, or consumption of certain sedatives, analgesics or diuretics all in the setting of chronic liver disease.
- **Option D:** The serum albumin level reflects hepatic synthetic ability, not level of consciousness. Elevated blood ammonia levels are often seen in patients with hepatic encephalopathy. It is more useful, however, to assess the clinical improvement or deterioration of a patient undergoing treatment rather than monitor serial arterial blood ammonia measurements.

82. A 58-year-old male patient with a 10-year history of rheumatoid arthritis (RA) is admitted to the rheumatology unit of a tertiary care hospital. He is currently experiencing an exacerbation of his symptoms, with notable severe joint pain in his hands, knees, and elbows. The patient has been on a regimen of nonsteroidal anti-inflammatory drugs (NSAIDs) for pain relief and is now being introduced to a new medication by his rheumatologist. Intrigued and somewhat overwhelmed, he inquires of the attending nurse, "Why do I need to take disease-modifying antirheumatic drugs (DMARDs) if I already take pain medications?" Which is the best response by the nurse?

- A. "Pain medications only provide temporary relief, but DMARDs can slow down the progression of rheumatoid arthritis."
- B. "DMARDs are more effective in managing joint pain compared to pain medications alone."
- C. "DMARDs are necessary to prevent the development of osteoporosis, which can worsen joint pain."
- D. "Taking DMARDs can help reduce the frequency and severity of flare-ups, leading to less joint pain overall."

Correct Answer: A. "Pain medications only provide temporary relief, but DMARDs can slow down the progression of rheumatoid arthritis."

This statement is correct. While NSAIDs and other pain medications target the symptoms (in this case, pain) of rheumatoid arthritis, DMARDs specifically target the underlying processes that drive the disease. By modifying the disease course, DMARDs have the potential to slow down or even halt the progression of RA, potentially preventing joint damage and disability.

- **Option B:** This is misleading. DMARDs are primarily used to slow or stop the disease progression, not specifically for pain management. While DMARDs might reduce symptoms as the disease is controlled, pain medications are specifically formulated to manage pain. Therefore, while DMARDs might have an indirect effect on pain by controlling disease activity, they are not primarily

analgesics.

- **Option C:** While RA is a risk factor for osteoporosis, DMARDs are not primarily prescribed for osteoporosis prevention. There are other medications and strategies specifically for the prevention and treatment of osteoporosis in RA patients. This statement can be misleading in the context of the question.
- **Option D:** This statement is also correct. By controlling the underlying disease process, DMARDs can decrease the frequency and severity of RA flare-ups. As flare-ups are associated with increased symptoms, including pain, reducing these flare-ups indirectly leads to reduced pain. However, it should be noted that the primary purpose of DMARDs isn't pain management but disease control.

83. A client is discharged following hospitalization for congestive heart failure. The nurse teaching the family suggests they encourage the client to rest frequently in which of the following positions?

- A. High Fowler's
- B. Supine
- C. Left lateral
- D. Low Fowler's

Correct Answer: A. High Fowler's

Sitting in a chair or resting in a bed in a high Fowler's position decreases the cardiac workload and facilitates breathing.

- **Option B:** Lying flat or in a supine position would be difficult for the client and may induce increased cardiac workload.
- **Option C:** Left lateral position may increase the client's cardiac workload.
- **Option D:** Low Fowler's may not be sufficient enough to support the client's cardiac workload.

84. Mr. Lim, who has chronic pain, loss of self-esteem, no job, and bodily disfigurement from severe burns over the trunk and arms, is admitted to a pain center. Which evaluation criteria would indicate the client's successful rehabilitation?

- A. The client remains free of the aftermath phase of the pain experience.
- B. The client experiences decreased frequency of acute pain episodes.
- C. The client continues normal growth and development with intact support systems.
- D. The client develops increased tolerance for severe pain in the future.

Correct Answer: C. The client continues normal growth and development with intact support systems.

Even though the client may experience an aftermath phase, progress is still possible, as is effective rehabilitation. Give positive reinforcement of progress and encourage endeavors toward the attainment of rehabilitation goals. Words of encouragement can support the development of positive coping behaviors.

- **Option A:** Aftermath reactions may occur but need not interfere with rehabilitation. Encourage family interaction with each other and with the rehabilitation team. To open lines of communication and provide ongoing support for the patient and family.
- **Option B:** Acute pain is not expected at this stage of recovery. Pain is nearly always present to some degree because of varying severity of tissue involvement and destruction but is usually most severe during dressing changes and debridement.
- **Option D:** Conditioning probably would produce less pain tolerance. Exercise is generally considered to be a safe and efficacious approach to restoring physiological function in patients with various chronic diseases. However, the inclusion of exercise regimens in the outpatient rehabilitation of patients who have undergone major trauma, such as a large burn, is not common.

85. A nurse is conducting a follow-up home visit to a client who has been discharged with parenteral nutrition(PN). Which of the following should the nurse most closely monitor in this kind of therapy?

- A. Blood pressure and temperature.
- B. Blood pressure and pulse rate.
- C. Height and weight.
- D. Temperature and weight.

Correct Answer: D. Temperature and weight.

The client's temperature is monitored to identify signs of infection which is one of the complications of this therapy. While the weight is monitored to detect hypervolemia and to determine the effectiveness of this nutritional therapy. Monitoring patients on parenteral nutrition (PN) requires a multidisciplinary approach with effective communication throughout the team. This will help to minimize potential complications and will aid safe, effective, and appropriate use of PN.

- **Option A:** Temperature should be monitored to watch for infection, however, blood pressure is not as important during total parenteral nutrition. But blood pressure should still be monitored routinely. The risk of infectious complications is increased due to venous access for PN. The likelihood of hyperglycemia-induced complications may depend on concomitant diseases, duration of PN, and life expectancy.
- **Option B:** Blood pressure and pulse rate may be checked routinely in a patient with TPN. Efficient monitoring in all types of PN can result in reduced PN-associated complications and reduced costs. Water and electrolyte balance, blood sugar, and cardiovascular function should regularly be monitored during PN.
- **Option C:** Monitoring the patient's height is not necessary during TPN administration. Nutritional status is most effectively assessed and monitored through a combination of anthropometric data, biochemical and clinical measures. A stand-alone measure e.g. weight can rarely provide adequate information.

86. The primary power involved in labor and delivery is:

- A. Bearing down ability of a mother.
- B. Cervical effacement and dilatation.
- C. Uterine contraction.

D. Valsalva technique.

Correct Answer: C. Uterine contraction

Uterine contraction is the primary force that will expel the fetus out through the birth canal. Maternal bearing down is considered the secondary power/force that will help push the fetus out.

- **Option A:** During the second stage of labor a common technique is to encourage women to take a deep breath at the beginning of a contraction then hold it and bear down throughout the contraction (this is known as directed pushing). Maternal pushing during the second stage of labor is an important and indispensable contributor to the involuntary expulsive force developed by uterine contraction.
- **Option B:** During the first stage of labor, the cervix opens (dilates) and thins out (effaces) to allow the baby to move into the birth canal. The cervix must be 100 percent effaced and 10 centimeters dilated before a vaginal delivery.
- **Option D:** When a person forcefully expires against a closed glottis, changes occur in intrathoracic pressure that dramatically affects venous return, cardiac output, arterial pressure, and heart rate. This forced expiratory effort is called a Valsalva maneuver.

87. During a community meeting on health promotion in a small town with a significant elderly population, the nurse is approached by a group of senior citizens. They express concerns about their chronic back pain and have heard about alternative treatments. One of them asks about the effectiveness of chiropractic treatments for their age group and associated ailments. Considering the demographic and the context, in responding, what should be the focus of the nurse's answer?

- A. Electrical energy fields and their role in pain management.
- B. Spinal column manipulation and its potential benefits for chronic back pain.
- C. Mind-body balance and its holistic approach to health.
- D. Exercise of joints and its importance in maintaining mobility.
- E. Acupuncture and its role in pain relief.
- F. The importance of regular medical check-ups alongside alternative treatments.

Correct Answer: B. Spinal column manipulation

Chiropractic care primarily focuses on the diagnosis and treatment of mechanical disorders of the musculoskeletal system, especially the spine. Spinal column manipulation is a central component of chiropractic treatments. Given the context of the question, where elderly individuals are specifically inquiring about chronic back pain, the nurse should focus on explaining the potential benefits and considerations of spinal column manipulation for their specific ailments.

88. Following myocardial infarction, a hospitalized patient is encouraged to practice frequent leg exercises and ambulate in the hallway as directed by his physician. Which of the following choices reflects the purpose of exercise for this patient?

- A. Increases fitness and prevents future heart attacks.
- B. Prevents bedsores.
- C. Prevents DVT (deep vein thrombosis).
- D. Prevent constipations.

Correct Answer: C. Prevents DVT (deep vein thrombosis).

Exercise is important for all hospitalized patients to prevent deep vein thrombosis. Muscular contraction promotes venous return and prevents hemostasis in the lower extremities. Encourage physical activity consistent with the patient's energy levels. Helps promote a sense of autonomy while being realistic about capabilities. Walking down the hall 20 feet or walking through the house, then slowly progressing walking outside the house, saving energy for the return trip.

- **Option A:** This exercise is not sufficiently vigorous to increase physical fitness. Encourage active ROM exercises. Encourage the patient to participate in planning activities that gradually build endurance. Exercise maintains muscle strength, joint ROM, and exercise tolerance. Physical inactive patients need to improve functional capacity through repetitive exercises over a long period of time. Strength training is valuable in enhancing endurance of many ADLs.
- **Option B:** Inspect skin regularly, particularly over bony prominences. Gently massage any reddened areas and provide aids such as sheepskin pads as necessary. Pressure points over bony prominences are most at risk for decreased perfusion. Circulatory stimulation and padding help prevent skin breakdown and decubitus development. Change positions at least every 2 hr (supine, side-lying) and possibly more often if placed on the affected side.
- **Option D:** It is not intended to prevent bedsores or constipation. Have the patient perform the activity more slowly, in a longer time with more rest or pauses, or with assistance if necessary. Gradually increase activity with active range-of-motion exercises in bed, increasing to sitting and then standing. Gradual progression of the activity prevents overexertion.

89. The nurse is caring for a client following the removal of the thyroid. Immediately post-op, the nurse should:

- A. Maintain the client in a semi-Fowler's position with the head and neck supported by pillows
- B. Encourage the client to turn her head side to side, to promote drainage of oral secretions
- C. Maintain the client in a supine position with sandbags placed on either side of the head and neck
- D. Encourage the client to cough and breathe deeply every 2 hours, with the neck in a flexed position

Correct Answer: A. Maintain the client in a semi-Fowler's position with the head and neck supported by pillows.

- Option A: Following a thyroidectomy, the client should be placed in semi-Fowler's position to decrease swelling that would place pressure on the airway.
- Options B, C, and D: These positions would increase the chances of post-operative complications that include bleeding, swelling, and airway obstruction.

90. A 50-year-old client is prescribed to take nitrate each day for his condition. As a competent nurse, you know the result of nitrate administration is:

- A. Decreased myocardial oxygen demand.

- B. Increased myocardial oxygen demand.
- C. Increased left ventricular end-diastolic volume.
- D. Increased atrial pressure.

Correct Answer: A. Decreased myocardial oxygen demand

Nitrate administration will result in reduced preload and a decrease in myocardial oxygen demand and left ventricular end-diastolic volume. Nitrates exert their pharmacological effect by being activated by mitochondrial or cytosolic aldehyde dehydrogenase (ALDH2) into nitric oxide (NO), an endothelium-derived relaxing factor (EDRF). NO is generally produced by the endothelium to dilate the blood vessels; however, endothelial dysfunction in diseases such as atherosclerosis can deplete NO levels.

- **Option B:** The venodilation increases the venous capacitance and lowers the preload; this subsequently lowers the left ventricular end-diastolic pressure, resulting in a reduction in myocardium workload, which decreases the oxygen demand of the heart.
- **Option C:** The decreased intracellular calcium levels subsequently inhibit myosin light chain kinase, and the unphosphorylated myosin light chain causes myosin head to detach from actin, resulting in smooth muscle relaxation.
- **Option D:** Nitrates exert their effects by dilating venous vessels, coronary arteries, and small arterioles; its maximal vasodilation is in the venous vessels. At higher doses, nitrates can also exert significant coronary artery dilation, allowing blood flow to ischemic areas during coronary artery occlusion and vasospastic angina.

91. A child diagnosed with intellectual disability (ID) is under the supervision of Nurse Tasha. The nurse is aware that the signs and symptoms of mild ID include which of the following?

- A. Few communication skills
- B. Lateness in walking
- C. Mental age of a toddler
- D. Noticeable developmental delays

Correct Answer: B. Lateness in walking

Mild intellectual disability is minimally noticeable in young children, with one of the signs being a delay in achieving developmental milestones, such as walking at a later stage. Individuals with an intellectual disability have neurodevelopmental deficits characterized by limitations in intellectual functioning and adaptive behavior. These disabilities originate and manifest before the age of 18 and can be associated with a considerable number of related and co-occurring problems.

- **Option A:** Severe intellectual disability is marked by little or no communication skills. Intellectual functioning is generally called intelligence and includes a wide range of mental activities such as the ability of logical reasoning and practical intelligence (problem-solving), ability in learning, verbal skills, and so on.
- **Option C:** Severe intellectual disability is marked by the mental age of a toddler. Concerning clinical history, symptoms of intellectual disability usually begin during childhood or adolescence. Moreover, delays in language or motor skills may be observed by age two. Nevertheless, a significant number of children with mild levels of intellectual disability may not get identified until school age.

- **Option D:** Children with moderate intellectual disability have noticeable developmental delays. All skills are learned throughout development and performed in response to common problems and simple/complex tasks as well as expectations from our community and society. Obviously, these behavioral responses become progressively more complex with age.

92. Jose who is receiving monoamine oxidase inhibitor antidepressant should avoid tyramine, a compound found in which of the following foods?

- A. Figs and cream cheese
- B. Fruits and yellow vegetables
- C. Aged cheese and Chianti wine
- D. Green leafy vegetables

Correct Answer: C. Aged cheese and Chianti wine

Aged cheese and Chianti wine contain high concentrations of tyramine. MAOIs prevent the breakdown of tyramine found in the body as well as certain foods, drinks, and other medications. Patients that take MAOIs and consume tyramine-containing foods or drinks will exhibit high serum tyramine level. A high level of tyramine can cause a sudden increase in blood pressure, called the tyramine pressor response. Even though it is rare, a high tyramine level can trigger a cerebral hemorrhage, which can even result in death.

- **Option A:** Eating foods with high tyramine can trigger a reaction that can have serious consequences. Patients should know that tyramine can increase with the aging of food; they should be encouraged to have foods that are fresh instead of leftovers or food prepared hours earlier. Tyramine is found in certain foods, beverages, and other substances. Protein-rich foods, for example, typically contain high amounts of tyramine. Foods that are aged (such as cheese) are also high in tyramine because the content of the substance in a food or beverage increases as they age.
- **Option B:** Examples of high levels of tyramine in food are types of fish, as well as types of meat, including sausage, turkey, liver, and salami. Also, certain fruits can contain tyramine like overripe fruits, avocados, bananas, raisins, or figs. Tyramine is a compound that affects your blood pressure. It's regulated and broken down by the MAO enzyme. MAOIs restrict the MAO enzyme to reduce symptoms of depression and anxiety. However, if the MAO enzyme is inhibited, tyramine can reach dangerously high levels in your body. Elevated tyramine can cause your blood vessels to narrow, possibly leading to critically high blood pressure.
- **Option D:** Further examples are cheeses, alcohol, and fava beans; all of these should be avoided even after two weeks of stopping MAOIs. Anyone taking MAOIs is at risk for an adverse hypertensive reaction, with accompanying morbidity. Only eat fresh and freshly cooked foods while taking MAOI as tyramine levels in food increase during the spoiling or decay process. Always use proper food handling, preparation, and safety practices to help prevent spoilage and food poisoning. Cook all foods to the proper temperature indicated for food safety.

93. Nurse Winona educates the family about symptom management for when the schizophrenic client becomes upset or anxious. Which of the following would Nurse Winona state be helpful?

- A. Call the therapist to request a medication change.

- B. Encourage the use of learned relaxation techniques.
- C. Request that the client be hospitalized until the crisis is over.
- D. Wait before the anxiety worsens before intervening.

Correct Answer: B. Encourage the use of learned relaxation techniques.

The client with schizophrenia can learn relaxation techniques, which help reduce anxiety. The family can be supportive and helpful by encouraging the client to use these techniques. When client is ready, introduce strategies that can minimize anxiety and lower voices and “worrying” thoughts, teach client to do the following: focus on meaningful activities; learn to replace negative thoughts with constructive thoughts; perform deep breathing exercise; use a calming visualization or listen to music; or seek support from staff, family, or other supportive people.

- **Option A:** Anxiety is a common experience for everyone, and is no reason to change medication. Handling anxiety is a learned skill that is important to reinforce. Keep the environment calm, quiet and as free of stimuli as possible to keep anxiety from escalating and increasing confusion and hallucinations/delusions.
- **Option C:** There is no indication that the client is in crisis. Use therapeutic techniques (clarifying feelings when speech and thoughts are disorganized) to try to understand the client’s concerns. Even if the words are hard to understand, try getting to the feelings behind them.
- **Option D:** It is much easier to intervene early in anxiety rather than waiting until escalation occurs. Assess and observe clients regularly for signs of increasing anxiety and hostility. Intervene before the client loses control. Use a non-judgmental, respectful, and neutral approach with the client. There is less chance for a suspicious client to misinterpret intent or meaning if the content is neutral and the approach is respectful and non-judgmental.

94. A female client with chronic renal failure (CRF) is receiving a hemodialysis treatment. After hemodialysis, nurse Sarah knows that the client is most likely to experience:

- A. Hematuria.
- B. Weight loss.
- C. Increased urine output.
- D. Increased blood pressure.

Correct Answer: B. Weight loss.

Because CRF causes loss of renal function, the client with this disorder retains fluid. Hemodialysis removes this fluid, causing weight loss. The client’s normal weight without any extra fluid in the body is called “dry weight.” Extra fluid can be dangerous and cause extra strain on the body, including the heart and lungs. When the client has kidney failure, her body depends on dialysis to get rid of the extra fluid and wastes that build up in her body between treatments.

- **Option A:** Hematuria is unlikely to follow hemodialysis because the client with CRF usually forms little or no urine. Hematuria in hemodialysis patients may be a manifestation of the bleeding diathesis seen in renal failure. But it certainly needs further evaluation for structural causes specific to the genitourinary tract and to prevent massive bleeding.
- **Option C:** Hemodialysis doesn’t increase urine output because it doesn’t correct the loss of kidney function, which severely decreases urine production in this disorder. Dialysis, a procedure that uses a special machine to replace the kidneys in filtering waste from the bloodstream, may reduce the

daily urine output that a person normally produces. This happens because as the blood is filtered during dialysis, fluid is removed, thus reducing the kidneys' traditional role.

- **Option D:** By removing fluids, hemodialysis decreases rather than increases the blood pressure. The most common side effect of hemodialysis is low blood pressure. It can occur when too much fluid is removed from the blood during hemodialysis. This causes pressure to drop, and nausea and dizziness can result.

95. A client with a cervical spine injury has Gardner-Wells tongs inserted for which of the following reasons?

- A. To hasten wound healing.
- B. To immobilize the cervical spine.
- C. To prevent autonomic dysreflexia.
- D. To hold bony fragments of the skull together.

Correct Answer: B. To immobilize the cervical spine.

Gardner-Wells, Vinke, and Crutchfield tongs immobilize the spine until surgical stabilization is accomplished. There are several uses for GWT, including the treatment of cervical spine fractures, patient positioning inside the operating room, and skeletal traction during spinal deformity surgery. Aside from GWT, different apparatuses have been utilized for skeletal traction, including Crutchfield's caliper, Cone's caliper, Blackburn's caliper, and halo traction.

- **Option A:** GWT have become popular in the United States due to their ease of use, and effectiveness in reducing cervical dislocations in a traumatic setting. Several advantages over previous traction devices include the lack of skin incisions, antiseptic instead of aseptic technique, and the lack of drill holes.
- **Option C:** Proper bladder and bowel care (ie, preventing fecal impaction, bladder distention) are mainstays in preventing episodes of autonomic dysreflexia. Regulation of the bladder routine via indwelling Foley catheter or intermittent catheterization and regular urologic follow-up is highly recommended for autonomic dysreflexia prevention.
- **Option D:** GWT has many advantages that have led to their increased popularity and usage. These include the relative ease of use, sterile technique, lack of incisions, reduced screw pullout, and elimination of burr holes.

96. During the administration of chemotherapy agents, Nurse Oliver observed that the IV site is red and swollen when the IV is touched Stacy shouts in pain. The first nursing action to take is:

- A. Notify the physician.
- B. Flush the IV line with saline solution.
- C. Immediately discontinue the infusion.
- D. Apply an ice pack to the site, followed by warm compress.

Correct Answer: C. Immediately discontinue the infusion.

Edema or swelling at the IV site is a sign that the needle has been dislodged and the IV solution is leaking into the tissues causing the edema. The patient feels pain as the nerves are irritated by pressure and the IV solution. The first action of the nurse would be to discontinue the infusion right away to prevent further edema and other complications.

- **Option A:** After discontinuing the infusion, the nurse should notify the physician.
- **Option B:** Flushing may aggravate the edema since the IV cannula might be dislodged.
- **Option D:** Compresses may be given as indicated by the physician.

97. Your patient with peritonitis is NPO and complaining of thirst. What is your priority?

- A. Increase the I.V. infusion rate.
- B. Use diversion activities.
- C. Provide frequent mouth care.
- D. Give ice chips every 15 minutes.

Correct Answer: C. Provide frequent mouth care.

Frequent mouth care helps relieve dry mouth. Maintain NPO with nasogastric or intestinal aspiration. This reduces hyperactivity of bowel and diarrhea losses. Observe skin or mucous membrane dryness, turgor. Note peripheral and sacral edema. Hypovolemia, fluid shifts, and nutritional deficits contribute to poor skin turgor, taut edematous tissues.

- **Option A:** Administer plasma or blood, fluids, electrolytes, diuretics as indicated. Replenishes circulating volume and electrolyte balance. Colloids (plasma, blood) help move water back into the intravascular compartment by increasing the osmotic pressure gradient. Diuretics may be used to assist in the excretion of toxins and to enhance renal function.
- **Option B:** Change position frequently, provide frequent skincare, and maintain dry or wrinkle-free bedding. Edematous tissue with compromised circulation is prone to breakdown.
- **Option D:** Eliminate noxious sights and smells from the environment. Limit intake of ice chips. This reduces gastric stimulation and vomiting response. Excessive use of ice chips during gastric aspiration can increase gastric washout of electrolytes.

98. Which of the following drugs should Nurse Mary prepare to administer to a client with a toxic acetaminophen (Tylenol) level?

- A. Deferoxamine mesylate (Desferal)
- B. Succimer (Chemet)
- C. Flumazenil (Romazicon)
- D. Acetylcysteine (Mucomyst)

Correct Answer: D. Acetylcysteine (Mucomyst)

The antidote for acetaminophen toxicity is acetylcysteine. It enhances conversion of toxic metabolites to nontoxic metabolites. Acetaminophen (N-acetyl-para-aminophenol, paracetamol, APAP) toxicity is common primarily because the medication is so readily available, and there is a perception that it is very safe. More than 60 million Americans consume acetaminophen on a weekly basis. All patients with

high levels of acetaminophen need admission and treatment with N-acetyl-cysteine (NAC). This agent is fully protective against liver toxicity if given within 8 hours after ingestion.

- **Option A:** Deferoxamine mesylate is the antidote for iron intoxication. Desferal is indicated for the treatment of acute iron intoxication and chronic iron overload due to transfusion-dependent anemias. Desferal is an adjunct to, and not a substitute for, standard measures used in treating acute iron intoxication, which may include the following: induction of emesis with syrup of ipecac; gastric lavage; suction and maintenance of a clear airway; control of shock with intravenous fluids, blood, oxygen, and vasopressors; and correction of acidosis.
- **Option B:** Succimer is an antidote for lead poisoning. Succimer is an oral heavy metal chelating agent used to treat lead and heavy metal poisoning. Succimer has been linked to a low rate of transient serum aminotransferase elevations during therapy, but its use has not been linked to cases of clinically apparent liver injury with jaundice. Succimer does not significantly chelate essential metals such as zinc, copper, or iron, and its specificity, safety and oral availability make it preferable to other chelating agents for treating lead poisoning such as Ca-EDTA which must be given intravenously and dimercaprol (British anti-Lewisite [BAL) which requires intramuscular administration.
- **Option C:** Flumazenil reverses the sedative effects of benzodiazepines. Flumazenil is a benzodiazepine antagonist. Flumazenil is also indicated for the management and treatment of benzodiazepine overdose in adults. It is useful in reversing coma due to benzodiazepine overdose. Flumazenil is more effective in reversing sedation or coma in patients with benzodiazepine intoxication rather than in patients with multiple drug overdoses.

99. Sheila tells the community nurse that her boyfriend has been abusive and she is afraid of him, but she doesn't want to leave. The client asks the nurse for assistance. Which nursing interventions are appropriate in this situation? Select all that apply.

- A. Help Sheila to develop a plan to ensure safety, including phone numbers for emergency help.
- B. Help Sheila to get her boyfriend into an appropriate treatment program.
- C. Communicate acceptance, avoiding any implication that Sheila is at fault for not leaving.
- D. Help Sheila to explore available options, including shelters and legal protection.
- E. Tell Sheila that she should leave because things will not improve.
- F. Reinforce concern for Sheila's safety and her right to be free of abuse.

Correct Answer: A, C, D, F

These are all appropriate nursing interventions for the victim of domestic violence. The client is not responsible for seeking help for the abuser, and encouraging her to do so may reinforce the client's feeling responsible for the abuse. Advising the client must decide for herself whether to leave, and the nurse must respect any decision the client makes. Making the decision for the client will erode her self-esteem and reinforce her sense of powerlessness.

- **Option A:** Initiate referral to a social worker, public health nurse, psychological counselor before discharge to home. Provides support to the client and family, and monitors behaviors following discharge. A considerable body of empirical data (cited earlier) indicates that women's readiness to act in ways that help them achieve nonviolence is shaped by (a) the level of violence they experience, (b) the supports and resources available to them, and (c) their appraisals of the nature of the abuse and the costs and benefits of taking action.

- **Option B:** Nurses can raise women's awareness that they are in abusive relationships and that they do not deserve to be in them by expressing concern for women's (and their children's) safety and pointing out the degree of vulnerability and danger they face. It can be useful in this context to note Walker's concept of "the cycle of violence, in which periods of violence alternate with periods of reconciliation" (1979).
- **Option C:** In the third stage, preparation, Brown (1997) claimed that women realize the abuse is not their fault and become determined to end the violence. Many acknowledge the loss of the relationship, begin to let go of the hope that abuse will end, and start to work through the associated grief. At this point, women may shift from reevaluating the violent components of the relationship to reevaluating the entire relationship and its meaning for them (Mills, 1985).
- **Option D:** Health care providers in most states cannot intervene directly to prevent women's partners' use of violence (the exceptions are a few states where reporting is mandatory and could lead to the arrest of an abusive partner). Nevertheless, they can intervene in ways that "shore up" women's resources, modify their appraisals of abuse, and help them consider taking actions that may prove beneficial in their quest for nonviolence. Ultimately, it is the responsibility of nurses to help women themselves determine what strategies will work best to achieve nonviolence in their specific situations and then provide support for those actions.
- **Option E:** Barriers to change may include fears related to retaliation from the intimate partner and loss of child custody, employment, or financial support and housing. Each setting should have a plan for assisting women in immediate danger, social service resources for dealing with economic issues, and protocols for providing effective safety planning. Women's past safety strategies should be assessed, and planning should build on strategies they have found effective.
- **Option F:** Self-liberation involves supporting women's own plans to achieve safety in their lives by listening to their deliberations about the meaning of change, identifying resources that will support change, discussing means for removing barriers to change, and providing safety planning. All health care settings should have a list of resources that are available to victims of IPV; these include hot lines, shelters, legal advisors, as well as counselors with experience in IPV.

100. When evaluating an arterial blood gas from a male client with a subdural hematoma, the nurse notes the Paco₂ is 30 mm Hg. Which of the following responses best describes the result?

- A. Appropriate; lowering carbon dioxide (CO₂) reduces intracranial pressure (ICP).
- B. Emergent; the client is poorly oxygenated.
- C. Normal.
- D. Significant; the client has alveolar hypoventilation.

Correct Answer: A. Appropriate; lowering carbon dioxide (CO₂) reduces intracranial pressure (ICP)

A normal Paco₂ value is 35 to 45 mm Hg CO₂ has vasodilating properties; therefore, lowering Paco₂ through hyperventilation will lower ICP caused by dilated cerebral vessels.

- **Option B:** Oxygenation is evaluated through Pao₂ and oxygen saturation.
- **Option C:** The normal PaCO₂ level is between 35 to 45 mmHg. PaCO₂ or the partial pressure of carbon dioxide is the measure of carbon dioxide within arterial or venous blood.
- **Option D:** Alveolar hypoventilation would be reflected in an increased Paco₂. Alveolar hypoventilation is defined as insufficient ventilation leading to hypercapnia, which is an increase in

the partial pressure of carbon dioxide as measured by arterial blood gas analysis.