

# Kevin's Review - 100 NCLEX Practice Questions

**1. Which of the following would lead the nurse to suspect that a child with meningitis has developed disseminated intravascular coagulation?**

- A. Hemorrhagic skin rash
- B. Edema
- C. Cyanosis
- D. Dyspnea on exertion

**Correct Answer: A. Hemorrhagic skin rash**

DIC is characterized by skin petechiae and a purpuric skin rash caused by spontaneous bleeding into the tissues. An abnormal coagulation phenomenon causes the condition. Disseminated intravascular coagulation (DIC) can be defined as a widespread hypercoagulable state that can lead to both microvascular and macrovascular clotting and compromised blood flow, ultimately resulting in multiple organ dysfunction syndrome or MODS. As this process begins consuming clotting factors and platelets in a positive feedback loop, hemorrhage can ensue, which may be the presenting symptom of a patient with DIC.

- **Option B:** Increased intracranial pressure from cerebral edema caused by increased intracellular fluid in the brain. Several factors are involved in the development of cerebral edema: increased blood-brain barrier permeability, cytotoxicity from cytokines, immune cells, and bacteria.
- **Option C:** Cyanosis, broadly speaking, is caused by disorders of deoxygenated hemoglobin and disorders of abnormal hemoglobin. Oxygen might not reach hemoglobin in an adequate or sufficient amount as a result of conditions affecting the respiratory system, cardiovascular system, and the central nervous system.
- **Option D:** Dyspnea on exertion is a symptom of various diseases rather than a disease itself. As such, its etiology can be designated as arising from two primary organ systems: the respiratory system and the cardiac system. Other systemic illnesses may be the culprit as well as a combination of different etiologies.

**2. Which of the following statements involving Type II diabetes mellitus is correct?**

- A. It involves inefficient insulin production.
- B. It involves cessation of Insulin production by the beta cells of the pancreas.
- C. It involves increased insulin receptor responsiveness.
- D. It involves the infant client.

**Correct Answer: A. It involves inefficient insulin production.**

In type II diabetes mellitus, insulin is produced in insufficient amounts along with reduced insulin receptor responsiveness. T2DM involves a more insidious onset where an imbalance between insulin levels and insulin sensitivity causes a functional deficit of insulin. Insulin resistance is multifactorial but commonly develops from obesity and aging.

- **Option B:** In type II diabetes mellitus, the beta cells do produce insulin but in inadequate amounts. A patient with DM has the potential for hyperglycemia. The pathology of DM can be unclear since several factors can often contribute to the disease. Hyperglycemia alone can impair pancreatic beta-cell function and contributes to impaired insulin secretion. Consequentially, there is a vicious

cycle of hyperglycemia leading to the impaired metabolic state. Blood glucose levels above 180 mg/dL are often considered hyperglycemic in this context, though because of the variety of mechanisms, there is no clear cutoff point.

- **Option C:** There is decreased rather than increased insulin responsiveness. Insulin resistance is attributable to excess fatty acids and proinflammatory cytokines, which leads to impaired glucose transport and increases fat breakdown. Since there is an inadequate response or production of insulin, the body responds by inappropriately increasing glucagon, thus further contributing to hyperglycemia. While insulin resistance is a component of T2DM, the full extent of the disease results when the patient has inadequate production of insulin to compensate for their insulin resistance.
- **Option D:** T1DM presents in children or adolescents, while T2DM is thought to affect middle-aged and older adults who have prolonged hyperglycemia due to poor lifestyle and dietary choices. The pathogenesis for T1DM and T2DM is drastically different, and therefore each type has various etiologies, presentations, and treatments.

### ***3. Which nursing statement is a good example of the therapeutic communication technique of giving recognition?***

- A. "You did not attend group today. Can we talk about that?"
- B. "I'll sit with you until it is time for your family session."
- C. "I notice you are wearing a new dress and you have washed your hair."
- D. "I'm happy that you are now taking your medications. They will really help."

**Correct Answer: C. "I notice you are wearing a new dress and you have washed your hair."**

This is an example of the therapeutic communication technique of giving recognition. Giving recognition acknowledges and indicates awareness. This technique is more appropriate than complimenting the client which reflects the nurse's judgment. It shows that the nurse recognizes the client as an individual. Such recognition does not carry the notion of value, that is, of being "good" or "bad".

- **Option A:** Theme identification refers to underlying issues or problems experienced by the client that emerge repeatedly during a nurse-client relationship. It allows the nurse to best promote the client's exploration and understanding of important problems.
- **Option B:** Offering self refers to making oneself available. The nurse can offer his presence, interest, and desire to understand. It is important that this offer is unconditional, that is, the client does not have to respond verbally to get the nurse's attention.
- **Option D:** Giving approval or sanctioning the client's behavior or ideas can be nontherapeutic. Saying what the client thinks or feels is "good" implies that the opposite is "bad". Approval, then, tends to limit the client's freedom to think, speak, or act in a certain way.

### ***4. When administering an antiarrhythmic agent, which of the following assessment parameters is the most important for the nurse to evaluate?***

- A. ECG
- B. Pulse rate
- C. Respiratory rate

D. Blood pressure

**Correct Answer: A. ECG**

The ECG is the most important parameter to assess. Vital signs such as RR, PR, and BP need to be monitored, but the ECG is the most important. The benefit of the classification is in the primary mechanism of action, and the broad, predictable side effects brought about by the primary mechanism. An example would include the class III K<sup>+</sup> channel blockers or “repolarization” blockers producing a prolonged phase 3 of the action potential and, by definition, also leading to a prolonged QT interval on the corresponding ECG.

- **Option B:** Therapy with beta-blockers may have cardiovascular side effects such as bradycardia and AV block. Noncardiac side effects of beta-blockers include exacerbation of asthma and COPD, lethargy, and dyslipidemia. Along with its needed effects, verapamil may cause some unwanted effects such as AV block, bradycardia, and constipation. The most frequently reported side effects of diltiazem include edema, headache, and dizziness.
- **Option C:** The adverse effect as bronchospasm makes it contraindicated in asthmatic patients. Adenosine should be avoided in patients with SVT involving accessory pathways (WPW, antidromic AVRT) due to the risk of tachycardia exacerbation.
- **Option D:** Minor adenosine adverse effects include flushing, sense of impending doom, and sweating are usually transient due to the short half-life of the drug. More severe side effects include hypotension, chest pain, AV block, and asystole.

**5.  $\beta$  blockers should be avoided in which of the following conditions?**

- A. Bronchoconstriction
- B. Hypertension
- C. Angina
- D. Myocardial infarction

**Correct Answer: A. Bronchoconstriction**

$\beta$  blockers should be avoided in bronchoconstrictive disease. Traditionally, beta-blockers have been contraindicated in asthmatic patients. However, recommendations have aligned for allowing cardio-selective beta-blockers, also known as beta-1 selective, in asthmatics but not non-selective beta-blockers.

- **Option B:** Patients who have either acute or chronic bradycardia and/or hypotension have relatively contraindication to beta-blocker usage. The patient’s heart rate and blood pressure require monitoring while using beta-blockers. Beta receptors are found all over the body and induce a broad range of physiologic effects. The blockade of these receptors with beta-blocker medications can lead to many adverse effects. Bradycardia and hypotension are two adverse effects that may commonly occur.
- **Option C:** All beta-blockers, especially in patients with cardiac risk factors, carry a risk of heart block. The negative chronotropic and inotropic effects lead to a decreased oxygen demand; that is how angina improves after beta-blocker usage. These medications also prolong the atrial refractory periods and have a potent antiarrhythmic effect.
- **Option D:** Once beta-blockers bind to the B1 and B2 receptors, they inhibit these effects. Therefore, the chronotropic and inotropic effects on the heart undergo inhibition, and the heart rate slows down as a result. Beta-blockers also decrease blood pressure via several mechanisms,

including decreased renin and reduced cardiac output.

**6. Dr. Rodriguez is managing the care of Mr. Hernandez, a 60-year-old retired firefighter with a known diagnosis of gout. However, complicating Mr. Hernandez's case is his medical history of peptic ulcer disease, which has caused recurrent hospitalizations over the past few years. Given the need to manage his gout for pain while minimizing the risk to his gastrointestinal system, which medication should the nurse anticipate being prescribed for gout management?**

- A. Colchicine
- B. Allopurinol
- C. Naproxen
- D. Celecoxib

**Correct Answer: D. Celecoxib.**

Celecoxib is a selective COX-2 inhibitor that provides pain relief without significantly affecting the stomach lining, making it a suitable choice for patients with a history of peptic ulcer disease.

- **Option A:** Colchicine is often used for acute gout flares and as prophylaxis during the initiation of urate-lowering therapy. It does not have anti-inflammatory properties like NSAIDs but can reduce gouty inflammation. It would be a safer choice for someone with a history of peptic ulcer disease than NSAIDs. However, it's not the primary drug for long-term uric acid level management. Colchicine can cause gastrointestinal side effects.
- **Option B:** Allopurinol is not contraindicated in peptic ulcer disease but does not specifically address pain relief. Allopurinol is a xanthine oxidase inhibitor and is used for long-term management of gout to reduce the levels of uric acid.
- **Option C:** NSAIDs are commonly used to treat the pain and inflammation of gout attacks. However, they can irritate the stomach lining and might exacerbate peptic ulcers, so they would likely be avoided in a patient with a history of peptic ulcer disease.

**7. Which of the following foods would the nurse Trish eliminate from the diet of a client in alcohol withdrawal?**

- A. Milk
- B. Orange Juice
- C. Soda
- D. Regular Coffee

**Correct Answer: D. Regular Coffee**

Regular coffee contains caffeine which acts as psychomotor stimulants and leads to feelings of anxiety and agitation. Serving coffee to the client may add to tremors or wakefulness. During acute alcohol intake, caffeine largely antagonizes the "unwanted" effects of alcohol by blocking A1 receptors, which mediate alcohol's somnogenic and ataxic effects. On the other hand, an alcohol-induced increase in the extracellular concentration of adenosine can decrease the A1 receptor-mediated "unwanted"

anxiogenic effects of caffeine. The mutual antagonism of “unwanted” effects gives the possibility of increasing significantly the intake of both drugs in the pursuit of the “wanted” reinforcing effects.

- **Option A:** Calcium is important for strong bones. Dairy such as milk contains plenty of calcium (but don't have too much, because of the fat content). Eating leafy greens like chard, spinach, and kale work wonders – why not make a kale and spinach omelet?
- **Option B:** Potassium is very important for heart and muscular health. Bananas are very high in potassium, as are sweet and white baked potatoes, peas, beans, spinach, fish and seafood, dried fruits, and greens.
- **Option C:** If you're going to undertake an alcohol detox, a fundamental rule is to cut out sugary foods, especially those with processed sugars and meals that have a high-fat content. Although we all need particular carbohydrates that are high in fiber, it is also recommended that you cut down on carbs too, such as crisps, bread, and pasta.

**8. An elderly client who experiences nighttime confusion wanders from his room into the room of another client. The nurse can best help decrease the client's confusion by:**

- A. Assigning a nursing assistant to sit with him until he falls asleep
- B. Allowing the client to room with another elderly client
- C. Administering a bedtime sedative
- D. Leaving a nightlight on during the evening and night shifts

**Correct Answer: D. Leaving a nightlight on during the evening and night shifts**

- Option D: Leaving a nightlight on during the evening and night shifts help the client remain oriented to the environment and fosters independence.
- Options A and B: Assigning a nursing assistant to sit with him and allowing the client to room with another client will not decrease the client's confusion.
- Option C: Administering a bedtime sedative will increase the likelihood of confusion in an elderly client.

**9. At an international dermatology symposium, Dr. Alvarez presents a riveting case study involving a patient who showed heightened skin sensitivity to an array of commonly used cosmetic products. Upon examination, it was revealed that there was a significant alteration in a specific type of skin cell responsible for immune surveillance and recognizing allergens. Citing this clinical instance, Dr. Alvarez queries the audience regarding the specific skin cell that plays a pivotal role in helping the body recognize and remember allergens. Which cell type is he referring to?**

- A. Cornified cells
- B. Fibroblasts
- C. Merkel cells
- D. Langerhans cells

**Correct Answer: D. Langerhans cells**

Langerhans cells are dendritic cells located in the epidermis. They function as antigen-presenting cells, capturing foreign substances (like allergens) that come into contact with the skin and presenting them to the immune system. They are essential components of the skin's immune defense mechanism and are particularly involved in recognizing and "remembering" allergens, thus priming the immune system for future encounters.

- **Option A:** Cornified cells are the final products of the keratinization process. They form the outermost layer of the skin, the stratum corneum, and are primarily involved in forming the protective barrier of the skin. They do not play a role in immune surveillance or allergen detection.
- **Option B:** Found primarily in the dermis, fibroblasts are responsible for producing extracellular matrix components, such as collagen and elastin, which give the skin its strength and elasticity. While crucial for skin's structural integrity, they do not participate in allergen recognition.
- **Option C:** Merkel cells are tactile cells found in the epidermis and are associated with nerve endings. They play a role in the sensation of light touch but are not involved in the immune response or allergen detection.

**10. Chuck, who is in the hospital, complains of abdominal pain that ranks 9 on a scale of 1 (no pain) to 10 (worst pain). Which interventions should the nurse implement? Select all that apply.**

- A. Assessing the client's bowel sounds.
- B. Taking the client's blood pressure and apical pulse.
- C. Obtaining a pulse oximeter reading.
- D. Notifying the health care provider.
- E. Determining the last time the client received pain medication.
- F. Encouraging the client to turn, cough, and deep breathe.

**Correct Answers: A, B, & E**

The nurse must rule out complications prior to administering pain medication, so her interventions would include assessing to make sure the client has bowel sounds and determining if the client is hemorrhaging by checking the client's blood pressure and pulse. The nurse must also make sure the pain medication is due according to the health care provider's orders. Obtaining a pulse oximeter reading and turning, coughing, and deep breathing will not help the client's pain.

- **Option A:** Additionally, the nurse should ask the following questions during pain assessment to determine its history: (1) effectiveness of previous pain treatment or management; (2) what medications were taken and when; (3) other medications being taken; (4) allergies or known side effects to medications.
- **Option B:** Pain should be screened every time vital signs are evaluated. Many health facilities set pain assessment as the "fifth vital sign" and should be added to during routine vital signs assessment.
- **Option C:** Investigate signs and symptoms related to pain. Bringing attention to associated signs and symptoms may help the nurse in evaluating the pain. In some instances, the existence of pain is disregarded by the patient.
- **Option D:** There is no need to notify the health care provider in this situation. Some patients may be satisfied when pain is no longer intense; others will demand complete elimination of pain. This

influences the perceptions of the effectiveness of the treatment modality and their eagerness to engage in further treatments.

- **Option E:** Some patients may be hesitant to try the effectiveness of nonpharmacological methods and may be willing to try traditional pharmacological methods (i.e., use of analgesics). A combination of both therapies may be more effective and the nurse has the duty to inform the patient of the different methods to manage pain.
- **Option F:** Stress correlates to an increase in pain perception by increasing muscle tension and activating the SNS. Eliciting a relaxation response decreases the effects of stress on pain. Examples include directed meditation, music therapy, deep breathing.

**11. Positive symptoms of schizophrenia include which of the following? A. Hallucinations, delusions, and disorganized thinking**

- A. Flat affect, avolition, and anhedonia
- B. Somatic delusions, echolalia, and a flat affect
- C. Waxy flexibility, alogia, and apathy
- D. Hallucinations, delusions, and disorganized thinking

**Correct Answer: A. Hallucinations, delusions, and disorganized thinking**

The positive symptoms of schizophrenia are distortions of normal functioning. Option A lists the positive symptoms of schizophrenia. The typical positive symptoms of schizophrenia, such as hallucinatory experiences or fixed delusional beliefs, tend to be very upsetting and disruptive—not a positive experience at all for you or someone you care about who is experiencing them. From the outside, a person with positive symptoms might seem distracted, as if they are listening to something (psychiatrists call this “responding to internal stimuli”).

- **Option A:** A flat affect, alogia, apathy, avolition, and anhedonia refer to the negative symptoms. Negative symptoms list the diminution or loss of normal function. Avolition is a form of emotional or behavioral paralysis that can diminish your drive to participate in social activities and meet goals as well as your ability to complete daily tasks. Many people mistake this negative symptom for “laziness.” In Greek, an means “without” and hedone means “pleasure,” so in simple terms, anhedonia is a state where you are unable to feel pleasure. For people with schizophrenia, this can mean a lack of enthusiasm for activities, hobbies, passions, and pleasures once enjoyed.
- **Option B:** As negative symptoms indicate deficits in functioning they are also called deficit symptoms. Negative symptoms, including lack of emotion, decreased joy or motivation, delayed speech, and difficulty beginning and sustaining activities, can be scary and extremely debilitating. The most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes negative symptoms as “restricted emotional expression and avolition,” and includes the following five types.
- **Option C:** Defined in DSM-5 as a “decrease in verbal output or verbal expressiveness,” alogia (also known as “poverty of speech”) can make it nearly impossible to communicate your thoughts and carry on a conversation. People with alogia may answer a monosyllabic “yes” or “no” when responding to questions and/or experience delays in getting the words out. It should be noted that these speech delays are not the same as those caused by positive symptoms like auditory or visual hallucinations and disorganized thinking.

**12. Which of the following nursing actions would be included in a care plan for a client with PTSD who states the experience was “bad luck”?**

- A. Encourage the client to verbalize the experience.
- B. Assist the client in defining the experience.
- C. Work with the client to take steps to move on with his life.
- D. Help the client accept positive and negative feelings.

**Correct Answer: B. Assist the client in defining the experience.**

The client must define the experience as traumatic to realize the situation wasn't under his personal control. Encourage the client to talk about traumatic experiences under non-threatening conditions. Help the client work through feelings of guilt related to the traumatic event. Help the client understand that this was an event to which most people would have responded in like manner. Support the client during flashbacks of the experience. Verbalization of feelings in a non-threatening environment may help the client come to terms with unresolved issues.

- **Option A:** Encouraging the client to verbalize the experience without first addressing the denial isn't a useful strategy. When the level of anxiety has been reduced, explore with the client the possible reasons for the occurrence. Recognition of precipitating factors is the first step in teaching the client to interrupt escalation of anxiety. Avoid asking or forcing the client to make choices. The client may not make sound and appropriate decisions or may be unable to make decisions at all.
- **Option C:** The client can move on with life only after acknowledging the trauma and processing the experience. Present and discuss the reality of the situation with the client in order to recognize aspects that can be changed and those that cannot. The client must accept the reality of the situation before the work of reducing fear can progress. Encourage the client to explore underlying feelings that may be contributing to irrational fears. Help the client to understand how facing these feelings, rather than suppressing them, can result in more adaptive coping abilities.
- **Option D:** Acknowledgement of the actual trauma and verbalization of the event should come before the acceptance of feelings. Explore things that may lower fear level and keep it manageable (e.g. singing while dressing, repeating a mantra, practicing positive self-talk while in a fearful situation). Provides the client with a sense of control over the fear. Distracts the client so that fear is not totally focused on and allowed to escalate.

**13. Which therapeutic communication technique is being used in this nurse-client interaction? Client: “My father spanked me often.” Nurse: “Your father was a harsh disciplinarian.”**

- A. Restatement
- B. Offering general leads
- C. Focusing
- D. Accepting

**Correct Answer: A. Restatement**

The nurse is using the therapeutic communication technique of restatement. Restatement involves repeating the main idea of what the client has said. The nurse uses this technique to communicate that the client's statement has been heard and understood.



- **Option B:** Providing a lead to the client enables the client to continue discussing things with the nurse and it also facilitates the client's beginning a new discussion that is focused on a particular thing. For example, the nurse may say, "Tell me about your concerns relating to your new medications". Hopefully, the client will take this lead and begin a discussion about their new medications and their concerns relating to them with the nurse.
- **Option C:** Focusing with the client is a therapeutic communication technique used by nurses, and other members of the health care team, that facilitates the client's abilities to focus on and pay attention to the matters at hand, which should reflect the client's priorities. At times, some clients may use the nurse's presence to talk about things not even related to their health care and their health care problems.
- **Option D:** Recognition, acknowledgment, and acceptance of the client and their thoughts which are conveyed during communication are therapeutic communication techniques and strategies that give the nurse the opportunity to let the client know that you are interested in them and respectful of them and their thoughts. It also allows the client to recognize that the nurse is open, honest and without any bias or judgments.

**14. Which of the following stages is the carcinogen irreversible?**

- A. Progression stage
- B. Initiation stage
- C. Regression stage
- D. Promotion stage

**Correct Answer: A. Progression stage**

Progression stage is the change of tumor from the preneoplastic state or low degree of malignancy to a fast-growing tumor that cannot be reversed. Tumor progression comprises the expression of the malignant phenotype and the tendency of malignant cells to acquire more aggressive characteristics over time. Also, metastasis may involve the ability of tumor cells to secrete proteases that allow invasion beyond the immediate primary tumor location. A prominent characteristic of the malignant phenotype is the propensity for genomic instability and uncontrolled growth.

- **Option B:** Initiation is the first step in the two-stage model of cancer development. Initiators cause irreversible changes to DNA that increase cancer risk. The early concept of tumor initiation indicated that the initial changes in chemical carcinogenesis are irreversible genetic damage. However, recent data from molecular studies of preneoplastic human lung and colon tissues implicate epigenetic changes as an early event in carcinogenesis.
- **Option C:** There is no regression stage in the development of cancer. Malignant conversion is the transformation of a preneoplastic cell into one that expresses the malignant phenotype. This process requires further genetic changes. The total dose of a tumor promoter is less significant than frequently repeated administrations, and if the tumor promoter is discontinued before malignant conversion has occurred, premalignant or benign lesions may regress.
- **Option D:** The promotion stage is considered to be a relatively lengthy and reversible process in which actively proliferating preneoplastic cells accumulate. Tumor promotion comprises the selective clonal expansion of initiated cells. Because the accumulation rate of mutations is proportional to the rate of cell division, or at least the rate at which stem cells are replaced, clonal expansion of initiated cells thus, produces a larger population of cells that are at risk of further genetic changes and malignant conversion.

**15. The nurse is aware that a neonate of a mother with diabetes is at risk for what complication?**

- A. Anemia
- B. Hypoglycemia
- C. Nitrogen loss
- D. Thrombosis

**Correct Answer: B. Hypoglycemia.**

- **Option B:** Neonates of mothers with diabetes are at risk for hypoglycemia due to increased insulin levels. During gestation, an increased amount of glucose is transferred to the fetus across the placenta. The neonate's liver cannot initially adjust to the changing glucose levels after birth. This may result in an overabundance of insulin in the neonate, resulting in hypoglycemia.

**16. A patient with a pulmonary embolism is receiving anticoagulation with IV heparin. What instructions would you give the nursing assistant who will help the patient with activities of daily living? Select all that apply.**

- A. Use a lift sheet when moving and positioning the patient in bed.
- B. Use an electric razor when shaving the patient each day.
- C. Use a soft-bristled toothbrush or tooth sponge for oral care.
- D. Use a rectal thermometer to obtain a more accurate body temperature.
- E. Be sure the patient's footwear has a firm sole when the patient ambulates.

**Correct Answers: A, B, C, and E.**

All of the other instructions are appropriate to the care of a patient receiving anticoagulants. Risk for bleeding may arise in any condition that disturbs the "close circuit" integrity of the circulatory system. Bleeding is the primary complication of anticoagulant therapy and is a risk of all anticoagulants even when maintained within the usual therapeutic ranges.

- **Option A:** Educate the at-risk patient about precautionary measures to prevent tissue trauma or disruption of the normal clotting mechanisms. Information about precautionary measures lessens the risk for bleeding.
- **Option B:** Be careful when using sharp objects like scissors and knives. Use an electric razor for shaving (not razor blades). The patient needs to avoid situations that may cause tissue trauma and increase the risk for bleeding.
- **Option C:** Use a soft-bristled toothbrush and nonabrasive toothpaste. Avoid the use of toothpicks and dental floss. This method providing oral hygiene reduces trauma to oral mucous membranes and the risk for bleeding from the gums.
- **Option D:** While a patient is receiving anticoagulation therapy, it is important to avoid trauma to the rectal tissue, which could cause bleeding (e.g., avoid rectal thermometers and enemas). These invasive devices or medications may cause trauma to the mucous membranes that line the rectum or vagina.
- **Option E:** Educate the patient and family members about signs of bleeding that need to be reported to a health care provider. Early evaluation and treatment of bleeding by a health care

provider reduces the risk for complications from blood loss.

**17. Jen, a nursing student is anxious about the upcoming board examination but is able to study intently and does not become distracted by a roommate's talking and loud music. The student's ability to ignore distractions and to focus on studying demonstrates:**

- A. Mild-level anxiety
- B. Panic-level anxiety
- C. Severe-level anxiety
- D. Moderate-level anxiety

**Correct Answer: D. Moderate-level anxiety**

A moderately anxious person can ignore peripheral events and focuses on central concerns. People with moderate levels of anxiety have more frequent or persistent symptoms than those with mild anxiety, but still have better daily functioning than someone with severe anxiety or panic disorder. For example, people with moderate anxiety may report experiencing symptoms such as feeling on edge, being unable to control their worrying or being unable to relax several days or the majority of days in a week, but not every day. Although moderate anxiety symptoms are disruptive, people with moderate anxiety may have success in managing their anxiety with the help of a doctor or self-help strategies.

- **Option A:** Although often described as sub-clinical or clinically non-significant, mild anxiety can impact emotional, social, and professional functioning. Mild anxiety symptoms may present as social anxiety or shyness and can be experienced in early childhood through to adulthood. If left unaddressed, mild anxiety can lead to maladaptive coping strategies or more severe mental conditions.
- **Option B:** Panic level anxiety, or panic disorder, is characterized by frequent, recurring, and unexpected panic attacks. Panic attacks usually last around 10 minutes. The triggers for panic attacks vary from person to person, and the cause of an attack may be familiar to a person or unknown.
- **Option C:** Severe anxiety is intensely debilitating, and symptoms of severe anxiety meet key diagnostic criteria for clinically-significant anxiety disorder. People with severe anxiety typically score higher on scales of distress and lower on functioning. Severe anxiety symptoms also frequently co-occur with major depression, which can contribute to greater disability. Symptoms of severe anxiety are frequent and persistent and may include increased heart rate, feelings of panic and social withdrawal. These symptoms can result in loss of work and increased health care costs. In addition, individuals with severe anxiety may turn to alcohol and drugs as a means to cope with their symptoms.

**18. Which of the following medications would the nurse expect the physician to order to reverse a dystonic reaction?**

- A. prochlorperazine (Compazine)
- B. diphenhydramine (Benadryl)
- C. haloperidol (Haldol)
- D. midazolam (Versed)

**Correct Answer: B. diphenhydramine (Benadryl)**

Diphenhydramine, 25 to 50 mg I.M. or I.V., would quickly reverse this condition. An acute dystonic reaction is characterized by involuntary contractions of muscles of the extremities, face, neck, abdomen, pelvis, or larynx in either sustained or intermittent patterns that lead to abnormal movements or postures. The symptoms may be reversible or irreversible and can occur after taking any dopamine receptor-blocking agents. Treatment of acute dystonic reaction centers around balancing the disrupted dopaminergic-cholinergic balance in the basal ganglia and discontinuation of the offending agent. The most commonly available drugs in the emergency setting for the treatment of acute dystonic reaction are diphenhydramine and benztropine.

- **Option A:** Prochlorperazine can be used to treat both acute psychotic episodes and chronic mental illnesses. As a first-generation antipsychotic, the drug is better at treating positive symptoms than negative ones, including delusions, hallucinations, agitation, and disorganized speech and behavior.
- **Option C:** Haloperidol is capable of causing dystonia, not reversing it. Due to the blockade of the dopamine pathway in the brain, typical antipsychotic medications such as haloperidol have correlations with extrapyramidal side effects. The extrapyramidal symptoms are muscular weakness or rigidity, a generalized or localized tremor that may be characterized by the akinetic or agitation types of movements, respectively. Haloperidol overdose is also associated with ECG changes known as torsade de pointes, which may cause arrhythmia or cardiac arrest.
- **Option D:** Midazolam would make this client drowsy. Midazolam can be used for anxiolysis and hypnosis during the maintenance phase of general anesthesia and is also superior to thiopental in the maintenance of anesthesia because of the less need for adjunct medications. Midazolam is used as an adjunct medication to regional and local anesthesia for a wide range of diagnostic and therapeutic procedures and has greater patient and physician acceptance.

**19. The clinic nurse notes that following several eye examinations, the physician has documented a diagnosis of legal blindness in the client's chart. The nurse reviews the results of the Snellen's chart test expecting to note which of the following?**

- A. 20/20 vision
- B. 20/40 vision
- C. 20/60 vision
- D. 20/200 vision

**Correct Answer: D. 20/200 vision**

Legal blindness is defined as 20/200 or less with corrected vision (glasses or contact lenses) or visual acuity of less than 20 degrees of the visual field in the better eye. The WHO describes individuals with low vision as having a best-corrected vision of 20/60 or worse, and blind as best corrected vision worse than 20/400, whereas legal blindness is identified as 20/200 in the United States.

- **Option A:** Although 20/20 visual acuity has been referred to as "perfect vision," it is important to remember that this is only one aspect of vision and does not include other elements such as depth perception, peripheral vision, and colorblindness.
- **Option B:** In the United States, visual acuity screening will typically begin as early as age 3. There is a critical line that the child should be able to complete on a visual acuity chart by age group. The critical line for children between the ages of three to four is 20/50, four to five is 20/40, and five or

older is 20/30.

- **Option C:** An individual with 20/60 vision would be able to distinguish the same optotype at 20 ft that another individual with normal (20/20) vision distinguishes at 60 ft. In the logMAR, visual acuity is reported as a single number where 0.0 is standard vision. Visual acuity decreases as the number increases and improves as the number decreases.

**20. In the later part of the 3rd trimester, the mother may experience shortness of breath. This complaint may be explained as:**

- A. A normal occurrence in pregnancy because the fetus is using more oxygen.
- B. The fundus of the uterus is high pushing the diaphragm upwards.
- C. The woman is having an allergic reaction to the pregnancy and its hormones.
- D. The woman may be experiencing complications of pregnancy.

**Correct Answer: B. The fundus of the uterus is high pushing the diaphragm upwards**

From the 32nd week of the pregnancy, the fundus of the enlarged uterus is pushing the respiratory diaphragm upwards. Thus, the lungs have reduced space for expansion consequently reducing the oxygen supply.

- **Option A:** At the same time that the lung capacity decreases due to the physical constraint of a growing uterus, the respiratory center in the brain is stimulated by the hormone progesterone to get the pregnant woman to take slower breaths. Progesterone is released during pregnancy. Although each breath may bring in less air, the air stays in the lungs longer so that the woman can extract the oxygen she and her baby needs.
- **Option C:** Swelling or narrowing of the throat or the airways to the lungs can cause wheezing. It can also result in shortness of breath because the lungs can't hold as much air when they are affected by swelling or mucus buildup.
- **Option D:** If asthma cannot be controlled, the woman may be at risk for a serious health problem called preeclampsia. Preeclampsia is a condition that can happen after the 20th week of pregnancy or right after pregnancy. It's when a pregnant woman has high blood pressure and signs that some of her organs, like her kidneys and liver, may not be working properly. Some of these signs include having protein in the urine, changes in vision, and severe headache.

**21. Pierre, who is diagnosed with acute pancreatitis, is under the care of Nurse Bryan. Which intervention should the nurse include in the care plan for the client?**

- A. Administration of vasopressin and insertion of a balloon tamponade
- B. Preparation for a paracentesis and administration of diuretics
- C. Maintenance of nothing-by-mouth status and insertion of nasogastric (NG) tube with low intermittent suction
- D. Dietary plan of a low-fat diet and increased fluid intake to 2,000 ml/day

**Correct Answer: C. Maintenance of nothing-by-mouth status and insertion of nasogastric (NG) tube with low intermittent suction**

With acute pancreatitis, the client is kept on nothing-by-mouth status to inhibit pancreatic stimulation and secretion of pancreatic enzymes. NG intubation with low intermittent suction is used to relieve nausea and vomiting, decrease painful abdominal distention, and remove hydrochloric acid. Prolonged bowel rest by nothing per os (NPO) to minimize pancreatic secretion was an important part of the therapy for any patient with acute pancreatitis.

- **Option A:** Vasopressin would be appropriate for a client diagnosed with bleeding esophageal varices. The most common cause of late death in acute necrotizing pancreatitis is represented by organ failure through infected pancreatic necrosis (IPN). Therefore there might be a theoretical benefit from antibiotic prophylaxis.
- **Option B:** Paracentesis and diuretics would be appropriate for a client diagnosed with portal hypertension and ascites. Fluid therapy in acute pancreatitis can be seen as double edge sword with risk of necrosis through tissue hypoperfusion by using low fluid quantities and liquid sequestration and increased morbidity with too high volumes
- **Option D:** A low-fat diet and increased fluid intake would further aggravate pancreatitis. The concept of nutritional support in AP has gradually moved towards enteral feeding, due to large evidence proving safety and efficiency. Timing and mode of nutritional support in acute pancreatitis should be based on risk prediction of severity.

## **22. Which of the following statements about morphine is correct?**

- A. Morphine is contraindicated in pain relief caused by head injury.
- B. Morphine's withdrawal symptoms cannot be relieved by methadone.
- C. Morphine is most effective by parenteral administration.
- D. Morphine quickly enters all body tissues.

**Correct Answer: D. Morphine quickly enters all body tissues.**

Morphine quickly enters all body tissues. Morphine is considered the classic opioid analgesic with which other painkillers are compared. Like other medications in this class, morphine has an affinity for delta, kappa, and mu-opioid receptors. This drug produces the majority of its analgesic effects by binding to the mu-opioid receptor within the central nervous system (CNS) and the peripheral nervous system (PNS).

- **Option A:** Morphine is not contraindicated for head-injured clients. FDA-approved usage of morphine sulfate includes moderate to severe pain that may be acute or chronic. Most commonly used in pain management, morphine provides significant relief to patients afflicted with pain. Clinical situations that benefit significantly by medicating with morphine include management of palliative/end-of-life care, active cancer treatment, and vaso-occlusive pain during sickle cell crisis.
- **Option B:** Withdrawal symptoms can be relieved by methadone. Morphine can potentially be a lethal medication when not used properly. It causes a host of symptoms related to depression of the CNS. Severe respiratory depression is the most feared complication of morphine in cases of overdose. Immediate injection of naloxone is required to reverse the effects of morphine.
- **Option C:** Morphine is equally effective by all routes when the proper dose is prescribed. Morphine administration can occur through various vehicles. Its administration is most often via the following routes: orally (PO), intravenously (IV), epidural, and intrathecal. Infusion dosing can vary significantly between patients and largely depends on how naive or tolerant they are to opiates. It is interesting to point out that IV morphine formulation is also commonly given intramuscularly (IM). Morphine is also available as a suppository.

**23. Which of the following complications is of greatest concern when caring for a preoperative abdominal aneurysm client?**

- A. HPN
- B. Aneurysm rupture
- C. Cardiac arrhythmias
- D. Diminished pedal pulses

**Correct Answer: B. Aneurysm rupture**

Rupture of an aneurysm is a life-threatening emergency and is of the greatest concern for the nurse caring for this type of client. The layers of the aortic wall can also separate (aortic dissection). This produces severe, tearing pain in the chest, back or abdomen. The potential for rupture is the most serious risk associated with an aortic aneurysm. A ruptured aortic aneurysm can cause life-threatening internal bleeding and/or a stroke.

- **Option A:** Hypertension should be avoided and controlled because it can cause the weakened vessel to rupture. Hypertension has been considered a potential risk factor for AAA; but the findings from prospective cohort studies have not been entirely consistent, nor have they been summarised in a comprehensive meta-analysis.
- **Option D:** Diminished pedal pulses, a sign of poor circulation to the lower extremities, are associated with an aneurysm but aren't life-threatening. The appearance of microembolic lower limb infarcts in a patient with easily palpable pedal pulses may suggest the presence of either popliteal or abdominal aneurysms.
- **Option C:** Cardiac arrhythmias aren't directly linked to an aneurysm. Ventricular aneurysms may cause shortness of breath, chest pain, or an irregular heartbeat (arrhythmia).

**24. Nurse Johnson is reviewing Mr. Garcia, a 58-year-old client with a history of hypertrophic cardiomyopathy and a recent episode of upper respiratory tract infection. During today's assessment, Nurse Johnson noted that Mr. Garcia's systolic blood pressure has decreased from 145 to 110 mm Hg since his last visit, his heart rate has risen from 72 to 96 beats per minute, and he has been experiencing periodic dizzy spells when standing up. Mr. Garcia mentioned he has been trying to drink less due to concerns about fluid retention. Considering his clinical picture and history, Nurse Johnson should advise Mr. Garcia to:**

- A. Increase fluids that are high in protein
- B. Restrict fluids
- C. Force fluids and reassess blood pressure
- D. Limit fluids to non-caffeine beverages

**Correct Answer: C. Force fluids and reassess blood pressure**

Given the drop in systolic blood pressure, increased heart rate (which could be compensatory mechanisms due to hypovolemia), and dizziness (potentially orthostatic hypotension), it might be appropriate to advise Mr. Garcia to increase his fluid intake. After doing so, reassessing his blood pressure can provide valuable feedback on his volume status. Orthostatic hypotension, a decrease in systolic blood pressure of more than 15 mmHg, and an increase in heart rate of more than 15 percent

usually accompanied by dizziness indicate volume depletion, inadequate vasoconstrictor mechanisms, and autonomic insufficiency.

- **Option A:** Fluids may not be necessarily protein-rich.
- **Option B:** Restricting fluids could aggravate the client's dizziness.
- **Option D:** There is no need to restrict the fluid intake of the client.

**25. Which of the following measures should the nurse focus on for the client with esophageal varices?**

- A. Recognizing hemorrhage.
- B. Controlling blood pressure.
- C. Encouraging nutritional intake.
- D. Teaching the client about varices.

**Correct Answer: A. Recognizing hemorrhage.**

Recognizing the rupture of esophageal varices, or hemorrhage is the focus of nursing care because the client could succumb to this quickly. A patient with bleeding esophageal varices is to be considered in critical condition. Nursing management is aimed at assisting the physician in controlling bleeding and preventing shock and death.

- **Option B:** Controlling blood pressure is also important because it helps reduce the risk of variceal rupture. As portal pressure increases, blood backs up into the spleen and bypasses the liver, returning to the right atrium via collateral circulation. The result is splenomegaly, ascites, and varicosities of the collateral veins (esophageal and gastric varices).
- **Option C:** It is also important to teach the client what foods he should avoid such as spicy foods. Additional teaching includes abstaining from alcohol, eating a healthy diet, and adhering to short-term antibiotic therapy to prevent infection. Because rebleeding is common.
- **Option D:** It is also important to teach the client what varices are. Assess for ecchymosis, epistaxis, petechiae, and bleeding gums. Monitor level of consciousness, vital signs, and urinary output to evaluate fluid balance. Use small-gauge needles, and apply pressure or cold for bleeding.

**26. A 4-month-old is brought to the well-baby clinic for immunization. In addition to the DPT and polio vaccines, the baby should receive:**

- A. HibTITER
- B. Mumps vaccine
- C. Hepatitis B vaccine
- D. MMR

**Correct Answer: A. HibTITER**

The Haemophilus influenza vaccine is given at 4 months with the polio vaccine. It protects the child from Hib disease, which can cause lifelong disability and be deadly; protects the child from the most common type of Hib disease, meningitis (an infection of the lining covering the brain and spinal cord); and keeps the child from missing school or child care, and the parents from missing work.



- **Option B:** Mumps vaccine is the best way to decrease the risk of getting mumps. It is usually given as part of a combination vaccine that protects against three diseases: measles, mumps, and rubella (MMR). This vaccine is only licensed for use in children who are 12 months through 12 years of age.
- **Option C:** Hepatitis B vaccine is given immediately after birth and for children up to 18 years. Hepatitis B vaccine is usually given as 2, 3, or 4 shots. Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age (sometimes it will take longer than 6 months to complete the series). Children and adolescents younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.
- **Option D:** MMR stands for measles, mumps and rubella vaccine, which is given at 9 months old. The MMR vaccine is safe and effective. Most children don't have any side effects from the vaccine. The side effects that do occur are usually very mild, such as a fever or rash. The first dose at 12 through 15 months of age, and the second dose at 4 through 6 years of age.

**27. A 21-year-old male with Hodgkin's lymphoma is a senior at the local university. He is engaged to be married and is to begin a new job upon graduation. Which of the following diagnoses would be a priority for this client?**

- A. Sexual dysfunction related to radiation therapy
- B. Anticipatory grieving related to terminal illness
- C. Tissue integrity related to prolonged bed rest
- D. Fatigue related to chemotherapy

**Correct Answer: A. Sexual dysfunction related to radiation therapy**

Radiation therapy often causes sterility in male clients and would be of primary importance to this client. The psychosocial needs of the client are important to address in light of the age and life choices. Hodgkin's disease, however, has a good prognosis when diagnosed early. Know the importance of sex to individual, partner, and patient's motivation for change. Because lymphomas often affect the relatively young who are in their productive years, these people may be affected more by these problems and may be less knowledgeable about the possibilities of change.

- **Option B:** Grieving may not be an appropriate diagnosis since the client would be experiencing new milestones in his life despite his condition. Let the patient describe the problem in own words. Provides a more accurate picture of patient experience with which to develop a plan of care.
- **Option C:** Option B is not applicable since the client is not on bed rest. Encourage the patient to share thoughts and concerns with his partner and to clarify values and impact of condition on relationship. Helps the couple begin to deal with issues that can strengthen or weaken the relationship.
- **Option D:** Fatigue may occur during chemotherapy, but it is not the priority diagnosis. Identify pre-existing and current stress factors that may be affecting the relationship. The patient may be concerned about other issues, such as job, financial, and illness-related problems.

**28. An ultrasound is performed on a client at term gestation that is experiencing moderate vaginal bleeding. The results of the ultrasound indicate that an abruptio placenta is present. Based on these findings, the nurse would prepare the client for:**

- A. Complete bed rest for the remainder of the pregnancy.
- B. Delivery of the fetus.
- C. Strict monitoring of intake and output.
- D. The need for weekly monitoring of coagulation studies until the time of delivery.

**Correct Answer: B. Delivery of the fetus.**

The goal of management in abruptio placentae is to control the hemorrhage and deliver the fetus as soon as possible. Delivery is the treatment of choice if the fetus is at term gestation or if the bleeding is moderate to severe and the mother or fetus is in jeopardy.

- **Option A:** Placental abruption occurs when there is a compromise of the vascular structures supporting the placenta. In other words, the vascular networks connecting the uterine lining and the maternal side of the placenta are torn away. These vascular structures deliver oxygen and nutrients to the fetus. Disruption of the vascular network may occur when the vascular structures are compromised because of hypertension or substance use or by conditions that cause stretching the uterus. The uterus is a muscle and is elastic whereas the placenta is less elastic than the uterus.
- **Option C:** Evaluation of vital signs to detect tachycardia or hypotension, which may be indicators of a concealed hemorrhage are taken. Blood specimens such as a complete blood count (CBC), fibrinogen, clotting profile, and type and RH may be collected. These laboratory values will not aid in the diagnosis of placental abruption but will provide baseline data against which to evaluate the patient's condition over time.
- **Option D:** Women classified with a class 1 or mild placental abruption and no signs of maternal or fetal distress and a pregnancy less than 37 weeks gestation may be managed conservatively. These patients are usually admitted to the obstetrical unit for close monitoring of maternal and fetus status. Intravenous access and blood work for type and crossmatch is part of the plan of care. The maternal-fetal dyad will continue to be monitored until there is a change in condition or until fetal maturity is reached.

**29. The clinic nurse asks a 13-year-old female to bend forward at the waist with arms hanging freely. Which of the following assessments is the nurse most likely conducting?**

- A. Spinal flexibility
- B. Leg length disparity
- C. Hypostatic blood pressure
- D. Scoliosis

**Correct Answer: D. Scoliosis.**

A check for scoliosis, a lateral deviation of the spine, is an important part of the routine adolescent exam. It is assessed by having the teen bend at the waist with arms dangling, while observing for lateral curvature and uneven rib level. Scoliosis is more common in female adolescents.

- **Options A:** The ability to move the spine through its full range of motion, both forward and backward, is called spinal flexibility. However, it is not included in routine adolescent exams.
- **Options B:** Leg length discrepancy or disparity is a condition in which the paired lower extremity limbs have a noticeably unequal length.

- **Option C:** Hypostatic or orthostatic blood pressure is a form of low blood pressure that happens when one is sitting or stands up suddenly.

**30. All of the following characteristics would indicate to the nurse that an elder client might experience undesirable effects of medicines except:**

- A. Increased oxidative enzyme levels.
- B. Alcohol taken with medication.
- C. Medications containing magnesium.
- D. Decreased serum albumin.

**Correct Answer: A. Increased oxidative enzyme levels.**

Oxidative enzyme levels decrease in the elderly, which affects the disposition of medication and can alter the therapeutic effects of medication. Oxidative stress causes cells and entire organisms to age. If reactive oxygen species accumulate, this causes damage to the DNA as well as changes in the protein molecules and lipids in the cell. The cell ultimately loses its functionality and dies. Over time, the tissue suffers, and the body ages.

- **Option B:** Alcohol has a smaller water distribution level in the elderly, resulting in higher blood alcohol levels. Alcohol also interacts with various drugs to either potentiate or interfere with their effects. The older one gets, the longer alcohol stays in the system. So it's more likely to be there when the client takes medicine. And alcohol can affect the way the meds work. It can also lead to serious side effects.
- **Option C:** Magnesium is contained in a lot of medications older clients routinely obtain over the counter. Magnesium toxicity is a real concern. Older adults have lower dietary intakes of magnesium than younger adults. In addition, magnesium absorption from the gut decreases, and renal magnesium excretion increases with age. Older adults are also more likely to have chronic diseases or take medications that alter magnesium status, which can increase their risk of magnesium depletion
- **Option D:** Albumin is the major drug-binding protein. Decreased levels of serum albumin mean that higher levels of the drug remain free and that there are fewer therapeutic effects and increased drug interactions.

**31. Which of the following metabolic effects may be a consequence of the administration of adrenergic agents?**

- A. Hypoglycemia
- B. Metabolic acidosis
- C. Hyperglycemia
- D. Respiratory alkalosis

**Correct Answer: C. Hyperglycemia**

Epinephrine-induced hyperglycemia is markedly accentuated by concomitant elevations of glucagon and cortisol or in patients with diabetes. In both cases, the effect of epinephrine on hepatic glucose production is converted from a transient to a sustained response, thereby accounting for the exaggerated hyperglycemia.

- **Option A:** Hypoglycemia increases plasma levels of both epinephrine and norepinephrine. These catechols are released primarily from the adrenal medulla. However, it is well documented that hypoglycemic increases muscle sympathetic nerve activity, and that both alpha and beta-adrenergic activity increase.
- **Option B:** Drugs that selectively bind to alpha-2 receptors may cause hypotension, dry mouth, and sedation. At higher doses, respiratory depression and somnolence may occur. These effects are most pronounced with clonidine and similarly acting drugs.
- **Option D:** Selective binding to beta-1 receptors commonly causes tachycardia, palpitations, and hypertension. Tachyarrhythmias and anxiety can also be common. High doses may induce dangerous arrhythmias. An example of a selective beta-1 receptor agonist is dobutamine.

**32. A nurse is giving instructions to a client taking ciprofloxacin (Cipro) for the treatment of gonorrhea. The nurse tells the client to?**

- A. Report any history of tendon problems.
- B. Resume daily exercise such as biking.
- C. Take an antacid 30 minutes prior.
- D. Take it with a yogurt as part of the treatment.

**Correct Answer: A. Report any history of tendon problems**

Ciprofloxacin may cause swelling or tearing of a tendon (the fiber that connects bones to muscles in the body), especially in the Achilles' tendon of the heel. This can happen during treatment or up to several months after the client stop taking ciprofloxacin

- **Option B:** This medication can cause dizziness so avoid any activity that requires alertness until the client is sure to perform such activities safely.
- **Option C:** Take ciprofloxacin at least 2 hours before or 6 hours after taking an antacid.
- **Option D:** Eating dairy products such as yogurt will impair the effectiveness of ciprofloxacin.

**33. During the assessment of a client's mouth, the nurse notes the absence of saliva. The client is also complaining of pain near the area of the ear. The client has been NPO for several days because of the insertion of a NG tube. Based on these findings, the nurse suspects that the client is developing which of the following mouth conditions?**

- A. Stomatitis
- B. Oral candidiasis
- C. Parotitis
- D. Gingivitis

**Correct Answer: C. Parotitis**

The lack of saliva, pain near the area of the ear, and the prolonged NPO status of the client should lead the nurse to suspect the development of parotitis, or inflammation of the parotid gland. Parotitis usually develops in cases of dehydration combined with poor oral hygiene or when clients have been NPO for an extended period. Preventative measures include the use of sugarless hard candy or gum to

stimulate saliva production, adequate hydration, and frequent mouth care.

- **Option A:** Stomatitis (inflammation of the mouth) produces excessive salivation and a sore mouth. Stomatitis may involve swelling and redness of the oral mucosa or discrete, painful ulcers (single or multiple). Less commonly, whitish lesions form, and, rarely, the mouth appears normal despite significant symptoms. Symptoms hinder eating, sometimes leading to dehydration and malnutrition. Secondary infection occasionally occurs, especially in immunocompromised patients.
- **Option B:** Oral candidiasis or thrush is an infection of the oral cavity by *Candida albicans*. Oral candidiasis is generally obtained secondary to immune suppression, whether a patient's oral cavity has decreased immune function or if it is systemic. This immunosuppression is dose-dependent.
- **Option D:** Gingivitis is an inflammatory condition of the gingival tissue, most commonly caused by bacterial infection. Unlike periodontitis, there is no attachment loss and therefore no migration of the junctional epithelium. The condition is restricted to the soft-tissue area of the gingival epithelium and connective tissue.

**34. The client arrives in the emergency department after a motor vehicle accident. Nursing assessment findings include BP 80/34, pulse rate 120, and respirations 20. Which is the client's most appropriate priority nursing diagnosis?**

- A. Alteration in cerebral tissue perfusion
- B. Fluid volume deficit
- C. Ineffective airway clearance
- D. Alteration in sensory perception

**Correct Answer: B. Fluid volume deficit**

The vital signs indicate hypovolemic shock. Monitor and document vital signs especially BP and HR. Decrease in circulating blood volume can cause hypotension and tachycardia. Alteration in HR is a compensatory mechanism to maintain cardiac output. Usually, the pulse is weak and may be irregular if electrolyte imbalance also occurs. Hypotension is evident in hypovolemia.

- **Option A:** The oxygen and nutrients subsequently diffuse from the blood into the interstitial fluid and then into the body cells. Insufficient arterial blood flow causes decreased nutrition and oxygenation at the cellular level. Decreased tissue perfusion can be temporary, with few or minimal consequences to the health of the patient, or it can be more acute or protracted, with potentially destructive effects on the patient.
- **Option C:** Ineffective airway clearance is the inability to clear secretions or obstructions from the respiratory tract to maintain a clear airway. Appropriate management is vital to prevent potentially life-threatening hypovolemic shock. Older patients are more likely to develop fluid imbalances. The goals of management are to treat the underlying disorder and return the extracellular fluid compartment to normal, to restore fluid volume, and to correct any electrolyte imbalances.
- **Option D:** Alterations sensory / perceptual (visual, auditory, kinesthetic, gustatory, tactile, olfactory) State in which an individual experiences a change in the amount or type of stimuli received, accompanied decrease towards exaggeration or disorder of the response to such stimuli.

**35. A client who is recovering from surgery has been ordered a change from a clear liquid diet to a full liquid diet. The nurse would offer which full liquid item**

**to the client?**

- A. Popsicle
- B. Carbonated beverages
- C. Gelatin
- D. Custard

**Correct Answer: D. Custard**

Full liquid food items include items such as plain ice cream, sherbet, breakfast drinks, milk, pudding, and custard, soups that are strained, refined cooked cereals, and strained vegetable juices. A full liquid diet is made up only of fluids and foods that are normally liquid and foods that turn to liquid when they are at room temperature, like ice cream.

- **Option A:** A clear liquid diet is a specific dietary plan that only includes liquids that are fully transparent at room temperature. Some items that may be allowed include water, ice, fruit juices without pulp, sports drinks, carbonated drinks, gelatin, tea, coffee, clear broths, and clear ice pops.
- **Option B:** Carbonated beverages are part of a clear liquid diet. Items can have color as long as they are transparent. Items such as milk and orange juice are not considered clear liquids because they are not fully transparent and may take more effort for the digestive system to break down, whereas grape juice is allowed (it is pigmented, but fully transparent).
- **Option C:** Gelatin is a clear liquid diet. The clear liquid diet assists in maintaining hydration, provides electrolytes and calories, and offers some level of satiety when a full diet is not appropriate, but may struggle to provide adequate caloric needs if employed for more than five days.

**36. Side effects of loperamide (Imodium) include all of the following except?**

- A. Diarrhea
- B. Epigastric pain
- C. Dry mouth
- D. Anorexia

**Correct Answer: A. Diarrhea**

Side effects associated with loperamide include CNS fatigue and dizziness, epigastric pain, abdominal cramps, nausea, dry mouth, vomiting, and anorexia. Diarrhea is an indication, not a side effect. Loperamide is a medication used in the treatment of diarrhea. It classifies as an anti-diarrheal agent.

- **Option B:** A number of the adverse events reported during the clinical investigations and post-marketing experience with loperamide are frequent symptoms of the underlying diarrheal syndrome (abdominal pain/discomfort, nausea, vomiting, dry mouth, tiredness, drowsiness, dizziness, constipation, and flatulence).
- **Option C:** Dry mouth has been reported as a side effect of prescription and over-the-counter (OTC) medications, like loperamide, to stop diarrhea. Dry mouth isn't always just thirst – other symptoms can include difficulty eating, speaking, swallowing, and bad breath, to name but a few.
- **Option D:** Bloating, loss of appetite, stomach pain, and skin rash are also rare side effects of loperamide. Anorexia is found among people who take Imodium, especially for people who are male, 60+ old, and have been taking the drug for < 1 month.

**37. The nurse is monitoring a client with glaucoma. Which of the following drugs, if prescribed for the client, would the nurse question?**

- A. metipranolol (Optipranolol).
- B. brimonidine (Alphagan P).
- C. dorzolamide (Trusopt).
- D. atropine (Isopto Atropine).

**Correct Answer: D. Atropine (Isopto Atropine).**

Atropine (Isopto Atropine) is a mydriatic and is contraindicated with glaucoma because of the risk of increased ocular pressure.

- **Options A, B, & C:** These are used to treat glaucoma.

**38. The nurse is caring for a client who suffered a spinal cord injury 48 hours ago. The nurse monitors for GI complications by assessing for:**

- A. A flattened abdomen.
- B. Hematest positive nasogastric tube drainage.
- C. Hyperactive bowel sounds.
- D. A history of diarrhea.

**Correct Answer: B. Hematest positive nasogastric tube drainage.**

Development of a stress ulcer can be detected by hematest positive NG tube aspirate or stool. Gastrointestinal dysfunction including constipation, straining, diarrhea, distention, abdominal pain, incontinence, rectal bleeding, hemorrhoids, and autonomic dysreflexia during bowel movements occur in 27% to 62% of individuals with a spinal cord injury. During the acute stage of spinal cord injury there is an increased risk of gastrointestinal complications within the first few days post injury, including gastrointestinal hemorrhage, perforation, and paralytic ileus, while neurogenic bowel, affecting almost half of those with a spinal cord injury (46.9%) is a major problem long term both in terms of physical and psychological well being.

- **Option A:** The paralysis does not need to be complete to cause ileus, but the intestinal muscles must be so inactive that it prevents the passage of food, and leads to a functional blockage of the intestine, which causes abdominal distension. A distended abdomen increases the work of breathing but also may cause vomiting, which increases the risk for aspiration pneumonia and further respiratory complications. Individuals with a paralytic ileus are typically managed Nil by Mouth (NPO) with nasogastric suction to regularly aspirate the stomach contents.
- **Option C:** After spinal cord injury, the client can develop paralytic ileus, which is characterized by the absence of bowel sounds and abdominal distention. Paralytic Ileus, often associated with spinal shock post an acute spinal cord injury, is an obstruction of the intestine secondary to paralysis of the intestinal muscles with no evidence of mechanical obstruction, which like spinal shock can last from a few days to a few weeks.
- **Option D:** A history of diarrhea is irrelevant. Lower Motor Neuron (LMN) Bowel Syndrome, occurring in a spinal cord injury at the injury at the conus medullaris or cauda equina results in an areflexic bowel, characterised by loss of spinal cord-mediated peristalsis and slow stool propulsion

with an atonic external anal sphincter. Typically associated with constipation and a significant risk of incontinence due to flaccid paralysis of the external anal sphincter and reduced motor control of levator ani.

**39. A client with schizotypal personality disorder is sitting in a puddle of urine. She's playing in it, smiling, and softly singing a child's song. Which action would be best?**

- A. Admonish the client for not using the bathroom.
- B. Firmly tell the client that her behavior is unacceptable.
- C. Ask the client if she's ready to get cleaned up now.
- D. Help the client to the shower, and change the bedclothes.

**Correct Answer: D. Help the client to the shower, and change the bedclothes.**

A client with schizotypal personality disorder can experience high levels of anxiety and regress to childlike behaviors. This client may require help needing self-care needs. The client may not respond to the other options or those options may generate more anxiety.

- **Option A:** Approach the client in a consistent manner in all interactions. Enhances feelings of security and provides structure. Exceptions encourage manipulative behavior. When the client is ready and interested, teach client coping skills to help defuse tension and trouble feelings (e.g., anxiety reduction, assertiveness skills).
- **Option B:** Be clear with the client as to the unit/hospital/clinic policies. Give brief concrete reasons for the rules, if asked, and then move on. Institutional policies provide structure and safety.
- **Option C:** Give the client positive attention when behaviors are appropriate and productive. Avoid giving any attention (when possible and not dangerous to self or others) when client's behaviors are inappropriate. Reinforcing positive behaviors might increase the likelihood of repetition. Ignoring negative behaviors (when feasible) robs the client of even negative attention.

**40. He opts to use a self-report method. Which of the following is not true about this method?**

- A. Most direct means of gathering information.
- B. Versatile in terms of content coverage.
- C. Most accurate and valid method of data gathering.
- D. Yields information that would be difficult to gather by another method.

**Correct Answer: C. Most accurate and valid method of data gathering.**

The most serious disadvantage of this method is the accuracy and validity of the information gathered. Self-reporting is a common approach for gathering data in epidemiologic and medical research. This method requires participants to respond to the researcher's questions without his/her interference.

- **Option A:** In general, they are inexpensive and simple to administer, making it possible to collect a broad amount of data in a short time. Today, the possibility of online surveys has made data collection even easier.



- **Option B:** Another important consideration is the relevance of the questions for the specific participants of the survey. If the participant finds the topic interesting and relevant, they are more motivated to respond and complete all the questions.
- **Option D:** In addition, the results can be automatically collected, reducing the risk of errors occurring with manual registration processes. Further, the results are not dependent on an interviewer's interpretation of behavior, which may influence the results from a clinical interview.

**41. The physician has ordered a low-potassium diet for a child with acute glomerulonephritis. Which fruit is suitable for the child with potassium restrictions?**

- A. Raisins
- B. Cantaloupe
- C. Blueberries
- D. Apricots

**Correct Answer: C. Blueberries**

- Option C: Patients with decreased kidney function are at risk for hyperkalemia. Blueberries are low in potassium, therefore, it is a suitable fruit on a potassium-restricted diet.
- Options A, B, and D: Raisins, cantaloupe, and apricots are all good sources of potassium.

**42. When planning the discharge of a client with chronic anxiety, Nurse Chris evaluates achievement of the discharge maintenance goals. Which goal would be A. The client eliminates all anxiety from daily situations. appropriately having been included in the plan of care requiring evaluation?**

- A. The client eliminates all anxiety from daily situations.
- B. The client ignores feelings of anxiety.
- C. The client identifies anxiety-producing situations.
- D. The client maintains contact with a crisis counselor.

**Correct Answer: C. The client identifies anxiety-producing situations**

Recognizing situations that produce anxiety allows the client to prepare to cope with anxiety or avoid specific stimulus. Observe for increasing anxiety. Assume a calm manner, decrease environmental stimulation, and provide temporary isolation as indicated. Early detection and intervention facilitate modifying a client's behavior by changing the environment and the client's interaction with it, to minimize the spread of anxiety.

- **Option A:** Establish and maintain a trusting relationship by listening to the client; displaying warmth, answering questions directly, offering unconditional acceptance; being available, and respecting the client's use of personal space. Therapeutic skills need to be directed toward putting the client at ease, because the nurse who is a stranger may pose a threat to the highly anxious client.
- **Option B:** Encourage the client to talk about traumatic experiences under non-threatening conditions. Help the client work through feelings of guilt related to the traumatic event. Help the

client understand that this was an event to which most people would have responded in like manner. Support the client during flashbacks of the experience.

- **Option D:** Teach signs and symptoms of escalating anxiety, and ways to interrupt its progression (e.g., relaxation techniques, deep-breathing exercises, physical exercises, brisk walks, jogging, meditation). So the client can start using relaxation techniques; gives the client confidence in having control over his anxiety.

**43. Patients with esophageal varices would reveal the following assessment:**

- A. Increased blood pressure
- B. Increased heart rate
- C. Decreased respiratory rate
- D. Increased urinary output

**Correct Answer: B. Increased heart rate**

Tachycardia is an early sign of compensation for patients with esophageal varices. Since the portal venous system has no valves, resistance at any level between the splanchnic vessels and the right side of the heart results in retrograde flow and elevated pressure. The collaterals slowly enlarge and connect the systemic circulation to the portal venous system.

- **Option A:** Esophageal varices are a direct result of high blood pressure in the portal vein. This condition is called portal hypertension. It causes blood to build up in nearby blood vessels, including those in your esophagus. Veins begin to dilate and swell as a result of increased blood flow.
- **Option C:** The respiratory rate is not decreased in esophageal varices. Esophageal varices are the major complication of portal hypertension. It is detected in about 50% of cirrhosis patients, and approximately 5–15% of cirrhosis patients show newly formed varices or worsening of varices each year.
- **Option D:** Effective resuscitation, accurate diagnosis, and early treatment are key to reducing mortality in variceal bleeding. The aims are not only to stop bleeding as soon as possible but also to prevent early re-bleeding. Early rebleeding, as with peptic ulcer disease, is significantly associated with worsening mortality.

**44. What is a characteristic of an audio recording of an unpublished research study reported at a professional conference?**

- A. Databased literature
- B. Secondary Sources
- C. Are more difficult to analyze than written reports.
- D. Are not useful because they are not published.

**Correct Answer: A. Databased literature**

Audio and video recordings of research presentations are examples of data based literature. As the name suggests, data-based literature is based on empirical information collected by the researcher. Non-data-based writings, on the other hand, 'reflect the writer's experiences or opinions and can range from the highly theoretical to popular testimonials' (Merriam 1988: 61).

- **Option B:** Secondary sources were created by someone who did not experience first-hand or participate in the events or conditions you're researching. For a historical research project, secondary sources are generally scholarly books and articles. A secondary source interprets and analyzes primary sources.
- **Option C:** As the name suggests, an annotated bibliography contains a list of relevant studies relating to the research question or issue. These may range from brief research reports to books. Each entry contains a summary or abstract of the particular work.
- **Option D:** A literature review differs from an annotated bibliography in that the researcher extracts and synthesizes the main points, issues, findings, and research methods that emerge from a critical review of the readings. Merriam (1988) suggests that, in carrying out a literature review, it is a good idea to differentiate between data-based research and non-data-based writings.

**45. A 58-year-old male patient has recently undergone a left thoracotomy and a partial pneumonectomy to treat lung cancer. Post-surgery, chest tubes are inserted, and one-bottle water-seal drainage is instituted. In the postanesthesia care unit, the nurse positions the client in Fowler's position on his right side or on his back. The nurse understands that this positioning is critical for postoperative recovery. Understanding the implications of postoperative positioning, the nurse is aware that placing the patient in Fowler's position on either his right side or on his back primarily:**

- A. Reduce incisional pain.
- B. Facilitate ventilation of the left lung.
- C. Equalize pressure in the pleural space.
- D. Increase venous return.

**Correct Answer: B. Facilitate ventilation of the left lung.**

Since only a partial pneumonectomy is done, there is a need to promote expansion of this remaining left lung by positioning the client on the opposite unoperated side.

- **Option A:** This position may reduce the pressure on the surgical incision site, but it is not its priority.
- **Option C:** Fowler's position is associated with improvement of functional residual capacity, oxygenation, and reduction of work of breathing.
- **Option D:** On the transition from sitting to standing, blood is pooled in the lower extremities as a result of gravitational forces. Venous return is reduced, which leads to a decrease in cardiac stroke volume, a decline in arterial blood pressure, and an immediate decrease in blood flow to the brain.

**46. It is described as a collection of people who share some attributes of their lives.**

- A. Family
- B. Illness
- C. Community

D. Nursing

**Correct Answer: C. Community**

A community is defined by the shared attributes of the people in it, and/or by the strength of the connections among them. When an organization is identifying communities of interest, the shared attribute is the most useful definition of a community.

- **Option A:** In human society, family is a group of people related either by consanguinity (by recognized birth) or affinity (by marriage or other relationship). The purpose of families is to maintain the well-being of its members and of society. Ideally, families would offer predictability, structure, and safety as members mature and participate in the community.
- **Option B:** Illness is a condition of being unhealthy in the body or mind; a specific condition that prevents the body or mind from working normally; a sickness or disease.
- **Option D:** Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people.

**47. A male client has an impairment of cranial nerve II. Specific to this impairment, the nurse would plan to do which of the following to ensure the client to ensure client safety?**

- A. Speak loudly to the client.
- B. Test the temperature of the shower water.
- C. Check the temperature of the food on the delivery tray.
- D. Provide a clear path for ambulation without obstacles.

**Correct Answer: D. Provide a clear path for ambulation without obstacles.**

Cranial nerve II is the optic nerve, which governs vision. The nurse can provide safety for the visually impaired client by clearing the path of obstacles when ambulating. Compromise of the optic nerve results in visual field defects and/or visual loss. The type of visual field defect depends on which region of the optic pathway is disrupted.

- **Option A:** Speaking loudly may help overcome a deficit of cranial nerve VIII (vestibulocochlear). CN VIII injuries are the result of pathological processes or injuries that commonly involve the cerebellopontine angle (CPA), the internal auditory canal (IAC), or the inner ear. In such cases, symptoms such as vertigo, nystagmus, tinnitus, and sensorineural hearing loss may occur.
- **Option B:** Testing the shower water temperature would be useful if there were an impairment of peripheral nerves. Peripheral nerve injury can cause sensory deficits, loss of motor function, or a combination of both. Recovery from peripheral nerve injury is often incomplete and patients may experience chronic pain.
- **Option C:** Cranial nerve VII (facial) and IX (glossopharyngeal) control taste from the anterior two-thirds and posterior third of the tongue, respectively. The facial nerve provides motor innervation of facial muscles that are responsible for facial expression, parasympathetic innervation of the glands of the oral cavity and the lacrimal gland, and sensory innervation of the anterior two-thirds of the tongue.

**48. Giving instructions for breast self-examination is particularly important for clients with which of the following medical problems?**

- A. Ovarian cancer
- B. Endometrial polyps
- C. Cervical dysplasia
- D. A dermoid cyst

**Correct Answer: A. Ovarian cancer**

- **Option A:** Clients with ovarian cancer are at increased risk for breast cancer. Breast self-examination supports early detection and treatment and is very important.
- **Option B:** Endometrial polyps are outgrowths in the endometrium that are mostly non cancerous and the exact cause is unknown.
- **Option C:** Cervical dysplasia is the abnormal cell growth in the lining of the cervix that is related with human papillomavirus (HPV) infection.
- **Option D:** Dermoid cysts are abnormal growth found in the ovary that usually contain material such as skin, hair, teeth, nails, fat, and sweat glands that were trapped during fetal development.

**49. The nurse should observe for side effects associated with the use of bronchodilators. A common side effect of bronchodilators is:**

- A. Decreased urine output
- B. Tremors
- C. Vision changes
- D. Hypotension

**Correct Answer: B. Tremors**

- **Option B:** Bronchodilators are medications that relax the muscles surrounding the airway. Common side effects of bronchodilators include nausea, dry mouth, increased heart rate, and tremors.
- **Options A, C, and D:** Decreased urine output, vision changes, and hypotension are signs of bronchodilator overdose.

**50. Spinnbarkeit is an indicator of ovulation which is characterized as:**

- A. Thin watery mucus which can be stretched into a long strand about 10 cm.
- B. Thick mucus that is detached from the cervix during ovulation.
- C. Thin mucus that is yellowish in color with fishy odor.
- D. Thick mucus vaginal discharge is influenced by high levels of estrogen.

**Correct Answer: A. Thin watery mucus which can be stretched into a long strand about 10 cm**

At the midpoint of the cycle when the estrogen level is high, the cervical mucus becomes thin and watery to allow the sperm to easily penetrate and get to the fallopian tubes to fertilize an ovum. This is

called spinnbarkeit. And the woman feels “wet”. When progesterone is secreted by the ovary, the mucus becomes thick and the woman will feel “dry”.

- **Option B:** Creamy cervical mucus is considered non-fertile since it greatly restricts the movement of sperm. It is often pearly white or creamy yellow. It is thick and feels like lotion when rubbed between the fingers.
- **Option C:** Although “yeast” is the name most women know, bacterial vaginosis (BV) actually is the most common vaginal infection in women of reproductive age. Bacterial vaginosis often will cause an abnormal smelling vaginal discharge. The discharge usually is thin and milky, and is described as having a “fishy” odor.
- **Option D:** Spinnbarkeit mucus is the stringy, stretchy quality of cervical mucus found especially around the time of ovulation. Usually a result of high estrogen levels, spinnbarkeit mucus refers to the egg white quality of cervical mucus that is easier for sperm to penetrate.

**51. Brenda, a 36 y.o. patient is on your floor with acute pancreatitis. Treatment for her includes:**

- A. Continuous peritoneal lavage.
- B. Regular diet with increased fat.
- C. Nutritional support with TPN.
- D. Insertion of a T tube to drain the pancreas.

**Correct Answer: C. Nutritional support with TPN.**

With acute pancreatitis, you need to rest the GI tract by TPN as nutritional support. In cases of severe pancreatitis or where peroral intake is not tolerated, nasojejunal feeding is superior to parenteral nutrition as it helps to minimize bacterial translocation by maintaining the intestinal barrier.

- **Option A:** The foundation of management for acute pancreatitis remains early aggressive fluid resuscitation. Lactated Ringer’s solution is the recommended fluid with an initial bolus of 15 to 20 mL/kg and following rates of 3 mL/kg per hour (usually approximately 250 to 500 mL per hour) for the first 24 hours if no other contraindications are present.
- **Option B:** Common practice is to keep nothing by mouth until abdominal pain, nausea, vomiting, appetite, and ileus improve. Early feeding in mild pancreatitis is safe and does not exacerbate symptoms. Soft, low residue, low-fat diet is recommended for initial feeding and advanced to regular consistency as tolerated.
- **Option D:** Further management depends upon the etiology of pancreatitis. In gallstone pancreatitis, early cholecystectomy is strongly recommended. Early ERCP (within 24 hours of presentation) is of benefit in cases of concurrent cholangitis and obvious biliary obstruction.

**52. Which of the following nursing interventions promotes patient safety?**

- A. Assess the patient’s ability to ambulate and transfer from a bed to a chair.
- B. Demonstrate the signal system to the patient.
- C. Check to see that the patient is wearing his identification band.
- D. All of the above.

**Correct Answer: D. All of the above**

Patient Safety is a healthcare discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in health care facilities. It aims to prevent and reduce risks, errors, and harm that occur to patients during the provision of health care. A cornerstone of the discipline is a continuous improvement based on learning from errors and adverse events.

- **Option A:** Assisting a patient with ambulation and transfer from a bed to a chair allows the nurse to evaluate the patient's ability to carry out these functions safely. Patient safety is fundamental to delivering quality essential health services. Indeed, there is a clear consensus that quality health services across the world should be effective, safe, and people-centered. In addition, to realize the benefits of quality health care, health services must be timely, equitable, integrated, and efficient.
- **Option B:** Demonstrating the signal system and providing an opportunity for a return demonstration ensures that the patient knows how to operate the equipment and encourages him to call for assistance when needed. To ensure successful implementation of patient safety strategies; clear policies, leadership capacity, data to drive safety improvements, skilled health care professionals, and effective involvement of patients in their care, are all needed.
- **Option C:** Checking the patient's identification band verifies the patient's identity and prevents identification mistakes in drug administration. Safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening health care systems and making progress towards effective universal health coverage (UHC) under Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages).

**53. Which of the following medications decreases their action while taking thyroid hormone?**

- A. Metformin
- B. Warfarin
- C. Zoloft
- D. Epinephrine

**Correct Answer: A. Metformin**

Metformin, an oral hypoglycemic drug when taken with a thyroid hormone decreases their action.

- **Options B, C, & D:** Warfarin (an anticoagulant), Zoloft (an antidepressant), and Epinephrine (a sympathomimetic) increases their action when taken with a thyroid hormone.

**54. A nurse is teaching a client with pancreatitis about following a low-fat diet. The nurse develops a list of high-fat foods to avoid and includes which food on the item list?**

- A. Chocolate milk
- B. Broccoli
- C. Apple
- D. Salmon

**Correct Answer: A. Chocolate milk**

Chocolate milk is a high-fat food. The pancreas helps with fat digestion, so foods with more fat make the pancreas work harder. Registered dietitian Deborah Gerszberg recommends that people with chronic pancreatitis limit their intake of refined carbohydrates, such as white bread and high sugar foods. Refined carbohydrates can lead to the pancreas releasing large amounts of insulin. Foods that are high in sugar can also raise triglycerides.

- **Option B:** Vegetables are low in fat because they do not come from animal sources. Vegetables, beans, lentils, and whole grains are beneficial because of their fiber content. Eating more fiber can lower the chances of having gallstones or elevated levels of fats in the blood called triglycerides. Both of those conditions are common causes of acute pancreatitis.
- **Option C:** Fruits are low in fat because they do not come from animal sources. Fruits are recommended for people with pancreatitis because they tend to be naturally low in fat, which eases the amount of work the pancreas needs to do to aid digestion.
- **Option D:** Salmon is naturally lower in fat. Many types of fish, such as salmon, lake trout, tuna, and herring, provide healthy omega-3 fat. But avoid fish canned in oil, such as sardines in olive oil. Bake, broil, or grill meats, poultry, or fish instead of frying them in butter or fat.

**55. The nurse is caring for a client with systemic lupus erythematosus (SLE). The major complication associated with systemic lupus erythematosus is:**

- A. Meningitis
- B. Nephritis
- C. Cardiomegaly
- D. Desquamation

**Correct Answer: B. Nephritis**

- Option B: Systemic lupus erythematosus is a form of lupus and an autoimmune disease in which the antibodies attack the body's own cells and tissue causing inflammation and damage to organs such as the kidneys resulting in complications such as nephritis.
- Options A and C: SLE affects the musculoskeletal, integumentary, renal, nervous, and cardiovascular systems, but the major complication is renal involvement.
- Option D: SLE produces a "butterfly" rash, not desquamation.

**56. A male client was on warfarin (Coumadin) before admission and has been receiving heparin I.V. for 2 days. The partial thromboplastin time (PTT) is 68 seconds. What should Nurse Carla do?**

- A. Stop the I.V. infusion of heparin and notify the physician.
- B. Continue treatment as ordered.
- C. Expect the warfarin to increase the PTT.
- D. Increase the dosage, because the level is lower than normal.

**Correct Answer: B. Continue treatment as ordered.**

The effects of heparin are monitored by the PTT is normally 30 to 45 seconds; the therapeutic level is 1.5 to 2 times the normal level.



- **Option A:** There is no need to stop the infusion since the PTT is at a therapeutic level. In patients receiving concomitant heparin and warfarin therapy, PTT reflects the combined effects of both drugs. Because of the marked effect of warfarin on the PTT, decreasing heparin dose in response to a high PTT frequently results in subtherapeutic heparin levels.
- **Option C:** The PTT is not used to monitor warfarin therapy, but PTT may be prolonged by warfarin at high doses.
- **Option D:** The level is correct; increasing the dosage is unnecessary. Warfarin markedly affects PTT, for each increase of 1.0 in the international normalized ratio, the PTT increases 16 seconds.

**57. When giving narcotic analgesics to a mother in labor, the special consideration to follow is:**

- A. The progress of labor is well established reaching the transitional stage.
- B. Uterine contraction is progressing well, and delivery of the baby is imminent.
- C. Cervical dilatation has already reached at least 8 cm. and the station is at least (+)2.
- D. Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.

**Correct Answer: D. Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.**

Narcotic analgesics must be given when uterine contractions are already well established so that it will not cause stoppage of the contraction thus protracting labor. Also, it should be given when delivery of a fetus is imminent or too close because the fetus may suffer respiratory depression as an effect of the drug that can pass through the placental barrier.

- **Option A:** Opioid analgesia offers a systemic alternative to regional analgesia procedures. Since the early 1940s, the most commonly used systemic analgesic has been meperidine (pethidine). As with all opioids, meperidine crosses the placenta and presents a dose-dependent risk of neonatal respiratory depression and reduction of fetal heart frequency. The mother may suffer from nausea, vomiting, respiratory depression, dysphoria, and delayed gastric emptying.
- **Option B:** The effects of systemic opioids in labor are predominantly sedative rather than analgesic; other opioids, when used in labor, are usually administered as patient-controlled analgesia.
- **Option C:** Visceral labor pain occurs during the early first stage and the second stage of childbirth. With each uterine contraction, pressure is transmitted to the cervix causing stretching and distension and activating excitatory nociceptive afferents. These afferents innervate the endocervix and lower segment from T10 – L1.

**58. A client appears upset and tearful, but denies pain and refuses pain medication, because “my sibling is a drug addict and has ruined our lives.” What is the priority intervention for this client?**

- A. Encourage expression of fears on past experiences.
- B. Provide accurate information about the use of pain medication.
- C. Explain that addiction is unlikely among acute care clients.
- D. Seek family assistance in resolving this problem.

**Correct Answer: A. Encourage expression of fears on past experiences.**

This client has strong beliefs and emotions related to the issue of sibling addiction. First, encourage expression. This indicated to the client that the feelings are real and valid. It is also an opportunity to assess beliefs and fears. Verbalization of feelings in a nonthreatening environment may help the client come to terms with unresolved issues.

- **Option B:** Giving facts and information is appropriate at the right time. Clients are often reluctant to share feelings for fear of ridicule and may have repeatedly been told to ignore feelings. Once the client begins to acknowledge and talk about these fears, it becomes apparent that the feelings are manageable.
- **Option C:** Encourage the client to explore underlying feelings that may be contributing to irrational fears. Help the client to understand how facing these feelings, rather than suppressing them, can result in more adaptive coping abilities.
- **Option D:** Family involvement is important, bearing in mind that their beliefs about drug addiction may be similar to those of the client. Present and discuss the reality of the situation with the client in order to recognize aspects that can be changed and those that cannot. The client must accept the reality of the situation before the work of reducing the fear can progress.

**59. Angela, a clinical instructor is conducting a lecture about chemotherapy. Which of the following statements is correct about the rate of cell growth in relation to chemotherapy?**

- A. Faster growing cells are more susceptible to chemotherapy
- B. Faster growing cells are less susceptible to chemotherapy
- C. Slower growing cells are more susceptible to chemotherapy
- D. Non-dividing cells are more susceptible to chemotherapy

**Correct Answer: A. Faster growing cells are more susceptible to chemotherapy**

- **Option A:** The faster the cell grows, the more susceptible it is to chemotherapy and radiation therapy.
- **Options B, C, and D:** Slow-growing and non-dividing cells are less susceptible to chemotherapy. Repeated cycles of chemotherapy are used to destroy nondividing cells as they begin active cell division.

**60. Examples of patients suffering from impaired awareness include all of the following except:**

- A. A semiconscious or over fatigued patient.
- B. A disoriented or confused patient.
- C. A patient who cannot care for himself at home.
- D. A patient demonstrating symptoms of drugs or alcohol withdrawal.

**Correct Answer: C. A patient who cannot care for himself at home**

A patient who cannot care for himself at home does not necessarily have impaired awareness; he may simply have some degree of immobility.

- **Option A:** Fatigue is the feeling of tiredness and decreased energy that results from inadequate sleep time or poor quality of sleep. Fatigue can also result from increased work intensity or long work hours. Sleep deprivation has long been known to impair various cognitive functions, including mood, motivation, response time, and initiative. In a classic review of sleep deprivation and decision-making, investigators argued that effective performance in health care environments requires naturalistic decision-making and situation awareness.
- **Option B:** Impaired self-awareness of deficits is a common finding in patients who have suffered a traumatic brain injury. Impaired awareness can limit motivation for treatment and contribute to a poor outcomes. Consequently, it is important for brain injury rehabilitation professionals to understand this phenomenon and utilize treatment approaches that may improve patient awareness.
- **Option D:** Most alcoholics exhibit mild-to-moderate deficiencies in intellectual functioning, along with diminished brain size and regional changes in brain-cell activity. The most prevalent alcohol-associated brain impairments affect visuospatial abilities and higher cognitive functioning. Visuospatial abilities include perceiving and remembering the relative locations of objects in 2- and 3-dimensional space. Examples include driving a car or assembling a piece of furniture based on instructions contained in a line drawing. Higher cognitive functioning includes the abstract-thinking capabilities needed to organize a plan, set it in motion, and change it as needed.

**61. The nursing assistant reports to you, the RN, that the patient with myasthenia gravis (MG) has an elevated temperature (102.20 °F or 39° C), heart rate of 120/minute, rise in blood pressure (158/94), and was incontinent of urine and stool. What is your best first action at this time?**

- A. Administer an acetaminophen suppository
- B. Notify the physician immediately
- C. Recheck vital signs in 1 hour
- D. Reschedule patient's physical therapy session

**Correct Answer: B. Notify the physician immediately.**

The changes that the nursing assistant is reporting are characteristics of myasthenia crisis, which often follows some type of infection. The patient is at risk for inadequate respiratory function. In addition to notifying the physician, the nurse should carefully monitor the patient's respiratory status. The patient may need intubation and mechanical ventilation.

- **Option A:** The nurse would notify the physician before giving the suppository because there may be orders for cultures before giving acetaminophen.
- **Option C:** This patient's vital signs need to be re-checked sooner than 1 hour.
- **Option D:** Rescheduling the physical therapy can be delegated to the unit clerk and is not urgent.  
Focus: Prioritization

**62. Which of the following conditions indicates that spinal shock is resolving in a client with C7 quadriplegia?**

- A. Absence of pain sensation in chest
- B. Spasticity

- C. Spontaneous respirations
- D. Urinary continence

**Correct Answer: B. Spasticity**

Spasticity, the return of reflexes, is a sign of resolving shock. Spinal or neurogenic shock is characterized by hypotension, bradycardia, dry skin, flaccid paralysis, or the absence of reflexes below the level of injury. Spinal shock is a result of severe spinal cord injury. It usually requires high-impact, direct trauma that leads to spinal cord injury and spinal shock. The initial encounter with a patient that has spinal shock is usually under a trauma scenario.

- **Option A:** The absence of pain sensation in the chest doesn't apply to spinal shock. With high cervical injuries, the diaphragmatic function will be compromised, and these patients will necessitate early tracheotomy since they will be ventilator dependent. Deep vein thrombosis is excessively high in these patients.
- **Option C:** Spinal shock descends from the injury, and respiratory difficulties occur at C4 and above. In spinal shock, there is a transient increase in blood pressure due to the release of catecholamines. This is followed by a state of hypotension, flaccid paralysis, urinary retention, and fecal incontinence. The symptoms of spinal shock may last a few hours to several days/weeks.
- **Option D:** The full spinal examination should include motor, sensory reflexes including bulbocavernosus reflex and anal wink reflex. Motor activity and strength decrease not only in the skeletal muscles but the motor activity of internal organs like bowel and bladder. This decrease leads to constipation and urinary retention.

**63. A client who is admitted after a thermal burn injury has the following vital signs: blood pressure, 70/40; heart rate, 140 beats/min; respiratory rate, 25/min. He is pale in color and it is difficult to find pedal pulses. Which action will the nurse take first?**

- A. Start intravenous fluids.
- B. Check the pulses using a Doppler device.
- C. Obtain a complete blood count (CBC).
- D. Obtain an electrocardiogram (ECG).

**Correct Answer: A. Start intravenous fluids.**

Hypovolemic shock is a common cause of death in the emergent phase of clients with serious injuries. Administration of fluids can treat this problem. For burns classified as severe (> 20% TBSA), fluid resuscitation should be initiated to maintain urine output > 0.5 mL/kg/hour.

- **Option C:** Following a severe burn injury, significant hematologic changes occur that are reflected in complete blood count (CBC) measurements. A CBC will be taken to ascertain if a cardiac or bleeding problem is causing these vital signs. However, these are not actions that the nurse would take immediately.
- **Option B:** Checking pulses would indicate perfusion to the periphery but this is not an immediate nursing action. Carefully check pulses in any extremity with circumferential burns. These burns can act as tourniquets as burn-associated edema begins, leading to compartment syndrome.
- **Option D:** In patients with extensive burns, it is sometimes a challenge to monitor the ECG, because the lack of natural skin and application of protective ointments prevent the adherence of

the ECG discs.

**64. While in a skilled nursing facility, a female client contracted scabies, which is diagnosed the day after discharge. The client is living at her daughter's home, where six other persons are living. During her visit to the clinic, she asks a staff nurse, "What should my family do?" The most accurate response from the nurse is:**

- A. "All family members will need to be treated."
- B. "If someone develops symptoms, tell him to see a physician right away."
- C. "Just be careful not to share linens and towels with family members."
- D. "After you're treated, family members won't be at risk for contracting scabies."

**Correct Answer: A. "All family members will need to be treated."**

When someone in a group of persons sharing a home contracts scabies, each individual in the home needs prompt treatment whether he's symptomatic or not.

- **Options B, C, & D:** Towels and linens should be washed in hot water. Scabies can be transmitted from one person to another before symptoms develop.

**65. David is preoccupied with numerous bodily complaints even after a careful diagnostic workup reveals no physiologic problems. Which nursing intervention would be therapeutic for him?**

- A. Acknowledge that the complaints are real to the client, and refocus the client on other concerns and problems.
- B. Challenge the physical complaints by confronting the client with the normal diagnostic findings.
- C. Ignore the client's complaints, but request that the client keeps a list of all symptoms.
- D. Listen to the client's complaints carefully, and question him about specific symptoms.

**Correct Answer: A. Acknowledge that the complaints are real to the client, and refocus the client on other concerns and problems.**

After physical factors are ruled out, somatic complaints are thought to be expressions of anxiety. The complaints are real to the client, but the nurse should not focus on them. Prompting the client about other concerns will encourage the expression of anxiety and dependency needs. The nurse must help the client establish a daily routine that includes improved health behaviors. Provide accommodation for the client and make them more comfortable (ie., pillows, temperature, positioning, etc.). This can help the client feel accepted and develop rapport and trust. This can allow the client to feel more comfortable and express their feelings and emotions more readily to the healthcare team.

- **Option B:** Clients may keep a detailed journal of their physical symptoms; the nurse might ask them to describe the situation at the time such as whether they were alone or with others, whether any disagreements were occurring, and so forth. Provide education about feared or actual medical conditions. This can help relieve acute pain and distress that the client may feel, but also helps them learn to control many symptoms through focus and calming the mind.

- **Option C:** Encourage behavior modification such as praising the client and offering more attention when symptoms improve. Change the focus from what's wrong to what's right. Helps the client feel accomplished and more positive about improvements in health condition instead of focusing on the symptoms. Encourage the client to keep a journal of symptoms and the events or factors that lead up to the development of symptoms and their resolution. This is a technique of cognitive behavior therapy that helps the client understand what factors (usually stress) that prompt the onset of symptoms. It can also help the client determine a pattern of emotions surrounding the symptoms.
- **Option D:** Discuss symptoms with the client and when they began, what makes them better or worse and how they have been managing these symptoms. Teach coping strategies. Emotion-focused strategies include progressive relaxation, deep breathing, guided imagery, and distractions such as music or other activities; problem-focused coping strategies include problem-solving methods, applying the process to identified problems, and role-playing interactions with others.

**66. Adriana, a 46-year-old fashion designer, was recently diagnosed with gout. Due to the severity and frequency of her flare-ups, her physician has prescribed a combination of allopurinol and colchicine. During her outpatient appointment, Nurse Nathan reviews her medication regimen. What instructions should Nurse Nathan emphasize to Adriana about her medications? Select all that apply.**

- A. "Take allopurinol with food to minimize gastrointestinal side effects."
- B. "Report any signs of skin rash or itching to your healthcare provider."
- C. "Continue taking colchicine even if you have diarrhea."
- D. "Avoid consuming grapefruit or grapefruit juice while on these medications."
- E. "Increase your fluid intake to prevent kidney stone formation."

**Correct Answers: B, D, and E.**

- **Option B:** Skin rashes can be a sign of a hypersensitive reaction to allopurinol, which can be severe. Patients should be educated to report these symptoms immediately.
- **Option D:** Grapefruit or grapefruit juice can interact with allopurinol and colchicine, so it should be avoided.
- **Option E:** Adequate fluid intake is crucial for patients with gout to promote uric acid excretion and reduce the risk of kidney stone formation, especially if they are on medications like allopurinol.
- **Options A & C:** Taking allopurinol with food is not necessary, and continuing colchicine despite diarrhea is not recommended due to potential gastrointestinal side effects.

**67. A client has been placed in blood and body fluid isolation. The nurse is instructing auxiliary personnel in the correct procedures. Which statement by the nursing assistant indicates the best understanding of the correct protocol for blood and body fluid isolation?**

- A. Masks should be worn with all client contact
- B. A private room is always indicated
- C. Isolation gowns are not needed

D. Gloves should be worn for contact with non intact skin, mucous membranes, or soiled items

**Correct Answer: D. Gloves should be worn for contact with nonintact skin, mucous membranes, or soiled items.**

Gloves should be worn for all contact with blood and body fluids, nonintact skin and mucous membranes; for handling soiled items; and for performing venipuncture. These precautions treat all blood and body fluids as potentially infectious for diseases that are transmitted in the blood. The organisms spreading these diseases are called blood-borne pathogens.

- **Option A:** Masks should only be worn during procedures that are likely to cause splashes of blood or body fluid. Masks and protective eyewear, such as goggles or a face shield, help protect the eyes, mouth, and nose from droplets of blood and other body fluids. Always wear a mask and protective eyewear if doing a procedure that may expose oneself to splashes or sprays of blood or body fluids.
- **Option B:** A private room is only indicated if the client's hygiene is poor. Blood and body fluid precautions are recommendations designed to prevent the transmission of HIV, hepatitis B, hepatitis C, and other diseases while giving first aid or other health care that includes contact with body fluids or blood.
- **Option C:** Gowns should be worn during procedures that are likely to cause splashes of blood or body fluids. Gowns or aprons protect the personnel from splashes of blood or body fluids. Always wear a gown or apron if doing a procedure that may expose oneself to splashes or sprays of blood or body fluids.

**68. The assigned LPN of the unit reports to you that a client's blood pressure and heart rate have decreased, and when her face is assessed, one side twitches. What is the most appropriate thing to do as a nurse?**

- A. Assess the client's pupillary reaction to light.
- B. Obtain a neurologic exam request for the client.
- C. Review the client's morning calcium level.
- D. Retake the client's blood pressure and heart rate.

**Correct Answer: C. Review the client's morning calcium level.**

Facial twitching of one side of the mouth, nose, and cheek in response to tapping the face just below and in front of the ear is a positive Chvostek sign. It is a neurologic manifestation of hypocalcemia.

- **Option A:** Pupillary light reflex is used to assess the brain stem function. Abnormal pupillary light reflex can be found in optic nerve injury, oculomotor nerve damage, brain stem lesions, such as tumors, and medications like barbiturates.
- **Option B:** The neurological examination is an assessment tool to determine a patient's neurologic function. It is beneficial in a variety of ways as it allows the localization of neurologic diseases and helps in ruling in or ruling out differential diagnoses.
- **Option D:** The LPN is experienced and holds the skills to carefully and accurately measure vital signs. The clinical manifestations of hypocalcemia can range from no symptoms if it is mild to life-threatening symptoms like seizures, heart failure, or laryngospasm if it is severe. Also, the clinical manifestation depends on the rate of development of hypocalcemia and its chronicity.

**69. A client with chronic schizophrenia receives 20 mg of fluphenazine decanoate (Prolixin Decanoate) by I.M. injection. Three days later, the client has muscle contractions that contort the neck. This client is exhibiting which extrapyramidal reaction?**

- A. Dystonia
- B. Akinesia
- C. Akathisia
- D. Tardive dyskinesia

**Correct Answer: A. Dystonia**

Dystonia, a common extrapyramidal reaction to fluphenazine decanoate, manifests as muscle spasms in the tongue, face, neck, back, and sometimes the legs. Dystonia is a dynamic disorder that changes in severity based on the activity and posture. Dystonia may assume a pattern of overextension or over-flexion of the hand, inversion of the foot, lateral flexion or retroflexion of the head, torsion of the spine with arching and twisting of the back, forceful closure of the eyes, or a fixed grimace. It may come to an end when the body is in action and during sleep.

- **Option B:** 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.
- **Option C:** Akathisia, to restlessness or inability to sit still. Akathisia is a movement disorder that may be associated with the use of antipsychotic medications. The primary movement disorders from antipsychotic agents are akathisia, acute dystonia, pseudoparkinsonism, and tardive dyskinesia. Akathisia may also rarely occur with antidepressant agents.
- **Option D:** Tardive dyskinesia, to abnormal muscle movements, particularly around the mouth. Tardive dyskinesia (TD) is a syndrome which includes a group of iatrogenic movement disorders caused due to a blockade of dopamine receptors. The movement disorders include akathisia, dystonia, buccolingual stereotypy, myoclonus, chorea, tics, and other abnormal involuntary movements which are commonly caused by the long-term use of typical antipsychotics.

**70. A patient who is hospitalized due to vomiting and a decreased level of consciousness displays slow and deep (Kussmaul breathing), and he is lethargic and irritable in response to stimulation. The doctor diagnosed him of having dehydration. Measurement of arterial blood gas shows pH 7.0, PaO<sub>2</sub> 90 mm Hg, PaCO<sub>2</sub> 22 mm Hg, and HCO<sub>3</sub> 14 mmol/L; other results are Na<sup>+</sup> 120 mmol/L, K<sup>+</sup> 2.5 mmol/L, and Cl<sup>-</sup> 95 mmol/L. As a knowledgeable nurse, you know that the normal value for PaCO<sub>2</sub> is:**

- A. 22 mm Hg
- B. 36 mm Hg
- C. 48 mm Hg
- D. 50 mm Hg



**Correct Answer: B. 36 mm Hg**

The normal range for PaCO<sub>2</sub> is from 35 to 45 mm Hg.

**71. The lower limit of viability for infants in terms of age of gestation is:**

- A. 21-24 weeks
- B. 25-27 weeks
- C. 28-30 weeks
- D. 38-40 weeks

**Correct Answer: A. 21-24 weeks**

Viability means the capability of the fetus to live/survive outside of the uterine environment. With the present technological and medical advances, 21 weeks AOG is considered as the minimum fetal age for viability.

- **Option B:** Fetal viability is a major issue that is dependent on the evolution and progress of modern neonatology (Beauthier, 2007). It is generally accepted that a 28-week-old fetus that doesn't need resuscitation is viable. However, according to WHO, fetal viability is possible after 20 weeks of fetal life (22 weeks of amenorrhea).
- **Option C:** A simple way to calculate fetal age (in lunar months) is to divide the fetal length (in cm) by 4 for fetuses less than 5 months' gestation. If it is less than 5 months' gestation the length (in cm) is divided by 5.
- **Option D:** Anthropometric measurements collected during examination of the fetus are used to estimate its age more accurately (Beauthier, 2011b). Three types of data can be gathered from radiologic investigations: direct fetal age estimation from measurement of the length of long bones; fetal age estimation from measurement of the long bones and calculation of fetal stature (crown-heel or crown-rump length); and a more difficult method involving the degree of deciduous teeth calcification; this method requires the conservation of dental crowns.

**72. A 60-year-old male with a history of hypertension and diabetes is admitted to the urology unit with symptoms of fatigue, decreased urine output, and nausea. He has a known diagnosis of chronic renal failure (CRF). The nurse reviews his recent laboratory test results. Which result is most consistent with a diagnosis of CRF?**

- A. Increased pH with decreased hydrogen ions.
- B. Increased serum levels of potassium, magnesium, and calcium.
- C. Blood urea nitrogen (BUN) 100 mg/dl and serum creatinine 6.5 mg/ dl.
- D. Uric acid analysis 3.5 mg/dl and phenolsulfonphthalein (PSP) excretion 75%.

**Correct Answer: C. Blood urea nitrogen (BUN) 100 mg/dl and serum creatinine 6.5 mg/dl.**

The normal BUN level ranges 8 to 23 mg/dl; the normal serum creatinine level ranges from 0.7 to 1.5 mg/dl. The test results in option C are abnormally elevated, reflecting CRF and the kidneys' decreased ability to remove nonprotein nitrogen waste from the blood.

- **Option A:** CRF causes decreased pH and increased hydrogen ions — not vice versa.

- **Option B:** CRF also increases serum levels of potassium, magnesium, and phosphorus, and decreases serum levels of calcium.
- **Option D:** A uric acid analysis of 3.5 mg/dl falls within the normal range of 2.7 to 7.7 mg/dl; PSP excretion of 75% also falls with the normal range of 60% to 75%.

**73. The client passes a urinary stone, and lab analysis of the stone indicates that it is composed of calcium oxalate. Based on this analysis, which of the following would the nurse specifically include in the dietary instructions?**

- A. Increase intake of meat, fish, plums, and cranberries.
- B. Avoid citrus fruits and citrus juices.
- C. Avoid green, leafy vegetables such as spinach.
- D. Increase intake of dairy products.

**Correct Answer: C. Avoid green, leafy vegetables such as spinach.**

Oxalate is found in dark green foods such as spinach. Other foods that raise urinary oxalate are rhubarb, strawberries, chocolate, wheat bran, nuts, beets, and tea. The more oxalate that is absorbed from the digestive tract, the more oxalate in the urine. Often a combination of calcium from foods or beverages with meals and fewer high-oxalate foods is required.

- **Option A:** Eating large amounts of protein may increase the risk of kidney stone formation. The daily protein needs can usually be met with 2-3 servings a day, or 4 to 6 ounces. Eating more than this if you are at risk of kidney stones is unnecessary.
- **Option B:** Oxalate is produced as an end product of Vitamin C (ascorbic acid) metabolism. Large doses of Vitamin C may increase the amount of oxalate in the urine, increasing the risk of kidney stone formation. If taking a supplement, do not take more than 500 mg of Vitamin C daily.
- **Option D:** A diet rich in calcium helps reduce the amount of oxalate being absorbed by the body, so stones are less likely to form. Eat calcium-rich foods and beverages every day (2 to 3 servings) from dairy foods or other calcium-rich foods.

**74. A nurse is providing instructions to a client who is taking doxapram (Dopram). Which of the following statements made by the client needs further instructions?**

- A. "I need to take the medication before meals".
- B. "I need to take the medication at bedtime".
- C. "I need to avoid drinking coffee".
- D. "I will not chew or crush long acting form of the medications".

**Correct Answer: B. "I need to take the medication at bedtime".**

Doxapram (Dopram) is a central nervous system stimulant. One of the side effects is insomnia so instruct the client to take it at least 6 hours before bedtime to prevent it.

- **Options A, C, & D:** These are appropriate instructions regarding the use of doxapram.

**75. Anna is 45 y.o. and has a bleeding ulcer. Despite multiple blood transfusions, her HGB is 7.5g/dl and HCT is 27%. Her doctor determines that surgical intervention is necessary and she undergoes partial gastrectomy. Postoperative nursing care includes:**

- A. Giving pain medication Q6H.
- B. Flushing the NG tube with sterile water.
- C. Positioning her in high Fowler's position.
- D. Keeping her NPO until the return of peristalsis.

**Correct Answer: D. Keeping her NPO until the return of peristalsis.**

After surgery, she remains NPO until peristaltic activity returns. This decreases the risk for abdominal distention and obstruction. Caution the patient to limit the intake of ice chips. Excessive intake of ice produces nausea and can wash out electrolytes via the NG tube.

- **Option A:** Monitor tolerance to fluid and food intake, noting abdominal distension, reports of increased pain, cramping, nausea, and vomiting. Complications of paralytic ileus, obstruction, delayed gastric emptying, and gastric dilation may occur, possibly requiring reinsertion of the NG tube.
- **Option B:** Maintain patency of NG tube. Notify the physician if the tube becomes dislodged. Provides rest for GI tract during the acute postoperative phase until the return of normal function. The physician or surgeon may need to reposition the tube endoscopically to prevent injury to the operative area.
- **Option C:** Auscultate for resumption of bowel sounds and note passage of flatus. Peristalsis can be expected to return about the third postoperative day, signaling readiness to resume oral intake.

**76. A nurse is assisting in performing an assessment on a client who suspects that she is pregnant and is checking the client for probable signs of pregnancy. Select all probable signs of pregnancy.**

- A. Uterine enlargement
- B. Fetal heart rate detected by a nonelectric device
- C. Outline of the fetus via radiography or ultrasound
- D. Chadwick's sign
- E. Braxton Hicks contractions
- F. Ballottement

**Correct Answer: A, D, E, & F.**

Probable signs of pregnancy are those signs commonly noted by the physician upon examination of the patient. These signs include uterine changes, abdominal changes, cervical changes, basal body temperature, positive pregnancy test by physician, and fetal palpation.

- **Option A:** The uterine increases in width and length approximately five times its normal size. Its weight increases from 50 grams to 1,000 grams. By the twelfth week, the uterus rises above the symphysis pubis and it should reach the xiphoid process by the 36th week of pregnancy.

- **Option B:** Fetal heart sounds are positive signs of pregnancy. The fetal heart begins beating by the 24th day following conception. It is audible with a doppler by 10 weeks of pregnancy and with a fetoscope after the 16th week (see figure 3-5). It is not to be confused with uterine soufflé or swishlike tone from pulsating uterine arteries. The normal fetal heart rate is 120 to 160 beats.
- **Option C:** Confirmation of fetal outline through ultrasound is a positive sign of pregnancy. The gestation sac can be seen and photographed. An embryo as early as the 4th week after conception can be identified. The fetal parts begin to appear by the 10th week of gestation.
- **Option D:** The cervix is normally firm like the cartilage at the end of the nose. The Goodell's sign is when there is marked softening of the cervix. This is present at 6 weeks of pregnancy.
- **Option E:** These contractions will, generally, cease with walking or other forms of exercise. The Braxton-Hicks contractions are distinct from contractions of true labor by the fact that they do not cause the cervix to dilate and can usually be stopped by walking.
- **Option F:** This is demonstrated during the bimanual exam at the 16th to 20th week. Ballottement is when the lower uterine segment or the cervix is tapped by the examiner's finger and left there, the fetus floats upward, then sinks back and a gentle tap is felt on the finger. This is not considered diagnostic because it can be elicited in the presence of ascites or ovarian cysts.

**77. A client at 24 weeks gestation has gained 6 pounds in 4 weeks. Which of the following would be the priority when assessing the client?**

- A. Glucosuria
- B. Depression
- C. Hand/face edema
- D. Dietary intake

**Correct Answer: C. Hand/face edema**

After 20 weeks' gestation, when there is a rapid weight gain, preeclampsia should be suspected, which may be caused by fluid retention manifested by edema, especially of the hands and face. The three classic signs of preeclampsia are hypertension, edema, and proteinuria.

- **Option A:** Although urine is checked for glucose at each clinic visit, this is not the priority. Routine dipstick screening for protein and glucose at each prenatal visit should be abandoned. Women who are known or perceived to be at high risk for gestational diabetes or preeclampsia should continue to be monitored closely at the discretion of their clinician.
- **Option B:** Depression may cause either anorexia or excessive food intake, leading to excessive weight gain or loss. This is not, however, the priority consideration at this time. About 6% of women, including up to 10% (one in 10) of women who are pregnant, will experience depression at some time during their lives.
- **Option D:** Weight gain thought to be caused by excessive food intake would require a 24-hour diet recall. However, excessive intake would not be the primary consideration for this client at this time. High gestational weight gain (GWG) is related to several complications in mothers, such as hypertension, diabetes, pre-eclampsia, macrosomia, and maternal weight retention postpartum. In addition, GWG may also influence body composition in childhood and later life. Studies have also suggested that excessive GWG is associated with higher fat mass in childhood and greater body mass index (BMI) and fat mass in later adulthood.

**78. A client is receiving intravenous heparin therapy. The nurse ensures the availability of which of the following medication?**

- A. acetylcysteine (Mucomyst)
- B. calcium gluconate (Calcium gluconate)
- C. vitamin K (Mephyton)
- D. protamine sulfate (Protamine)

**Correct Answer: D. protamine sulfate (Protamine)**

Protamine sulfate is the antidote that reverses the anticoagulant effects of heparin by binding to it.

- **Option A:** Acetylcysteine (Mucomyst) is the antidote for acetaminophen toxicity.
- **Option B:** Calcium gluconate is the antidote for magnesium sulfate toxicity.
- **Option C:** Vitamin K (Mephyton) is the antidote for warfarin sodium toxicity.

**79. A patient with ESRD has an arteriovenous fistula in the left arm for hemodialysis. Which intervention do you include in his plan of care?**

- A. Apply pressure to the needle site upon discontinuing hemodialysis.
- B. Keep the head of the bed elevated 45 degrees.
- C. Place the left arm on an arm board for at least 30 minutes.
- D. Keep the left arm dry.

**Correct Answer: A. Apply pressure to the needle site upon discontinuing hemodialysis.**

Apply pressure when discontinuing hemodialysis and after removing the venipuncture needle until all the bleeding has stopped. Bleeding may continue for 10 minutes in some patients. The AV fistula is the safest type of vascular access. It can last for years and is least likely to get infections or blood clots. A surgeon connects an artery (a large blood vessel that carries blood from the heart) and a vein (a blood vessel that carries blood to the heart) under the skin in the arm. Usually, they do the AV fistula in the non-dominant arm.

- **Option B:** Remove any restrictive clothing or jewelry from the arm. To prevent injuries, place an armband on the patient or a sign over the bed that says no BP measurements, venipunctures, or injections on the affected side. When blood flow through the vascular access is reduced, it can clot.
- **Option C:** Perform hand hygiene before you assess or touch the vascular access. If it's new vascular access with a wound, don gloves. Position the patient's arm so the vascular access is easily visualized. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency.
- **Option D:** Check the patient's circulation by palpating his pulses distal to the vascular access; observing capillary refill in his fingers; and assessing him for numbness, tingling, altered sensation, coldness, and pallor in the affected extremity.

**80. The nurse is caring for a severely depressed client who has just been admitted to the in-client psychiatric unit. Which of the following is a priority of care?**

- A. Nutrition
- B. Elimination
- C. Rest
- D. Safety

**Correct Answer: D. Safety**

Safety is a priority of care for the depressed client. Precautions to prevent suicide must be a part of the plan. Identify the level of suicide precautions needed. If there is a high-risk, does a hospitalization require it? Or if there is a low risk, will the client be safe to go home with supervision from a family member or a friend? A client with a high-risk will require constant supervision and a safe environment.

- **Option A:** Encourage small, high-calorie, and high-protein snacks and fluids frequently throughout the day and evening if weight loss is noted. Minimize weight loss, constipation, and dehydration. Encourage eating with others. Increases socialization, decreases focus on the food. Weight the client weekly and observe the eating patterns of the client. Give the information needed for revising the intervention.
- **Option B:** Monitor intake and output, especially bowel movements. Most of the depressed clients are constipated. If this problem is not addressed, it can lead to fecal impaction. Encourage the intake of nonalcoholic and non-caffeinated fluids, 6 to 8 glasses a day. Fluids can help prevent constipation. Offer fiber-rich foods and periods of exercise. Roughage and exercise stimulate peristalsis and help evacuation of fecal material.
- **Option C:** Provide rest periods after activities. Fatigue can intensify feelings of depression. Encourage relaxation measures in the evening (e.g., drinking warm milk, back rub, or tepid bath). These measures induce sleep and relaxation. Encourage the client to get up and dress and to stay out of bed during the day. Minimizing sleep during the day increases the likelihood of sleep at night. Reduce environmental and physical stimulants in the evening; Provide decaffeinated coffee, soft music, soft lights, and quiet activities.

**81. Clients should be taught that repeatedly ignoring the sensation of needing to defecate could result in which of the following?**

- A. Constipation
- B. Diarrhea
- C. Incontinence
- D. Hemorrhoids

**Correct Answer: A. Constipation**

Habitually ignoring the urge to defecate can lead to constipation through loss of the natural urge and the accumulation of feces. Functional constipation is a prevalent condition in childhood, about 29.6% worldwide. In the United States, it represents 3% to 5% of pediatric visits and a considerable annual health care cost. Most children do not have an etiological factor, and one third continue to have problems beyond adolescence.

- **Option B:** Diarrhea will not result-if anything, there is increased opportunity for water reabsorption because the stool remains in the colon, leading to firmer stool. Diarrhea is described as three or more loose or watery stools a day. Infection commonly causes acute diarrhea. Noninfectious etiologies are more common as the duration of diarrhea becomes chronic. Treatment and

management are based on the duration and specific etiology.

- **Option C:** Ignoring the urge shows a strong voluntary sphincter, not a weak one that could result in incontinence. Fecal incontinence (FI) is the involuntary passage of fecal matter through anus or inability to control the discharge of bowel contents. Its severity can range from an involuntary passage of flatus to complete evacuation of fecal matter. Depending on the severity of the disease, it has a significant impact on a patient's quality of life
- **Option D:** Hemorrhoids would only occur only if severe drying out of the stool occurs, and thus repeated need to strain to pass stool. Hemorrhoids are rich in vascular supply and have a tendency to engorge and prolapse. Symptoms can vary from mild itching, bleeding to severe pain. Unfortunately, because of the location, many patients never seek treatment for fear of embarrassment.

**82. Nurse Michelle should know that the drainage is normal four (4) days after a sigmoid colostomy when the stool is:**

- A. Green liquid
- B. Solid formed
- C. Loose, bloody
- D. Semiformed

**Correct Answer: C. Loose, bloody**

Normal bowel function and soft-formed stool usually do not occur until around the seventh day following surgery. The stool consistency is related to how much water is being absorbed.

- **Option A:** Food, medicines, and other things ingested can affect the consistency or color of the stool.
- **Option B:** A formed stool may occur a week after the surgery.
- **Option D:** The stool from a colostomy can be thin or thick liquid, or semiformed.

**83. Which of the following classes of medications maximizes cardiac performance in clients with heart failure by increasing ventricular contractility?**

- A. Beta-adrenergic blockers
- B. Calcium channel blockers
- C. Diuretics
- D. Inotropic agents

**Correct Answer: D. Inotropic agents**

Inotropic agents are administered to increase the force of the heart's contractions, thereby increasing ventricular contractility and ultimately increasing cardiac output. Inotropic agents such as milrinone, digoxin, dopamine, and dobutamine are used to increase the force of cardiac contractions. Intravenous positive inotropic agents should only be used in inpatient settings — and then only in patients who manifest signs and symptoms of low cardiac output syndrome (volume overload with evidence of organ hypoperfusion).

- **Option A:** The catecholamines, epinephrine, and norepinephrine bind to B1 receptors and increase cardiac automaticity as well as conduction velocity. B1 receptors also induce renin release, and this leads to an increase in blood pressure. In contrast, binding to B2 receptors causes relaxation of the smooth muscles along with increased metabolic effects such as glycogenolysis.
- **Option B:** Calcium channel antagonists block the inward movement of calcium by binding to the L-type “long-acting” voltage-gated calcium channels in the heart, vascular smooth muscle, and pancreas. The non-dihydropyridines have inhibitory effects on the sinoatrial (SA), and atrioventricular (AV) nodes are resulting in a slowing of cardiac conduction and contractility.
- **Option C:** They act by diminishing sodium reabsorption at different sites in the nephron, thereby increasing urinary sodium and water losses. The second class of diuretics, sometimes termed aquaretics, instead inhibit water reabsorption by blocking vasopressin receptors along the connecting tubule and collecting duct.

**84. A nurse is assisting with caloric testing of the oculovestibular reflex of an unconscious client. Cold water is injected into the left auditory canal. The client exhibits eye conjugate movements toward the left followed by a rapid nystagmus toward the right. The nurse understands that this indicates the client has:**

- A. A cerebral lesion
- B. A temporal lesion
- C. An intact brainstem
- D. Brain death

**Correct Answer: C. An intact brainstem**

Caloric testing provides information about differentiating between cerebellar and brainstem lesions. After determining patency of the ear canal, cold or warm water is injected in the auditory canal. A normal response that indicates intact function of cranial nerves III, IV, and VIII is conjugate eye movements toward the side being irrigated, followed by rapid nystagmus to the opposite side. Absent or disconjugate eye movements indicate brainstem damage.

- **Option A:** Caloric testing is clinically useful as a bedside test to isolate the peripheral vestibular system and rule out central etiology of vertigo. When there is a high suspicion for a peripheral lesion, bi-thermal caloric testing is typically performed. However, in cases in which there is a low pretest probability, it can be appropriate only to utilize mono thermal caloric testing and stop when the test is negative or in other words, responses are symmetric (therefore likely indicating a central process).
- **Option B:** The advantage caloric testing has over other studies, such as the vestibular evoked myogenic potential and video head impulse test, is that it does not require head movement to be conducted, rendering better patient compliance in those patients whose symptoms worsen with movement, as well as in patients with limited cervical mobility.
- **Option D:** Another indication for the use of this test is for brain stem testing in comatose patients. As described above, the reflex arc requires an intact brain stem, and therefore lack of nystagmus could indicate a brainstem lesion.

**85. Which of the following outcome criteria is appropriate for the client with dementia?**



- A. The client will return to an adequate level of self-functioning.
- B. The client will learn new coping mechanisms to handle anxiety.
- C. The client will seek out resources in the community for support.
- D. The client will follow an establishing schedule for activities of daily living.

**Correct Answer: D. The client will follow an establishing schedule for activities of daily living.**

Following established activity schedules is a realistic expectation for clients with dementia. Frequently orient the client to reality and surroundings. Allow the client to have familiar objects around him or her; use other items, such as a clock, a calendar, and daily schedules, to assist in maintaining reality orientation. Teach prospective caregivers how to orient the client to time, person, place, and circumstances, as required. These caregivers will be responsible for client safety after discharge from the hospital.

- **Option A:** Assess and identify the patient's previous history of grooming and bathing, and attempt to maintain similar care. This promotes familiarity with routine bathing time and type of bath or shower and lessens further confusion and agitation. Instruct the patient in activity with a short step-by-step method; do not rush the patient. This promotes self-esteem and feelings of accomplishment; rushing the patient causes frustration.
- **Option B:** Assist in defining problems and use of techniques to cope and solve problems. This provides support for problem solving and management of the family's fatigue and chronic stress. Provide an opportunity for the family to express concerns and lack of control of the situation to provide an opportunity for the family to express concerns and lack of control of the situation.
- **Option C:** All of the remaining outcome statements require a higher level of cognitive ability than can be realistically expected of clients with this disorder. Identify possible support systems and ability to participate in social activities. Community resources are available for clients and families dealing with stages of AD that provide information and assistance. Provide diversional activities as appropriate for functional ability. Provide rest and sleep periods; avoid situations that cause frustration, agitation, or sensory overload.

**86. A 6-year-old child, who has recently moved to a high-altitude region with his family, has been diagnosed with cystic fibrosis. The parents bring him to a pediatric clinic for an initial assessment and are concerned about how the altitude might impact his condition. They also mention that he has been more active and playing outside with new friends. Considering the early stage of this disease and the child's recent environmental changes, which later-stage symptom associated with cystic fibrosis would the nurse NOT expect to observe at this time?**

- A. Positive sweat test
- B. Bulky greasy stools
- C. Moist, productive cough
- D. Meconium ileus
- E. Clubbing of the fingers and toes
- F. Shortness of breath after mild activity

**Correct Answer: C. Moist, productive cough**

Cystic fibrosis is a progressive genetic disorder that affects the respiratory and digestive systems. A moist, productive cough is a symptom that typically develops in the later stages of the disease as the lungs become more affected by thick mucus secretions. In the early stages of cystic fibrosis, symptoms like a positive sweat test, bulky greasy stools, and meconium ileus (in newborns) are more common. While clubbing of the fingers and toes and shortness of breath can also be seen in later stages, the moist, productive cough is a hallmark later-stage symptom that would not be expected in a 6-year-old with a recent diagnosis. Respiratory failure is the most dangerous complication of CF.

**87. What is the priority nursing diagnosis with your patient diagnosed with end-stage renal disease?**

- A. Activity intolerance
- B. Fluid volume excess
- C. Knowledge deficit
- D. Pain

**Correct Answer: B. Fluid volume excess**

Fluid volume excess because the kidneys aren't removing fluid and wastes. The other diagnoses may apply, but they don't take priority. Renal disorder impairs glomerular filtration that results in fluid overload. With fluid volume excess, hydrostatic pressure is higher than the usual pushing excess fluids into the interstitial spaces.

- **Option A:** Schedule care and provide rest periods following an activity; allow the client to set own limits in the amount of exertion tolerated. Promotes autonomy and control of situations as the presence of a chronic disease may encourage independence.
- **Option C:** Review disease process and prognosis and future expectations. Provides a knowledge base from which the patient can make informed choices. If fluid overload is present, diuretic therapy or dialysis will be part of the regimen.
- **Option D:** Perform a comprehensive assessment of pain (location, onset, characteristics, and frequency) to be able to compare changes from previous reports to rule out worsening of underlying condition/developing complications.

**88. A client with Type II diabetes has an order for regular insulin 10 units SC each morning. The client's breakfast should be served within:**

- A. 15 minutes
- B. 20 minutes
- C. 30 minutes
- D. 45 minutes

**Correct Answer: C. 30 minutes**

- **Option C:** The client's breakfast should be served within 30 minutes to coincide with the onset of the client's regular insulin.

**89. Which of the following conditions is associated with elevated serum chloride levels?**

- A. Cystitis
- B. Diabetes
- C. Eclampsia
- D. Hypertension

**Correct Answer: C. Eclampsia**

Eclampsia is associated with increased levels of serum chloride. Metabolic alkalosis is uncommon in pregnancy and is most often the result of severe vomiting. If this is present at the time of delivery, transient metabolic derangement in the fetus can occur, potentially requiring additional organ support.

- **Option A:** Urinalysis, when indicated, is the most important laboratory test in the diagnosis of UTI. Pyuria, which is the presence of at least 10 WBCs or leukocytes in an unspun midstream urine specimen, is almost always present. They detect the presence of leukocyte esterase, an enzyme produced by leukocytes, and nitrite, which is indicative of the presence of Enterobacteriaceae.
- **Option B:** Present study showed the importance of measuring serum electrolytes in patients with type 2 diabetes mellitus. As fasting blood glucose rises, electrolytes mainly sodium, chloride, and potassium become more deranged significantly. Also, raised fasting blood glucose worsens renal function, as shown by an increase in microalbumin levels in urine.
- **Option D:** Among the environmental factors that affect blood pressure, dietary sodium chloride has been studied the most, and there is general consensus that increased sodium chloride intake increases blood pressure. The role for NaCl is supported by insights from the pressure-natriuresis mechanism, monogenic forms of hypertension, and dietary salt reduction studies.

**90. Albert, who suffered severe burns 6 months ago, is expressing concern about the possible loss of job-performance abilities and physical disfigurement. Which intervention is the most appropriate for him?**

- A. Referring the client for counseling and occupational therapy.
- B. Staying with the client as much as possible and building trust.
- C. Providing cutaneous stimulation and pharmacologic therapy.
- D. Providing distraction and guided imagery techniques.

**Correct Answer: A. Referring the client for counseling and occupational therapy**

Because it has been 6 months, the client needs professional help to get on with life and handle the limitations imposed by the current problems. Staying with the client, building trust, and providing methods of pain relief, such as cutaneous stimulation, medications, distraction, and guided imagery interventions, would have been more appropriate in earlier stages of postburn injury when physical pain was most severe and fewer psychological factors needed to be addressed.

- **Option B:** Explain to the patient what happened. Provide opportunities for questions and give honest answers. Compassionate statements reflecting the reality of the situation can help the patient and SO acknowledge that reality and begin to deal with what has happened.
- **Option C:** The burned patient may require around-the-clock medication and dose titration. IV method is often used initially to maximize drug effect. Concerns of patient addiction or doubts

regarding the degree of pain experienced are not valid during the emergent/acute phase of care, but narcotics should be decreased as soon as feasible and alternative methods for pain relief initiated.

- **Option D:** Encourage use of stress management techniques: progressive relaxation, deep breathing, guided imagery, and visualization. Refocuses attention, promotes relaxation, and enhances the sense of control, which may reduce pharmacological dependency.

**91. Ivy, who is in the psychiatric unit is copying and imitating the movements of her primary nurse. During recovery, she says, “I thought the nurse was my mirror. I felt connected only when I saw my nurse.” This behavior is known by which of the following terms?**

- A. Modeling
- B. Echopraxia
- C. Ego-syntonicity
- D. Ritualism

**Correct Answer: B. Echopraxia**

Echopraxia is the copying of another's behaviors and is the result of the loss of ego boundaries. The involuntary imitation of the movements of another person. Echopraxia is a feature of schizophrenia (especially the catatonic form), Tourette syndrome, and some other neurologic diseases. From echo + the Greek praxia meaning action.

- **Option A:** Modeling is the conscious copying of someone's behaviors. Modeling is one way in which behavior is learned. When a person observes the behavior of another and then imitates that behavior, he or she is modeling the behavior. This is sometimes known as observational learning or social learning. Modeling is a kind of vicarious learning in which direct instruction need not occur.
- **Option C:** Ego-syntonicity refers to behaviors that correspond with the individual's sense of self. Thoughts, wishes, impulses, and behavior are said to be ego-syntonic when they form no threat to the ego and can be acted upon without interference from the superego.
- **Option D:** Ritualism behaviors are repetitive and compulsive. Ritualism is a concept developed by American sociologist Robert K. Merton as a part of his structural strain theory. It refers to the common practice of going through the motions of daily life even though one does not accept the goals or values that align with those practices.

**92. The nurse is aware that the following solutions are routinely used to flush an IV device before and after the administration of blood to a patient is:**

- A. 0.9 percent sodium chloride.
- B. 5 percent dextrose in water solution.
- C. Sterile water.
- D. Heparin sodium.

**Correct Answer: A. 0.9 percent sodium chloride**

0.9 percent sodium chloride is normal saline. This solution has the same osmolarity as blood. Its use prevents red cell lysis. The solutions given in options 2 and 3 are hypotonic solutions and can cause red cell lysis. An isotonic concentration of sodium chloride, which is best suited for parenteral replacement of chloride losses that exceed or equal the sodium loss. Within each 100 mL of 0.9% sodium chloride Injection USP, there is 154 mEq of sodium ions and 154 mEq of chloride ions. Additionally, the osmolarity is 308 mOsmol/liter and a pH range of 4.5 to 7.

- **Option B:** A crystalloid fluid is an aqueous solution of mineral salts and other small, water-soluble molecules. Most commercially available crystalloid solutions are isotonic to human plasma. These fluids approximate concentrations of various solutes found in plasma and do not exert an osmotic effect in vivo. Crystalloid fluids function to expand intravascular volume without disturbing ion concentration or causing significant fluid shifts between intracellular, intravascular, and interstitial spaces.
- **Option C:** Sterile water contains water that is sterilized and packaged for use as an irrigant. No antimicrobial agent or other substance has been added. The pH is 5.5 (5.0 to 7.0). Sterile Water for Irrigation is hypotonic with an osmolarity of zero mOsmol/L.
- **Option D:** Heparin sodium affects the patient coagulation and result in bleeding. Once administered, heparin binds to several proteins; however, it is binding to antithrombin that is important, as this causes a surface change and inactivates thrombin. By binding to antithrombin, it blocks several different factors of the clotting cascade, but two are predominant: thrombin (Factor IIa) and Factor Xa. By inactivating thrombin, it blocks the conversion of fibrinogen to fibrin; this prevents the formation of clots and prolongs the clotting time of blood. Heparin does not affect bleeding time, but it does prolong the time that blood takes to clot.

### **93. Pediculicides are used to treat which of the following disorders?**

- A. Scabies
- B. Fungal infections
- C. Viral infections
- D. Head lice

#### **Correct Answer: D. Head lice**

Pediculicides are an effective treatment for head lice. An anti-parasite medication used to treat head lice, onchocerciasis, strongyloidiasis, ascariasis, trichuriasis, and enterobiasis.

- **Option A:** Scabicides are used to treat scabies. Products used to treat scabies are called scabicides because they kill scabies mites; some also kill mite eggs. Scabicides used to treat human scabies are available only with a doctor's prescription. No "over-the-counter" (non-prescription) products have been tested and approved to treat scabies.
- **Option B:** Antifungals are used to treat fungal infections. An antifungal medication, also known as an antimycotic medication, is a pharmaceutical fungicide or fungistatic used to treat and prevent mycosis such as athlete's foot, ringworm, candidiasis (thrush), serious systemic infections such as cryptococcal meningitis, and others.
- **Option C:** Antivirals are used to treat viral infections. Antivirals are medications that reduce the ability of flu viruses to multiply. The CDC considers antiviral drugs as a "second line of defense against the flu." The first line of defense is getting an annual flu vaccine. When taken at the onset of flu, these drugs help decrease the severity and duration of flu symptoms.

**94. A male client is admitted for treatment of glomerulonephritis. On initial assessment, Nurse Miley detects one of the classic signs of acute glomerulonephritis of sudden onset. Such signs include:**

- A. Generalized edema, especially of the face and periorbital area.
- B. Green-tinged urine.
- C. Moderate to severe hypotension.
- D. Polyuria.

**Correct Answer: A. Generalized edema, especially of the face and periorbital area.**

Generalized edema, especially of the face and periorbital area, is a classic sign of acute glomerulonephritis of sudden onset. Other classic signs and symptoms of this disorder include hematuria (not green-tinged urine), proteinuria, fever, chills, weakness, pallor, anorexia, nausea, and vomiting. The client also may have moderate to severe hypertension (not hypotension), oliguria or anuria (not polyuria), headache, reduced visual acuity, and abdominal or flank pain.

- **Option B:** Acute glomerulonephritis is defined as inflammation and subsequent damage of the glomeruli leading to hematuria, proteinuria, and azotemia; it may be caused by primary renal disease or systemic conditions. The diagnosis of acute glomerulonephritis is usually made on the basis of urinary findings, especially the presence of red blood cell casts.
- **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.
- **Option D:** Most intrinsic causes of acute glomerulonephritis fall under the classification of nephritic syndromes. Nephritic syndromes are classified by hematuria, proteinuria, and red blood cell casts with hypertension and decreased urine production.

**95. After receiving an oral dose of codeine for an intractable cough, the male client asks the nurse, “How long will it take for this drug to work?” How should the nurse respond?**

- A. In 30 minutes
- B. In 1 hour
- C. In 2.5 hours
- D. In 4 hours

**Correct Answer: A. In 30 minutes**

Codeine's onset of action is 30 minutes. Within the nervous system, activation of mu receptors in the midbrain is the dominant mechanism of opioid-induced analgesia. The cough reflex primarily gets mediated through the opioid receptors present in the medulla.

- **Option B:** Its peak concentration occurs in about 1 hour. In patients who are on around-the-clock continuous codeine with breakthrough pain, short-acting opioids may be an option. The dose can vary from 15 mg to 120 mg a day. It is, however, indicated in the management of prolonged cough (in specific populations like lung cancer) usually as 30 mg every 4 to 6 hours as needed.

- **Option C:** Its half-life, in 2.5 hours. Initial dosing and titration can be individualized depending on the patient's health status, previous opioid exposure, attainment of therapeutic outcomes, and predicted or observed adverse events.
- **Option D:** Its duration of action is 4 to 6 hours. Codeine is useful in the treatment of various etiologies producing chronic cough. Also, 46% of patients with chronic cough do not have a distinct etiology despite a proper diagnostic evaluation. Codeine produces a decrease in cough frequency and severity in these patients.

**96. A pediatric client with burns to the hands and arms has dressing changes with Sulfamylon (mafenide acetate) cream. The nurse is aware that the medication:**

- A. Will cause gray staining on the surrounding skin
- B. Produces a cooling sensation when applied
- C. Produces a burning sensation when applied
- D. Will cause unusual hair growth in the treated areas

**Correct Answer: C. Produces a burning sensation when applied**

- Option C: Sulfamylon is a topical agent indicated for patients with a second and third-degree burn. It produces a painful burning sensation upon application so the client should receive pain medication 30 minutes before the application.
- Option A: Gray or blue-black discoloration of the skin is a side effect of repeated application of silver nitrate.
- Option B: The cooling sensation is associated with the application of Silvadene.
- Option D: Unusual hair growth is related to the chronic application of topical steroids.

**97. Your patient's ABG reveals an acidic pH, an acidic CO<sub>2</sub>, and a normal bicarbonate level. Which of the following indicates this acid-base disturbance?**

- A. Respiratory acidosis
- B. Respiratory alkalosis
- C. Metabolic acidosis
- D. Metabolic alkalosis

**Correct Answer: A. Respiratory acidosis**

A pH of 7.35 indicates acidosis, as does an acidic CO<sub>2</sub> and bicarbonate. The primary disturbance of elevated arterial PCO<sub>2</sub> is the decreased ratio of arterial bicarbonate to arterial PCO<sub>2</sub>, which leads to a lowering of the pH. In the presence of alveolar hypoventilation, 2 features commonly are seen are respiratory acidosis and hypercapnia. To compensate for the disturbance in the balance between carbon dioxide and bicarbonate (HCO<sub>3</sub><sup>-</sup>), the kidneys begin to excrete more acid in the forms of hydrogen and ammonium and reabsorb more base in the form of bicarbonate. See also: 8-Step Guide to ABG Analysis: Tic-Tac-Toe Method

- **Option B:** Respiratory alkalosis is 1 of the 4 basic classifications of blood pH imbalances. Normal human physiological pH is 7.35 to 7.45. A decrease in pH below this range is acidosis, an increase

above this range is alkalosis. Respiratory alkalosis is by definition a disease state where the body's pH is elevated to greater than 7.45 secondary to some respiratory or pulmonary process.

- **Option C:** Determining the type of metabolic acidosis can help clinicians narrow down the cause of the disturbance. Acidemia refers to a pH less than the normal range of 7.35 to 7.45. In addition, metabolic acidosis requires a bicarbonate value less than 24 mEq/L. Further classification of metabolic acidosis is based on the presence or absence of an anion gap, or concentration of unmeasured serum anions.
- **Option D:** HCO<sub>3</sub> functions as an alkalotic substance. CO<sub>2</sub> functions as an acidic substance. Therefore, increases in HCO<sub>3</sub> or decreases in CO<sub>2</sub> will make blood more alkalotic. The opposite is also true where decreases in HCO<sub>3</sub> or an increase in CO<sub>2</sub> will make blood more acidic. CO<sub>2</sub> levels are physiologically regulated by the pulmonary system through respiration, whereas the HCO<sub>3</sub> levels are regulated through the renal system with reabsorption rates. Therefore, metabolic alkalosis is an increase in serum HCO<sub>3</sub>.

**98. Nurse Kim is teaching a group of parents about otitis media. When discussing why children are predisposed to this disorder, the nurse should mention the significance of which anatomical feature?**

- A. Eustachian tubes
- B. Nasopharynx
- C. Tympanic membrane
- D. External ear canal

**Correct Answer: A. Eustachian tubes**

In a child, Eustachian tubes are short and lie in a horizontal plane, promoting entry of nasopharyngeal secretions into the tubes and thus setting the stage for otitis media. Due to the constricted anatomical space of the middle ear, the edema caused by the inflammatory process obstructs the narrowest part of the Eustachian tube leading to a decrease in ventilation.

- **Option B:** Otitis media begins as an inflammatory process following a viral upper respiratory tract infection involving the mucosa of the nose, nasopharynx, middle ear mucosa, and Eustachian tubes.
- **Option C:** The growth of microbes in the middle ear then leads to suppuration and eventually frank purulence in the middle ear space. This is demonstrated clinically by a bulging or erythematous tympanic membrane and purulent middle ear fluid.
- **Option D:** The external ear canal has no unusual features that would predispose a child to otitis media. Acute otitis media is defined as an infection of the middle ear space. In AOM, the TM may be erythematous or normal, and there may be fluid in the middle ear space.

**99. The physician orders laboratory tests to confirm hyperthyroidism in a female client with classic signs and symptoms of this disorder. Which test result would confirm the diagnosis?**

- A. No increase in the thyroid-stimulating hormone (TSH) level after 30 minutes during the TSH stimulation test.
- B. A decreased TSH level.



- C. An increase in the TSH level after 30 minutes during the TSH stimulation test.
- D. Below-normal levels of serum triiodothyronine (T3) and serum thyroxine (T4) as detected by radioimmunoassay.

**Correct Answer: A. No increase in the thyroid-stimulating hormone (TSH) level after 30 minutes during the TSH stimulation test**

In the TSH test, failure of the TSH level to rise after 30 minutes confirms hyperthyroidism.

- **Option B:** A decreased TSH level indicates a pituitary deficiency of this hormone.
- **Option C:** If the TSH level rises after 30 minutes, then the client has no hyperthyroidism.
- **Option D:** Below-normal levels of T3 and T4, as detected by radioimmunoassay, signal hypothyroidism. A below-normal T4 level also occurs in malnutrition and liver disease and may result from the administration of phenytoin and certain other drugs.

**100. Nurse Davis is preparing an anatomy and physiology lecture for a group of first-year nursing students. As part of the skeletal system discussion, she presents a contrast between the bones of the limbs and other bones in the body. She poses the following question: “While most bones of the upper and lower limbs are categorized as long bones, how would you categorize the sacrum and facial bones?”**

- A. Irregular bones
- B. Flat bones
- C. Short bones
- D. Sesamoid bones

**Correct Answer: A. Irregular bones**

Irregular bones vary in shape and structure and therefore do not fit into any other category (flat, short, long, or sesamoid). Examples are the irregular bones of the vertebral column, bones of the pelvis (pubis, ilium, and ischium) and facial bones.

- **Option B:** Flat bones have relatively thin, flattened shape. Examples are the ribs, scapulae, and the sternum.
- **Option C:** Short bones are approximately as broad as they are long, such as the bones of the wrist and ankles.
- **Option D:** Sesamoid bones are bones embedded in tendons. These small, round bones are commonly found in the tendons of the hands, knees, and feet.