

Kevin's Review - 100 NCLEX Practice Questions

1. A week after kidney transplantation the client develops a temperature of 101, the blood pressure is elevated, and the kidney is tender. The X-ray results show the transplanted kidney is enlarged. Based on these assessment findings, the nurse would suspect which of the following?

- A. Acute rejection
- B. Chronic rejection
- C. Kidney infection
- D. Kidney obstruction

Correct Answer: A. Acute rejection

Acute rejection most often occurs in the first two (2) weeks after transplant. Clinical manifestations include fever, malaise, elevated WBC count, acute hypertension, graft tenderness, and manifestations of deteriorating renal function. It is related to preexisting circulating antibodies in the recipient's blood against the donor antigen (usually ABO blood group or HLA antigen), which is present at the time of transplantation. These antibodies attack and destroy the transplanted organ as soon as or within a few hours after allograft is revascularized.

- **Option B:** Chronic rejection occurs gradually during a period of months to years. Chronic rejection is related to both immune and nonimmune mediated factors. The primary risk factor for chronic rejection is non-compliance with immunosuppressive medication. It can be either chronic antibody-mediated rejection, which is mainly related to the presence of donor HLA-antigens donor Specific Antibody (DSA) or Chronic cellular rejection, which is uncommon.
- **Option C:** Kidney infection (pyelonephritis) is a type of urinary tract infection (UTI) that generally begins in the urethra or bladder and travels to one or both of the kidneys. A kidney infection requires prompt medical attention. If not treated properly, a kidney infection can permanently damage the kidneys or the bacteria can spread to the bloodstream and cause a life-threatening infection.
- **Option D:** Although kidney obstruction can occur, the symptoms presented in the question do not relate specifically to these disorders. The most common cause for blockage is a kidney stone, but scarring and blood clots can also cause acute unilateral obstructive uropathy. A blocked ureter can cause urine to go back up into the kidney, which causes swelling. This backflow of urine is known as vesicoureteral reflux (VUR).

2. A 16-year-old is admitted to the hospital for acute appendicitis, and an appendectomy is performed. Which of the following nursing interventions is most appropriate to facilitate normal growth and development?

- A. Allow the family to bring in the child's favorite computer games
- B. Encourage the parents to room-in with the child
- C. Encourage the child to rest and read
- D. Allow the child to participate in activities with other individuals in the same age group when the condition permits

Correct Answer: D. Allow the child to participate in activities with other individuals in the same age group when the condition permits.

Adolescents often are not sure whether they want their parents with them when they are hospitalized. Because of the importance of the peer group, separation from friends is a source of anxiety. Ideally, the members of the peer group will support their ill friend.

- **Option A:** Adolescents love computer games, however, peer groups and spending time with friends is extremely important. Self-esteem is largely influenced by peer acceptance.
- **Option B:** Having the parent's room-in is more appropriate with a toddler or preschooler because they have a fear of separation. Going to the hospital can be overwhelming, boring, and frustrating for children. It's normal for children to behave in some unexpected ways.
- **Option C:** Reading a book while in the hospital may be appropriate, but this can isolate the child from the peer group. Set up ways for the child to keep in contact with family, friends, and schoolmates. This can be done by asking people to visit, letting the child use email or social media to keep in touch, or setting up video calls.

3. The spouse of a client admitted to the mental health unit for alcohol withdrawal says to the nurse "I should get out of this bad situation." The most helpful response by the nurse would be:

- A. "I agree with you. You should get out of this situation."
- B. "What do you find difficult about this situation?"
- C. "Why don't you tell your husband about this?"
- D. "This is not the best time to make that decision."

Correct Answer: B. "What do you find difficult about this situation?"

The most helpful response is one that encourages the client to problem solve. Giving advice implies that the nurse knows what is best and can foster dependency. Develop a trusting relationship through frequent contact being honest and nonjudgmental. Project an accepting attitude about alcoholism. Provides the patient with a sense of humanness, helping to decrease paranoia and distrust. The patient will be able to detect biased or condescending attitudes of caregivers.

- **Option A:** Determine the cause of anxiety, involving the patient in the process. Explain that alcohol withdrawal increases anxiety and uneasiness. Reassess level of anxiety on an ongoing basis. Person in an acute phase of withdrawal may be unable to identify and accept what is happening. Anxiety may be physiologically or environmentally caused. Continued alcohol toxicity will be manifested by increased anxiety and agitation as effects of the medication wear off.
- **Option C:** The nurse should not agree with the client, nor should the nurse request that the client provide explanations. Inform the patient about what you plan to do and why. Include the patient in the planning process and provide choices when possible. Enhances sense of trust, and explanation may increase cooperation and reduce anxiety. Provides a sense of control over self in circumstances where loss of control is a significant factor. Note: Feelings of self-worth are intensified when one is treated as a worthwhile person.
- **Option D:** Reorient frequently to person, place, time, and surrounding environment as indicated; may reduce confusion, prevent and limit misinterpretation of external stimuli. Avoid bedside discussion about the patient or topics unrelated to the patient that do not include the patient. Provide a calm environment, minimizing noise and shadows.

4. In pediatric gastroesophageal reflux disease (GERD), the immaturity of lower esophageal sphincter function is manifested by frequent transient lower esophageal relaxations, which result in retrograde flow of gastric contents into the esophagus. Which statement about the esophagus is true? Select all that apply.

- A. It is a cartilaginous tube.
- B. It has upper and lower sphincters.
- C. It lies anterior to the trachea.
- D. It extends from the nasal cavity to the stomach.
- E. It is a highway for food and drinks to travel along to make it to the stomach.
- F. All statements describe the esophagus.

Correct Answer: B & E

Upper and lower esophageal sphincters, located at the upper and lower ends of the esophagus, respectively, regulate the movement of food into and out of the esophagus. If the mouth is the gateway to the body, then the esophagus is a highway for food and drink to travel along to make it to the stomach.

- **Option A:** The esophagus is a muscular tube, lined with moist stratified squamous epithelium. The esophagus is a muscular channel that carries food from the pharynx to the stomach. It starts with the upper esophageal sphincter, formed in part by the cricopharyngeus muscle, and ends with the lower esophageal sphincter, surrounded by the crural diaphragm.
- **Option C:** It lies anterior to the vertebrae and posterior to the trachea within the mediastinum. Additionally, the trachea and the diaphragm closely neighbor the esophagus, with the former being anterior to it and the latter surrounding the LES through its crural part.
- **Option D:** It extends from the pharynx to the stomach. It is about 25 centimeters (cm) long. The esophagus serves as a conduit for the transportation of a bolus from the pharynx to the stomach. Thus, events occurring upstream, in the mouth, and downstream, in the stomach impact the esophagus.

5. The nurse knows that the physician has ordered the liquid form of the drug chlorpromazine (Thorazine) rather than the tablet form because the liquid:

- A. Has a more predictable onset of action.
- B. Produces fewer anticholinergic effects.
- C. Produces fewer drug interactions.
- D. Has a longer duration of action.

Correct Answer: A. Has a more predictable onset of action.

A liquid phenothiazine preparation will produce effects in 2 to 4 hours. The onset of tablets is unpredictable. If your medicine comes in a dropper bottle, measure each dose with the special dropper provided with your prescription and dilute it in a small glass (4 ounces) of orange or grapefruit juice or water just before taking it. The dose medicines in this class will be different for different patients. Follow your doctor's orders or the directions on the label. The following information includes only the average

doses of these medicines. If your dose is different, do not change it unless your doctor tells you to do so.

- **Option B:** Before using any prescription or over-the-counter (OTC) medicine for colds or allergies, check with your doctor. These medicines may increase the chance of developing heatstroke or other unwanted effects, such as dizziness, dry mouth, blurred vision, and constipation, while you are taking a phenothiazine.
- **Option C:** Certain medicines should not be used at or around the time of eating food or eating certain types of food since interactions may occur. Using alcohol or tobacco with certain medicines may also cause interactions to occur. Discuss with your healthcare professional the use of your medicine with food, alcohol, or tobacco.
- **Option D:** The amount of medicine that you take depends on the strength of the medicine. Also, the number of doses you take each day, the time allowed between doses, and the length of time you take the medicine depend on the medical problem for which you are using the medicine.

6. A nurse provides medication instructions to a first-time mother. Which statement made by the mother indicates a need for further instructions?

- A. "I should mix the medication in the baby food and give it when I feed the child".
- B. "I should administer the oral medication sitting in an upright position and with the head elevated".
- C. "I will give my child a toy after giving the medication".
- D. "I will offer my child a juice drink after swallowing the medication".

Correct Answer: A. "I should mix the medication in the baby food and give it when I feed the child".

The nurse would teach the mother to avoid putting medications in foods because it may cause an unpleasant taste to the food, and the child may refuse to accept the same food in the future. Additionally, the child may not consume the entire serving and would not require medication dosage.

- **Option B:** Administering the medication in an upright position and head elevation will prevent the risk of aspiration. Do not squirt medicine directly at the back of the baby's throat. This may cause the child to choke.
- **Option C:** Offering a toy will provide comfort measures to the child. Praise the child every time he takes the medicine without a struggle. (Giving a special sticker works well for some children.)
- **Option D:** The mother should offer drinks such as juice or a soft drink to lessen the aftertaste of the medication. Some medicines can be put in a small amount of juice or sugar water. Follow the instructions from the doctor, nurse, or pharmacist. Do not put medicine in a full bottle or cup in case the infant does not drink very much.

7. All of which are examples of antiviral influenza medications except?

- A. baloxavir marboxil (Xofluza)
- B. ethionamide (Trecator)
- C. oseltamivir (Tamiflu)
- D. zanamivir (Relenza)

Correct Answer: B. ethionamide (Trecator)

Ethionamide (Trecator) is an antibiotic used in the treatment of tuberculosis.

- **Options A, C, & D:** These are antiviral medications that are effective in the prevention and treatment of flu.

8. The nurse is caring for a client after a supratentorial craniotomy in which a large tumor was removed from the left side. Choose the positions in which the nurse can safely place the client. Select all that apply.

- A. On the left side
- B. With the neck flexed
- C. Supine on the left side
- D. With extreme hip flexion
- E. In a semi-Fowler's position
- F. With the head in a midline position

Correct Answer: E and F.

The postoperative course of clients undergoing surgery for cranial tumors depends on the extent and location of surgery, intraoperative issues and complications, and postoperative complications.

- **Option A:** If a large tumor has been removed, the client should be placed on the non-operative side to prevent the displacement of the cranial contents.
- **Option B:** Avoid extreme flexion of the upper legs or flexion of the neck. The nurse may place the patient on his side to promote airway and facilitate drainage of secretions.
- **Option C:** The HOB after supratentorial craniotomy should be at least at 30 degrees. Avoidance of prolonged pressure directly on the incision will prevent breakdown or added discomfort.
- **Option D:** Depending on the extent of surgery and immediate postoperative condition, the client may start mobilizing the following day, depending on age, but sitting up, sitting in a chair, standing, and eventually walking if able.
- **Option E:** Clients who have undergone supratentorial surgery should have the head of the bed elevated 30 degrees to promote venous drainage from the head.
- **Option F:** The client is positioned to avoid extreme hip or neck flexion, and the head is maintained in a midline, neutral position.

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

- A. The client remains free of the aftermath phase of the pain experience.
- B. The client experiences decreased frequency of acute pain episodes.
- C. The client continues normal growth and development with intact support systems.

D. The client develops increased tolerance for severe pain in the future.

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

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

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

10. Nikki reveals that the boyfriend has been pressuring her to engage in premarital sex. The most therapeutic response by the nurse is:

- A. "I can refer you to a spiritual counselor if you like."
- B. "You shouldn't allow anyone to pressure you into sex."
- C. "It sounds like this problem is related to your paralysis."
- D. "How do you feel about being pressured into sex by your boyfriend?"

Correct Answer: D. "How do you feel about being pressured into sex by your boyfriend?"

Focusing on the expression of feelings is therapeutic. The central force of the client's condition is anxiety. Focusing, an approach to therapeutic treatment in which the therapist works to help the individual in treatment gain awareness into their bodily felt sense, is meant to help people seeking treatment learn to direct their attention toward things they experience that are difficult to describe in a concrete way.

- **Option A:** This is not therapeutic because the nurse passes the responsibility to the counselor. Focusing can help people become reacquainted with internal awareness of their emotions, helping them become better able to more readily address them. Many of those who pursue focusing therapy or incorporate it into other treatment approaches find they can better describe what they feel and/or desire, cultivate independence from belief systems they no longer subscribe to, and experience greater success in therapy. People also report greater attentiveness in their lives, decreased tension and chronic pain, and increased decision-making and problem-solving abilities. Relationships and life experiences or situations may also be positively impacted.
- **Option B:** Giving advice is not therapeutic. Also influencing the approach is the concept that change is more than a verbal process. Often, the concepts and ideas addressed in therapy are emotions and feelings, things that often cannot be easily put into words. Though a person might be easily aware of these emotions, thoughts, and behaviors on a surface level of awareness, and may even experience some level of insight into them, focusing therapy aims to help them target the deeper "felt" sense. Practitioners of the approach believe that those who are able to access and

target this felt sense may be better able to achieve results in therapy, work through the issues concerning them, and produce a physical change in the body through the release of chronic tension.

- **Option C:** This is not therapeutic because it confronts the underlying cause. Grounded in the person-centered approach to treatment, focusing therapy holds that individuals possess within themselves the answers they are seeking and is founded on the concept that individuals know themselves better than a therapist could ever hope to. This “knowing” refers to the knowledge of the body (the body’s awareness), however, not the knowledge of the thinking brain. In focusing therapy, therapist and person in treatment work to reaffirm the bodily knowledge a person has and allow the body to steer a person within future situations.

11. Which of the following symptoms would you expect to a client with a phenytoin level of 35 mg/dL?

- A. Ataxia
- B. Potassium deficit
- C. Neglect syndrome
- D. Tetraplegia

Correct Answer: A. Ataxia

A therapeutic phenytoin level is 10 to 20 mg/dl. A level of 35 mg/dl signifies toxicity. Symptoms of this level of concentration include ataxia, tremor, slurred speech, nausea, and vomiting.

- **Options B, C, & D:** Phenytoin does not cause hypokalemia, neglect syndrome (client unaware of the existence of his or her paralyzed side), or tetraplegia (paralysis of all four extremities).

12. A client tells the nurse that people from Mars are going to invade the earth. Which response by the nurse would be most therapeutic?

- A. “That must be frightening to you. Can you tell me how you feel about it?”
- B. “There are no people living on Mars.”
- C. “What do you mean when you say they’re going to invade the earth?”
- D. “I know you believe the earth is going to be invaded, but I don’t believe that.”

Correct Answer: A. “That must be frightening to you. Can you tell me how you feel about it?”

This response addresses the client’s underlying fears without feeding the delusion. Attempt to understand the significance of these beliefs to the client at the time of their presentation. Important clues to underlying fears and issues can be found in the client’s seemingly illogical fantasies.

- **Option B:** Refuting the client’s delusion would increase anxiety and reinforce the delusion. Initially do not argue with the client’s beliefs or try to convince the client that the delusions are false and unreal. Arguing will only increase a client’s defensive position, thereby reinforcing false beliefs. This will result in the client feeling even more isolated and misunderstood.
- **Option C:** Asking the client to elaborate on the delusion would also reinforce it. Interact with clients on the basis of things in the environment. Try to distract the client from their delusions by engaging in reality-based activities (e.g., card games, simple arts and crafts projects, etc). When thinking is focused on reality-based activities, the client is free of delusional thinking during that time. Helps

focus attention externally.

- **Option D:** Voicing disbelief about the delusion wouldn't help the client deal with underlying fears. Show empathy regarding the client's feelings; reassure the client of your presence and acceptance. The client's delusion can be distressing. Empathy conveys your caring, interest, and acceptance of the client.

13. An elderly client with Alzheimer's disease becomes agitated and combative when a nurse approaches to help with morning care. The most appropriate nursing intervention in this situation would be to:

- A. Tell the client family that it is time to get dressed.
- B. Obtain assistance to restrain the client for safety.
- C. Remain calm and talk quietly to the client.
- D. Call the doctor and request an order for sedation.

Correct Answer: C. Remain calm and talk quietly to the client.

Maintaining a calm approach when intervening with an agitated client is extremely important. Divert attention to a client when agitated or dangerous behaviors like getting out of bed by climbing the fence bed. Eliminate or minimize sources of hazards in the environment. Maintain security by avoiding a confrontation that could improve the behavior or increase the risk for injury.

- **Option A:** Telling the client firmly that it is time to get dressed may increase his agitation, especially if the nurse touches him. Assess the degree of impaired ability of competence, emergence of impulsive behavior, and a decrease in visual perception. Impairment of visual perception increases the risk of falling. Identify potential risks in the environment and heighten awareness so that caregivers are more aware of the danger.
- **Option B:** Restraints are a last resort to ensure client safety and are inappropriate in this situation. Assess the patient's surroundings for hazards and remove them. AD decreases awareness of potential dangers, and disease progression coupled with a hazardous environments that could lead to accidents. Help the people closest to identify the risk of hazards that may arise. An impaired cognitive and perceptual disorder are beginning to experience the trauma as a result of the inability to take responsibility for basic security capabilities or evaluating a particular situation.
- **Option D:** Sedation should be avoided, if possible because it will interfere with CNS functioning and may contribute to the client's confusion. During the middle and later stages of AD, the patient must not be left unattended. Patients with AD have impaired thinking and cannot rationalize cause and effect. This can result in wandering outside without clothes on, exposure to extreme cold or heat, and may cause dehydration in the long run.

14. Which statement made by the client indicates that the mother understands the limitations of breastfeeding her newborn?

- A. "Breastfeeding my infant consistently every 3 to 4 hours stops ovulation and my period."
- B. "Breastfeeding my baby immediately after drinking alcohol is safer than waiting for the alcohol to clear my breast milk."
- C. "I can start smoking cigarettes while breastfeeding because it will not affect my breast milk."

D. "When I take a warm shower after I breastfeed, it relieves the pain from being engorged between breastfeedings."

Correct Answer: A. "Breastfeeding my infant consistently every 3 to 4 hours stops ovulation and my period."

Continuous breastfeeding on a 3- to 4-hour schedule during the day will cause a release of prolactin, which will suppress ovulation and menses, but is not completely effective as a birth control method.

- **Option B:** Drinking alcohol immediately before breastfeeding is incorrect because alcohol can immediately enter breast milk.
- **Option C:** Nicotine is transferred to the infant in breast milk
- **Option D:** Taking a warm shower will stimulate the production of milk, which will be more painful after breastfeedings

15. The nurse in-charge is reviewing a patient's prenatal history. Which finding indicates a genetic risk factor?

- A. The patient is 25 years old.
- B. The patient has a child with cystic fibrosis.
- C. The patient was exposed to rubella at 36 weeks' gestation.
- D. The patient has a history of preterm labor at 32 weeks' gestation.

Correct Answer: B. The patient has a child with cystic fibrosis

Cystic fibrosis is a recessive trait; each offspring has a one in four chance of having the trait or the disorder.

- **Option A:** Maternal age is not a risk factor until age 35, when the incidence of chromosomal defects increases.
- **Option C:** Maternal exposure to rubella during the first trimester may cause congenital defects.
- **Option D:** Although a history of preterm labor may place the patient at risk for preterm labor, it does not correlate with genetic defects.

16. The client is instructed regarding foods that are low in fat and cholesterol. Which diet selection is lowest in saturated fats?

- A. Macaroni and cheese
- B. Shrimp with rice
- C. Turkey breast
- D. Spaghetti

Correct Answer: C. Turkey breast

Turkey contains the least amount of fats and cholesterol. Both turkey and chicken are rich in high-quality protein. Chicken breast has slightly more protein than turkey breast, but turkey thigh is minimally higher in protein than chicken thigh. The other meat cuts provide equal amounts of protein.

- **Option A:** It's typically high in calories because it's made with pasta, cheese, cream, and butter, although the calorie content varies significantly between brands, ingredients, and serving size. Mac and cheese contain large amounts of fat and refined carbs, both of which contribute to its high calorie count. Eating more calories than you burn, regardless of which foods they come from, can lead to weight gain.
- **Option B:** White rice is highly processed and missing its hull (the hard protective coating), bran (outer layer), and germ (nutrient-rich core). Meanwhile, brown rice only has the hull removed. White rice is considered empty carbs since it loses its main sources of nutrients.
- **Option D:** Spaghetti is one of the most popular forms of pasta, and it's used in dishes all around the world. Most spaghetti is made from durum wheat, so it's high in complex carbohydrates and includes all the nutrients found in refined white flour. Liver, eggs, beef, cream sauces, shrimp, cheese, and chocolate should be avoided by the client. The client should bake meat rather than frying to avoid adding fat to the meat during cooking.

17. A 42-year-old man is recovering from a thoracic surgery that was performed to remove a lung nodule. The procedure went smoothly, but during his recovery, he expressed concerns about his lung's function and anatomy. Eager to understand more about the structure of his lungs and how it relates to his post-operative recovery, he initiates a conversation with the nurse. The nurse sees this as an opportunity to educate him about the respiratory system. After discussing the lungs' anatomical aspects, the nurse aims to assess his understanding by asking, "Considering what we discussed and keeping in mind the intricacies of the right lung, can you tell me: "The right lung has ___ lobes and ___ bronchopulmonary segments." Fill in the blanks.

- A. 2 lobes and 5 bronchopulmonary segments
- B. 3 lobes and 10 bronchopulmonary segments
- C. 1 lobe and 3 bronchopulmonary segments
- D. 4 lobes and 8 bronchopulmonary segments

Correct Answer: B. 3 lobes and 10 bronchopulmonary segments

The right lung is divided into three lobes: the upper, middle, and lower lobes. There are 10 bronchopulmonary segments in the right lung – 3 in the upper lobe, 2 in the middle lobe, and 5 in the lower lobe.

- **Option A:** Incorrect. The right lung does have more lobes than the left, but it has 3 lobes, not 2. The number of bronchopulmonary segments is also incorrect; the right lung has 10 segments.
- **Option C:** Incorrect. The right lung has more than one lobe, and the number of segments mentioned here is not accurate for any human lung.
- **Option D:** Incorrect. Humans have a maximum of 3 lobes in the right lung and not 4. The number of bronchopulmonary segments is also incorrect; the right lung has 10 segments.

18. The nurse is teaching the parents of a 3 month-old infant about nutrition. What is the main source of fluids for an infant until about 12 months of age?

- A. Formula or breastmilk

- B. Dilute nonfat dry milk
- C. Warmed fruit juice
- D. Fluoridated tap water

Correct Answer: A. Formula or breastmilk

Formula or breast milk are the perfect food and source of nutrients and liquids up to 1 year of age. Breastfeeding with appropriate supplementation is the preferred method for feeding infants 0-12 months old. Iron-fortified formulas are recommended if the child is not breastfed or requires supplemental formula in addition to breast milk.

- **Option B:** The American Academy of Pediatrics Committee on Nutrition updated their recommendations concerning infant feeding practices during the second six months of life. The committee stated that breastfeeding is the preferred method of feeding during the first year of life and that whole cow's milk may be introduced after six months of age if adequate supplementary feedings are given. Reduced fat content milk is not recommended during infancy.
- **Option C:** When the infants are consuming one-third of their calories from a balanced mixture of iron-fortified cereals, vegetables, fruits, and other foods providing adequate sources of both iron and Vitamin C it is considered adequate supplementary feeding.
- **Option D:** The World Health Organization (WHO) notes that babies that are breastfed don't need additional water, as breast milk is over 80 percent water and provides the fluids your baby needs. Children who are bottle-fed will stay hydrated with the help of their formula. Water feedings tend to fill up your baby, making them less interested in nursing. This could actually contribute to weight loss and elevated bilirubin levels.

19. A pregnant woman who is having labor pains is receiving an opioid analgesic. Which of the following medications should be ready in case a respiratory depression occurs?

- A. oxycodone (Oxycontin)
- B. naloxone (Narcan)
- C. meperidine hydrochloride (Demerol)
- D. morphine sulfate (Roxanol)

Correct Answer: B. naloxone (Narcan)

Opioid analgesics are prescribed for pregnant women who are experiencing moderate to severe labor pains. Respiratory depression may occur as a sign of opioid toxicity. Naloxone (Narcan) is an opioid antagonist, which reverses the effects of opioid toxicity such as respiratory depression.

- **Options A, C, & D:** These are opioid analgesics.

20. You have just finished assisting the physician with a thoracentesis for a patient with recurrent left pleural effusion caused by lung cancer. The thoracentesis removed 1800 mL of fluid. Which patient assessment information is important to report to the physician?

- A. The patient starts crying and says she can't go on with treatment much longer.

- B. The patient complains of sharp, stabbing chest pain with every deep breath.
- C. The patient's blood pressure is 100/48 mm Hg and her heart rate is 102 beats/ min.
- D. The patient's dressing at the thoracentesis site has 1 cm of bloody drainage.

Correct Answer: C. The patient's blood pressure is 100/48 mm Hg and her heart rate is 102 beats/ min

Removal of large quantities of fluid from the pleural space can cause fluid to shift from the circulation into the pleural space, causing hypotension and tachycardia. The patient may need to receive IV fluids to correct this.

- **Option A:** A large build up of fluid can make it hard to breathe. Removing some fluid may make the person more comfortable. To remove this fluid for evaluation (testing) or improve a patient's breathing, a procedure called a thoracentesis is done.
- **Option B:** Discomfort can result from the needle at the time it is inserted. Doctors try to lessen any pain or discomfort by giving a local numbing medicine (local anesthetic). The discomfort is usually mild and goes away once the needle or tube is removed.
- **Option D:** During insertion of the needle, a blood vessel in the skin or chest wall may be accidentally nicked. Bleeding is usually minor and stops on its own. Sometimes, bleeding can cause a bruise on the chest wall.

21. A client has been diagnosed with hypertension. The nurse priority nursing diagnosis would be:

- A. Ineffective health maintenance
- B. Impaired skin integrity
- C. Deficient fluid volume
- D. Pain

Correct Answer: A. Ineffective health maintenance

Managing hypertension is the priority for the client with hypertension. Clients with hypertension frequently do not experience pain, deficient volume, or impaired skin integrity. It is the asymptomatic nature of hypertension that makes it so difficult to treat. Monitor and record BP. Measure both arms and thighs three times, 3–5 min apart while the patient is at rest, then sitting, then standing for initial evaluation. Use correct cuff size and accurate technique.

- **Option B:** Impaired skin integrity is an inappropriate nursing diagnosis because there is no alteration in the skin in hypertension. Comparison of pressures provides a more complete picture of vascular involvement or scope of problem. Severe hypertension is classified in the adult as a diastolic pressure elevation to 110 mmHg; progressive diastolic readings above 120 mmHg are considered first accelerated, then malignant (very severe). Systolic hypertension also is an established risk factor for cerebrovascular disease and ischemic heart disease, when diastolic pressure is elevated.
- **Option C:** The client with hypertension experiences no fluid deficit. Note presence, quality of central and peripheral pulses. Bounding carotid, jugular, radial, and femoral pulses may be observed and palpated. Pulses in the legs and feet may be diminished, reflecting effects of vasoconstriction (increased systemic vascular resistance [SVR]) and venous congestion.

- **Option D:** There is no pain experienced in hypertension. Auscultate heart tones and breath sounds. S4 heart sound is common in severely hypertensive patients because of the presence of atrial hypertrophy (increased atrial volume and pressure). Development of S3 indicates ventricular hypertrophy and impaired functioning. Presence of crackles, wheezes may indicate pulmonary congestion secondary to developing or chronic heart failure.

22. A 45-year-old man is involved in a minor motor vehicle accident and presents to the emergency room complaining of neck pain. The attending physician, suspecting a potential neck strain, requests a neurological examination to assess any muscle or nerve damage. The nurse, while assessing the patient's range of motion, focuses on the sternocleidomastoid muscle due to its significant role in neck movements. The nurse uses this opportunity to educate the patient on the functions of this muscle and tests his understanding with a question about the right sternocleidomastoid muscle. "Given our conversation about the sternocleidomastoid and its role in neck movement, can you identify the combination below that accurately represents the types of movement produced when the right sternocleidomastoid muscle contracts?" 1. Right cervical flexion 2. Right cervical rotation 3. Left cervical flexion 4. Left cervical rotation

- A. 1 and 3
- B. 1 and 4
- C. 2 and 3
- D. 2 and 4

Correct Answer: B. 1 and 4

Contraction of only one sternocleidomastoid muscle causes rotation of the head to the left side. Contraction of both sternocleidomastoids results in flexion of the neck or extension of the head, depending on what other neck muscles are doing.

23. Early signs and symptoms of local anesthetic toxicity include all but one of the following. Indicate the exception:

- A. Tinnitus
- B. Perioral numbness
- C. Dizziness
- D. Hypertension

Correct Answer: D. Hypertension

Manifestations of local anesthetic toxicity typically appear 1-5 minutes after the injection, but onset may range from 30 seconds to as long as 60 minutes. Initial manifestations may also vary widely. Classically, patients experience symptoms of central nervous system (CNS) excitement such as the following: Circumoral and/or tongue numbness, metallic taste, lightheadedness, dizziness, visual and auditory disturbances (difficulty focusing and tinnitus), disorientation and drowsiness.

- **Option A:** Local anesthetic systemic toxicity (LAST) is a life-threatening adverse event associated with the increasingly prevalent utilization of local anesthetic (LA) techniques throughout various health care settings, with an incidence currently estimated to be 0.03% or 0.27 episodes per 1,000 peripheral nerve blocks.
- **Option B:** Increasing plasma concentrations of LA initially compromises cortical inhibitory pathways by blockade of NaV channels, disrupting inhibitory neuron depolarization. Inhibiting these pathways leads to excitatory clinical features of sensory and visual changes, muscular activation, and subsequent seizure activity. As the plasma concentrations of LA rise, excitatory pathways are affected, producing a depressive phase of neurological toxicity, with loss of consciousness, coma, and respiratory arrest.
- **Option C:** Prompt and effective airway management is crucial to prevent hypoxia, hypercapnia, and acidosis (metabolic or respiratory), which are known to potentiate LAST. The airway should be secured and 100% oxygen administered, bearing in mind that hyperventilation and respiratory alkalosis have also been demonstrated to be injurious.

24. While Lawrence is being assessed at the clinic, Nurse Rachel observed that the child appears to be small, with an immature face and chubby body build. Her parents stated that their child's rate of growth of all body parts is somewhat slow, but her proportions and intelligence remain normal. As a knowledgeable nurse, you know that the child has a deficiency of which of the following?

- A. Antidiuretic hormone (ADH)
- B. Parathyroid hormone (PTH)
- C. Growth hormone (GH)
- D. Melanocyte-stimulating hormone (MSH)

Correct Answer: C. Growth hormone (GH)

GH stimulates protein anabolism, promoting bone and soft-tissue growth. A lack of GH would lead to decreased synthesis of somatomedin, resulting in decreased linear growth and decreased fat metabolism, and increased glucose uptake in muscles, resulting in excessive subcutaneous fat hypoglycemia.

- **Option A:** A deficiency in ADH results in diabetes insipidus, marked by dehydration and hypernatremia. Diabetes insipidus (DI) is a disease process that results in either decreased release of antidiuretic hormone (ADH, also known as vasopressin or AVP) or decreased response to ADH, causing electrolyte imbalances.
- **Option B:** Deficiency of PTH causes hypocalcemia, marked by tetany, convulsions, and muscle spasms. It's not uncommon after thyroid or other head and neck surgeries to get transient or permanent hypoparathyroidism leading to hypocalcemia. This can be a result of unintentional removal of parathyroid glands or a loss of blood supply in some cases.
- **Option D:** Deficiency of MSH causes diminished or absent skin pigmentation. Melanocyte-stimulating hormone (alpha-melanotropin, MSH) may function in a number of diverse physiological roles. MSH stimulates (1) rapid translocation of melanosomes (melanin granules) in dermal melanophores to effect rapid color change and (2) melanogenesis in normal and abnormal (melanoma) epidermal melanocytes.

25. Nurse Maureen knows that the non-antipsychotic medication used to treat some clients with schizoaffective disorder is:

- A. phenelzine (Nardil)
- B. chlordiazepoxide (Librium)
- C. lithium carbonate (Lithane)
- D. imipramine (Tofranil)

Correct Answer: C. lithium carbonate (Lithane)

Lithium carbonate, an antimanic drug, is used to treat clients with cyclical schizoaffective disorder, a psychotic disorder once classified under schizophrenia that causes affective symptoms, including manic-like activity. Lithium helps control the affective component of this disorder. Lithium was the first mood stabilizer and is still the first-line treatment option, but is underutilized because it is an older drug. Lithium is a commonly prescribed drug for a manic episode in bipolar disorder as well as maintenance therapy of bipolar disorder in a patient with a history of a manic episode. The primary target symptoms of lithium are mania and unstable mood.

- **Option A:** Phenelzine is a monoamine oxidase inhibitor prescribed for clients who don't respond to other antidepressant drugs such as imipramine. Phenelzine is an FDA-approved drug for the management of depression in adults. Off label, the drug may be used for the management of treatment-resistant depression, panic disorder, and social anxiety disorder. Phenelzine is also specifically useful for young women who have depression and mood disorders. Research has not established the safety and efficacy for children or adolescents.
- **Option B:** Chlordiazepoxide, an anti-anxiety agent, generally is contraindicated in psychotic clients. Chlordiazepoxide is a long-acting benzodiazepine and is an FDA approved medication for adults with mild-moderate to severe anxiety disorder, preoperative apprehension and anxiety, and withdrawal symptoms of acute alcohol use disorder. It is also FDA approved for pediatric patients greater than six years old for anxiety.
- **Option D:** Imipramine, primarily considered an antidepressant agent, is also used to treat clients with agoraphobia and those undergoing cocaine detoxification. Imipramine is a tertiary amine tricyclic antidepressant. Tricyclic antidepressants (TCAs) had been approved by the Food and Drug Administration (FDA) as antidepressants in the 1950s. Although it is FDA approved for the treatment of depression, it is a second-line treatment notably in severe depression with melancholic and atypical features, due to its undesirable side effects and due to its toxicity in overdose.

26. A client with emphysema should receive only 1 to 3 L/minute of oxygen if needed, or he may lose his hypoxic drive. Which of the following statements is correct about hypoxic drive?

- A. The client doesn't notice he needs to breathe.
- B. The client breathes only when his oxygen levels climb above a certain point.
- C. The client breathes only when his oxygen levels dip below a certain point.
- D. The client breathes only when his carbon dioxide level dips below a certain point.

Correct Answer: C. The client breathes only when his oxygen levels dip below a certain point.

Clients with emphysema breathe when their oxygen levels drop to a certain level; this is known as the hypoxic drive. In the meantime, his carbon dioxide levels continue to climb, and the client will pass out,

leading to a respiratory arrest. The hypoxic drive theory then goes on to say that if the healthcare provider gives these patients too much oxygen they blunt their hypoxic drive. As their chemoreceptors are already tolerant of high levels of carbon dioxide, and therefore they have also lost that drive, their respirations will begin to slow causing a further rise in carbon dioxide levels, and a consequent acidosis.

- **Option A:** They don't take a breath when their levels of carbon dioxide are higher than normal, as do those with healthy respiratory physiology. COPD patients tend to have chronically elevated levels of carbon dioxide due to the nature of their illness. The theory goes then that because of this chronically elevated level of carbon dioxide in the chemoreceptors become tolerant of these high levels and therefore the carbon dioxide ceases to be that person's drive to breathe. What therefore drives them to breathe is the hypoxic drive or the lower levels of oxygen.
- **Option B:** If too much oxygen is given, the client has little stimulus to take another breath. The peripheral chemoreceptors are sensitive to the levels of oxygen in the body. They will send a signal to breathe when the partial pressure of oxygen begins to fall. This is referred to as the hypoxic drive but this drive has a much more minor role in breathing.
- **Option D:** The central chemoreceptors monitor carbon dioxide levels in the body. When those carbon dioxide levels are high a signal is sent to speed up the drive to breathe to blow off the excess carbon dioxide. So the levels of carbon dioxide dictate how fast we will breathe.

27. The nurse is conducting nutrition counseling for a patient with cholecystitis. Which of the following information is important to communicate?

- A. The patient must maintain a low-calorie diet.
- B. The patient must maintain a high protein/low carbohydrate diet.
- C. The patient should limit sweets and sugary drinks.
- D. The patient should limit fatty foods.

Correct Answer: D. The patient should limit fatty foods.

Cholecystitis, inflammation of the gallbladder, is most commonly caused by the presence of gallstones, which may block bile (necessary for fat absorption) from entering the intestines. Patients should decrease dietary fat by limiting foods like fatty meats, fried foods, and creamy desserts to avoid irritation of the gallbladder.

- **Option A:** The patient may maintain a moderate to a high-calorie diet, as a very low-calorie diet may increase the risk for gallstones that predisposes to cholecystitis.
- **Option B:** Both animal fat and animal protein may contribute to the formation of gallstones. Vitamin C, which is abundant in plants and absent from meat affects the rate-limiting step in the catabolism of cholesterol to bile acids and is inversely related to the risk of gallstones and cholecystitis. Individuals consuming the most refined carbohydrates have a 60% greater risk for developing gallstones, compared with those who consumed the least.
- **Option C:** Replacing sugary drinks with drinks high in fiber would reduce the risk of gallbladder stones by 15%.

28. The nurse is teaching a psychiatric client about her prescribed drugs, chlorpromazine, and benztropine. Why is benztropine administered?

- A. To reduce psychotic symptoms.
- B. To reduce extrapyramidal symptoms.
- C. To control nausea and vomiting.
- D. To relieve anxiety.

Correct Answer: B. To reduce extrapyramidal symptoms

Benzotropine is an anticholinergic medication, administered to reduce the extrapyramidal adverse effects of chlorpromazine and other antipsychotic medications. Consequently, it reduces central cholinergic effects by blocking muscarinic receptors that appear to improve the symptoms of Parkinson's disease. Thus, benzotropine blocks the cholinergic muscarinic receptor in the central nervous system. Therefore, it reduces the cholinergic effects significantly during Parkinson's disease which becomes more pronounced in the nigrostriatal tract because of reduced dopamine concentrations.

- **Option A:** The first-generation antipsychotics work by inhibiting dopaminergic neurotransmission. Their effectiveness is best when they block about 72% of the D2 dopamine receptors in the brain. They also have noradrenergic, cholinergic, and histaminergic blocking action. Second-generation antipsychotics work by blocking D2 dopamine receptors as well as serotonin receptor antagonist action. The 5-HT_{2A} subtype of serotonin receptor is most commonly involved.
- **Option C:** Benzodiazepines are mainly used as adjunctive agents to reduce anxiety, anticipatory nausea and vomiting, and refractory emesis occurring despite adequate prophylaxis regimens. Lorazepam (Ativan) and alprazolam (Xanax) are the most commonly used drugs in this class.
- **Option D:** Acute anxiety may require treatment with a benzodiazepine. Chronic anxiety treatment consists of psychotherapy, pharmacotherapy, or a combination of both. Pharmacotherapy: selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), benzodiazepines, tricyclic antidepressants, mild tranquilizers, and beta-blockers treat anxiety disorders.

29. A 72-year-old patient, who is a retired miner, is getting discharged from a skilled nursing facility (SNF) after a 3-week stay for a lower limb fracture. The patient has a history of severe COPD, likely due to his occupational exposure, and PVD. He lives alone in a two-story house and is primarily concerned about his ability to breathe easily, especially when he needs to climb stairs to his bedroom. Given his living situation, medical history, and concerns, which of the following would be the best instruction for this patient to manage his respiratory challenges?

- A. Practice deep breathing techniques regularly to increase oxygen levels and improve lung function.
- B. Cough regularly and deeply to clear airway passages, especially before attempting to climb stairs.
- C. Use a bronchodilator and wait for a few minutes, then cough to clear airway passages.
- D. Focus on decreasing CO₂ levels by increasing oxygen intake, especially during meals when metabolism is higher.
- E. Consider rearranging his living space to avoid frequent stair climbing.

Correct Answer: C. Cough following bronchodilator utilization

For a patient with severe COPD, deep breathing techniques can help increase oxygen levels in the blood and improve overall lung function. This can be particularly beneficial for activities that may exacerbate shortness of breath, such as climbing stairs. While the other options have their merits, deep breathing techniques offer a proactive approach to managing the patient's primary concern about breathing easily.

30. A client with a fractured hip is being taught correct use of the walker. The nurse is aware that the correct use of the walker is achieved if the:

- A. Palms rest lightly on the handles
- B. Elbows are flexed 0°
- C. Client walks to the front of the walker
- D. Client carries the walker

Correct Answer: A. Palms rest lightly on the handles

The client's palms should rest lightly on the handles. The elbows should be flexed no more than 30° but should not be extended. Once a model of the walker has been selected, the "fit" of the walker becomes important. When holding on to the walker, the elbows should be bent in a position that feels comfortable and natural. The top of the walker should be even with the crease on the underside of the wrist when the arms are relaxed at the side.

- **Option B:** A 0° is not a relaxed angle for the elbows and will not facilitate correct walker use. Walkers that are too low cause the client to stoop over while walking, which impedes proper body mechanics. If the walker is at the wrong height, the client will be prone to aches and pains.
- **Option C:** The client should walk to the middle of the walker, not to the front of the walker. To get started, the client should push the walker slightly ahead, then step into the walker. Keep that pattern going—walker slightly ahead, then step into the walker. The walker should never be too far ahead and the client should have excellent posture as he takes steps. Also, the client should not look at feet, rather in front of him.
- **Option D:** The client should be taught not to carry the walker because this would not provide stability. If there is trouble gripping the walker, platform walkers are available that may prove to be a better option. The platform allows the client to rest the elbow and forearm, taking stress off the hands.

31. A nurse is preparing the client's morning NPH insulin dose and notices a clumpy precipitate inside the insulin vial. The nurse should:

- A. Draw up and administer the dose.
- B. Shake the vial in an attempt to disperse the clumps.
- C. Draw the dose from a new vial.
- D. Warm the bottle under running water to dissolve the clump.

Correct Answer: C. Draw the dose from a new vial.

The nurse should always inspect the vial of insulin before use for solution changes that may signify a loss of potency. NPH insulin is normally uniformly cloudy. Clumping, frosting, and precipitates are signs of insulin damage. In this situation, because potency is questionable, it is safer to discard the vial and

draw up the dose from a new vial.

- **Option A:** Crystalline NPH insulin administration is subcutaneous. Administration is not Intramuscular or intravenous. NPH insulin is available in a two-phase solution, which means that apart from NPH, it has a solvent or a rapid-acting insulin solution. It comes in the form of a subcutaneous suspension or suspension pen-injector.
- **Option B:** The abdominal subcutaneous injection causes quicker absorption as compared to arms or thighs. The most significant advantage of NPH is that it can be included in premixed formulation with regular insulin. NPH in premixed formulations does not affect the potency and time-action profile of regular insulin. Exercise, massage, and local heat application increase NPH insulin absorption.
- **Option D:** NPH insulin has a somewhat higher risk of hypoglycemia. Inadequate resuspension is thought to contribute to the high day to day variability in the pharmacodynamic and pharmacokinetic profile of NPH insulin, leading to hypoglycemia. Patients can adequately resuspend NPH by rotating the vial several times until it's uniformly cloudy.

32. A client is about to receive metolazone (Zaroxolyn). The nurse in charge understands which of the following laboratory results are related to the administration of the medication?

- A. Hyperkalemia and hypocalcemia
- B. Hyperkalemia and hypoglycemia
- C. Hypouricemia and hypoglycemia
- D. Hypokalemia and hyperglycemia

Correct Answer: D. Hypokalemia and hyperglycemia

Metolazone is a thiazide diuretic that may put the client's risk for hypokalemia, hyperglycemia, hyperlipidemia, hypercalcemia, and hyperuricemia.

33. The nurse is planning care for a client who has a phobic disorder manifested by a fear of elevators. Which goal would need to be accomplished first?

- A. The client will demonstrate the relaxation response when asked.
- B. The client will verbalize the underlying cause of the disorder.
- C. The client will ride the elevator in the company of the nurse.
- D. The client will roleplay the use of an elevator.

Correct Answer: A. The client will demonstrate the relaxation response when asked.

The ability to use relaxation is basic to treatment of phobia. Support the patient in recognizing strategies used in the past to deal with fearful situations. This method allows the patient to think that fear is a natural part of life and can be dealt with successfully. Initiate alternative treatments. Provide verbal and nonverbal (touch and hug with permission) reassurances of safety if safety is within control. Meditation, prayer, music, therapeutic touch, and healing touch techniques help lighten fear.

- **Option B:** Clients with phobias are resistant to insight therapy. Insight Therapy is a type of psychotherapy in which the therapist helps their patient understand how their feelings, beliefs,

actions, and events from the past are influencing their current mindset. Importance is placed on the relationship between the therapist and the patient with the therapist identifying behavioral patterns from the patient's past that could be affecting their behavior and relationships at the present time.

- **Option C:** Riding the elevator accompanied by the nurse is an appropriate long-term goal. As the fear subsides, encourage the patient to involve himself or herself to specific events preceding the onset of the fear. Recognition and explanation of factors leading to fear are vital in developing alternative responses.
- **Option D:** Role-playing may be appropriate after the client has learned relaxation. Expose the client to a predetermined list of anxiety-provoking stimuli rated in hierarchy from the least frightening to the most frightening. Experiencing fear in progressively more challenging but attainable steps allows the client to realize that dangerous consequences will not occur. Helps extinguish conditioned avoidance response.

34. Three-year-old Adrian is admitted to the hospital with a diagnosis of asthma and respiratory distress syndrome. The mother of the child reports to the nurse on duty that she has witnessed slight tremors and behavioral changes in her child over the past four days. The attending physician orders routine ABGs following an assessment of the ABCs. The ABG results are pH 7.35, PaCO₂ 72 mmHg, and HCO₃ 38 mEq/L. What acid-base disorder is shown?

- A. Respiratory Acidosis, Uncompensated
- B. Respiratory Acidosis, Fully Compensated
- C. Respiratory Alkalosis, Fully Compensated
- D. Metabolic Alkalosis, Partially Compensated

Correct Answer: B. Respiratory Acidosis, Fully Compensated

The patient has respiratory acidosis (raised carbon dioxide) resulting from asthma and respiratory distress syndrome, with compensation having normal pH value within 7.35 to 7.45, increased PaCO₂ which is acidic and increased HCO₃ which is basic.

35. Which of the following organisms is the most common cause of urinary tract infection (UTI) in children?

- A. Klebsiella
- B. Staphylococcus
- C. Escherichia coli
- D. Pseudomonas

Correct Answer: C. Escherichia coli

E. coli is the most common organism associated with the development of UTI. Escherichia coli is the most common organism in uncomplicated UTI by a large margin. Pathogenic bacteria ascend from the perineum, causing the UTI. Women have shorter urethras than men and therefore are far more susceptible to UTI. Very few uncomplicated UTIs are caused by blood-borne bacteria.

- **Option A:** E.coli causes the vast majority of UTIs but other organisms of importance include proteus, klebsiella, and enterococcus. The diagnosis of UTI is made from the clinical history (symptoms) and urinalysis with confirmation by a urine culture, but the proper collection of the urine sample is important.
- **Option B:** Staphylococcus aureus is a major bacterial human pathogen that causes a wide variety of clinical manifestations. Infections are common both in community-acquired as well as hospital-acquired settings and treatment remains challenging to manage due to the emergence of multi-drug resistant strains such as MRSA (Methicillin-Resistant Staphylococcus aureus).
- **Option D:** Although Klebsiella, Staphylococcus, and Pseudomonas species may cause UTIs, the incidence of UTIs related to each is less than that for E. coli. Pseudomonas aeruginosa is commonly found in the environment, particularly in freshwater. It is commonly an opportunistic pathogen and is also an important cause of nosocomial infections like ventilator-associated pneumonia, catheter-associated urinary tract infections, and others.

36. A nurse is providing instructions to a client who is on nicotinic acid for the treatment of hyperlipidemia. Which statement made by the nurse indicates a comprehension of the instructions?

- A. "I should take aspirin 30 minutes before nicotinic acid".
- B. "I will drink alcohol in moderation".
- C. "Yellowing of the skin is a common side effect".
- D. "This medication is taken on an empty stomach".

Correct Answer: A. "I should take aspirin 30 minutes before nicotinic acid".

The use of aspirin or a nonsteroidal anti-inflammatory drug 30 minutes before decreases flushing which is a side effect of taking nicotinic acid.

- **Option B:** Drinking alcohol will cause liver abnormalities.
- **Option C:** Yellowing of the skin is a sign of liver dysfunction and should immediately inform the physician.
- **Option D:** This medication is taken with meals to decrease gastrointestinal upset.

37. A nurse is preparing to care for a client who had undergone an above-knee amputation of the right leg. The nurse plans to allow which position for the client in the first 24 hours?

- A. Supine position, with the affected limb flat on the bed.
- B. Supine position, with the affected limb supported with pillows.
- C. Prone position, with the affected limb in a dependent position.
- D. Trendelenburg's position.

Correct Answer: B. Supine position, with the affected limb supported with pillows.

The amputated limb is usually supported with pillows on the first post-op day to promote venous return and reduce edema. Preventing contractures is very important. A contracture occurs when a joint becomes stuck in one position. If this happens, it may be hard or impossible to straighten the remaining

limb and use an artificial leg.

- **Option A:** Make sure the client puts equal weight on both hips when he sits. Use firm chairs, and sit up straight. The client should keep the remaining limb flat with both legs together while lying on the back. The client should not sit for more than an hour or two. He must stand, or lie on his stomach now and then.
- **Option C:** If the affected limb is put in a dependent position, edema might occur. Edema in the residual limb is also a common complication after LLA surgery. Controlling the amount of edema post-surgically is vital for promoting wound-healing, pain control, protecting the incision during rehabilitation, and assisting in shaping the stump for prosthetic fitting
- **Option D:** The main goal of good positioning at any time is to prevent adjacent joint contractures. The patient should be advised on how to position themselves while sitting and lying in the hospital bed or standing to prevent contractures. Make sure you explain to the patient the dangers of the dependent position (residual limb hanging down) in the early post-op phase as this may increase edema, pain, and healing time.

38. A centrally located tumor would produce which of the following symptoms?

- A. Shoulder pain
- B. Pleuritic pain
- C. Coughing
- D. Hemoptysis

Correct Answer: C. Coughing

- **Option C:** Centrally located pulmonary tumors are found in the upper airway (vocal cords) and usually obstruct airflow, producing such symptoms as coughing, wheezing, and stridor.
- **Option A:** Pancoast tumors that occur in the apices may cause shoulder pain.
- **Option B:** As the tumor invades the pleural space, it may cause pleuritic pain.
- **Option D:** Small cell tumors tend to be located in the lower airways and often cause hemoptysis.

39. Fetal presentation refers to which of the following descriptions?

- A. Fetal body part that enters the maternal pelvis first.
- B. Relationship of the presenting part to the maternal pelvis.
- C. Relationship of the long axis of the fetus to the long axis of the mother.
- D. A classification according to the fetal part.

Correct Answer: A. Fetal body part that enters the maternal pelvis first.

Presentation is the fetal body part that enters the pelvis first; it's classified by the presenting part; the three main presentations are cephalic/occipital, breech, and shoulder.

- **Option B:** The relationship of the presenting fetal part to the maternal pelvis refers to fetal position.
- **Option C:** The relationship of the long axis to the fetus to the long axis of the mother refers to fetal lie; the three possible lies are longitudinal, transverse, and oblique.

- **Option D:** Fetal station refers to where the presenting part is in the pelvis. The presenting part. The presenting part is the part of the baby that leads the way through the birth canal. Most often, it is the baby's head, but it can be a shoulder, the buttocks, or the feet.

40. An adult client's insulin dosage is 10 units of regular insulin and 15 units of NPH insulin in the morning. The client should be taught to expect the first insulin peak:

- A. As soon as food is ingested.
- B. In two to four hours.
- C. In six hours.
- D. In ten to twelve hours.

Correct Answer: B. In two to four hours.

The first insulin peak will occur two to four hours after administration of regular insulin. Regular insulin is classified as rapid-acting and will peak two to four hours after administration. The second peak will be eight to twelve hours after the administration of NPH insulin. This is why a snack must be eaten mid-morning and also three to four hours after the evening meal.

- **Option A:** Rapid Acting Insulin Analogs (Insulin Aspart, Insulin Lyspro, Insulin Glulisine) has an onset of action of 5 to 15 minutes, peak effect in 1 to 2 hours, and duration of action that lasts 4-6 hours. With all doses, large and small, the onset of action and the time to peak effect is similar, The duration of insulin action is, however, affected by the dose – so a few units may last 4 hours or less, while 25 or 30 units may last 5 to 6 hours. As a general rule, assume that these insulins have a duration of action of 4 hours.
- **Option C:** Regular Human Insulin has an onset of action of 1/2 hour to 1 hour, peak effect in 2 to 4 hours, and duration of action of 6 to 8 hours. The larger the dose of regular the faster the onset of action, but the longer the time to peak effect and the longer the duration of the effect.
- **Option D:** Long-acting insulin analogs (Insulin Glargine, Insulin Detemir) have an onset of insulin effect in 1 1/2-2 hours. The insulin effect plateaus over the next few hours and is followed by a relatively flat duration of action that lasts 12-24 hours for insulin detemir and 24 hours for insulin glargine.

41. A 38-year-old patient is admitted to the emergency department with severe pain in the lower right quadrant of the abdomen, nausea, and a low-grade fever, raising concerns about possible appendicitis. The nurse is considering pain relief strategies. Which of the following actions should the nurse prioritize?

- A. Encourage the patient to change positions frequently in bed.
- B. Administer Demerol 50 mg IM q 4 hours and PRN, as prescribed.
- C. Apply warmth to the abdomen with a heating pad.
- D. Use comfort measures and pillows to position the patient comfortably.
- E. Administer an antiemetic as prescribed for nausea relief.

Correct Answer: D. Use comfort measures and pillows to position the patient comfortably.

Using comfort measures and pillows to position the client is a non-pharmacological method of pain relief.

- **Option A:** Gentle position changes can help alleviate pain, but changing positions often might aggravate the pain felt by the client.
- **Option B:** Demerol may be given if prescribed by the physician.
- **Option C:** The client may be experiencing acute appendicitis; warm compresses may cause rupture of the inflamed appendix.
- **Option E:** Addressing associated symptoms like nausea can improve overall comfort but is not the priority as of the moment.

42. The nurse is discussing the purpose of an electroencephalogram (EEG) with the family of a client with massive cerebral hemorrhage and loss of consciousness. It would be most accurate for the nurse to tell family members that the test measures which of the following conditions?

- A. Extent of intracranial bleeding.
- B. Sites of brain injury.
- C. Activity of the brain.
- D. Percent of functional brain tissue.

Correct Answer: C. Activity of the brain.

An EEG measures the electrical activity of the brain. An electroencephalogram (EEG) is an essential tool that studies the brain's electrical activity. It is primarily used to assess seizures and conditions that may mimic seizures. It is also useful to classify seizure types, assess comatose patients in the intensive care unit, and evaluate encephalopathies, among other indications.

- **Option A:** Extent of intracranial bleeding would be determined by CT or MRI. CT scans can be used to identify disease or injury within various regions of the body. For example, CT has become a useful screening tool for detecting possible tumors or lesions within the abdomen. A CT scan of the heart may be ordered when various types of heart disease or abnormalities are suspected. CT can also be used to image the head in order to locate injuries, tumors, clots leading to stroke, hemorrhage, and other conditions.
- **Option B:** MR Imaging is a procedure, without the use of x-rays and "ionizing" radiation for obtaining comprehensive images of tissues and organs throughout the human body. In contrast to CT that uses x-ray beams, MRI employs a high strength main magnetic field, magnetic field gradients, radio waves, and a computer to generate images that show if there is a disease process, or pathological condition and an injury present.
- **Option D:** Percent of functional brain tissue would be determined by a series of tests. Electroencephalography, or EEG, is probably the second-best known technique for recording neural activity. Whereas fMRI records blood flow, a proxy of neuron activation, EEG directly records the brain's electrical activity via electrodes placed on the scalp of the subject.

43. The nurse is providing home care instructions to a client who has recently had a skin graft. It's most important that the client remember to:

- A. Use cosmetic camouflage techniques.
- B. Protect the graft from direct sunlight.
- C. Continue physical therapy.
- D. Apply lubricating lotion to the graft site.

Correct Answer: B. Protect the graft from direct sunlight.

To avoid burning and sloughing, the client must protect the graft from direct sunlight. Protect the grafted area and the donor site from direct exposure to sunlight. Keep it covered for the first year and then protect it with a sunblock thereafter. The other three interventions are helpful to the client and his recovery but are less important.

- **Option A:** Ask the surgeon about camouflage make-up if concerned about the appearance of the graft. Expect skin discoloration at both the graft and the donor sites. This will gradually improve over the following 9-12 months.
- **Option C:** The client should take it easy for two weeks, building up slowly into his normal routine. Do not exert the grafted area. Depending on where the graft is, how big it is and what type of job the client has he may need to take time off work, two weeks or more. Exercise that might stretch or injure the graft should be avoided for 3-4 weeks.
- **Option D:** Once healed, the client may use a moisturizing cream such as E45, Nivea cream, or Vaseline two or three times a day, on both grafted site and the donor site for three months or longer if the area remains dry.

44. An 85-year-old male has been losing mobility and gaining weight over the last two (2) months. The patient also has the heater running in his house 24 hours a day, even on warm days. Which of the following tests is most likely to be performed?

- A. CBC (complete blood count)
- B. ECG (electrocardiogram)
- C. Thyroid function tests
- D. CT scan

Correct Answer: C. Thyroid function tests

Weight gain and poor temperature tolerance indicate something may be wrong with the thyroid function. Thyroid function tests are designed to distinguish hyperthyroidism and hypothyroidism from the euthyroid state. To accomplish this task, direct measurements of the serum concentration of the two thyroid hormones—triiodothyronine (T3) and tetraiodothyronine (T4)—more commonly known as thyroxine, are extensively employed.

- **Option A:** The complete blood count and metabolic profile may show abnormalities in patients with hypothyroidism. Thyroid dysfunction induces different effects on blood cells such as anemia, erythrocytosis, leukopenia, thrombocytopenia, and in rare cases causes' pancytopenia.
- **Option B:** Signs of hypothyroidism on ECG include sinus bradycardia, T-wave inversions (TWIs), QTc prolongation, and ventricular arrhythmias. Hypothyroidism can affect the cardiovascular system physiology and structure. These changes are often reflected on ECG.

- **Option D:** Ultrasonography of the neck and thyroid can be used to detect nodules and infiltrative disease. High-resolution ultrasonography (USG) is the most sensitive imaging modality available for examination of the thyroid gland and associated abnormalities. Ultrasound scanning is non-invasive, widely available, less expensive, and does not use any ionizing radiation. Further, real-time ultrasound imaging helps to guide diagnostic and therapeutic interventional procedures in cases of thyroid disease.

45. During a hypertensive crisis, the nurse makes sure which of this medicine is readily available?

- A. Phentolamine
- B. Diazepam
- C. Lithium citrate
- D. Phenobarbital sodium

Correct Answer: A. Phentolamine

In a hypertensive emergency, the first goal is to bring down the blood pressure as quickly as possible with intravenous (IV) blood pressure medications to prevent further organ damage. Phentolamine Mesylate (phentolamine mesylate) is used as an antidote for a hypertensive crisis.

- **Option B:** Diazepam is a benzodiazepines.
- **Option C:** Lithium citrate is a mood stabilizer.
- **Option D:** Phenobarbital sodium is a barbiturate and sedative-hypnotics.

46. The nurse is developing a bowel-retraining plan for a client with multiple sclerosis. Which measure is likely to be least helpful to the client:

- A. Elevating the toilet seat for easy access
- B. Limiting fluid intake to 1000 mL per day
- C. Establishing a regular schedule for toileting
- D. Providing a high-roughage diet

Correct Answer: B. Limiting fluid intake to 1000 mL per day

- **Option B:** Bowel retraining plan is a behavioral program that helps people with chronic constipation or bowel loss control such as in multiple sclerosis. The program includes increasing fluid intake to at least 6 to 8 glasses of water, fiber therapy, and kegel exercise.
- **Options A, B, and C:** These measures would help the client to have a bowel movement.

47. Which of the following medical treatments should the nurse anticipate administering to a client with increased intracranial pressure due to brain hemorrhage, except?

- A. acetaminophen (Tylenol)
- B. dexamethasone (Decadron)

- C. mannitol (Osmitrol)
- D. phenytoin (Dilantin)
- E. nitroglycerin (Nitrostat)

Correct Answer: E. nitroglycerin (Nitrostat)

Decreasing blood pressure is essential to prevent exacerbation of intracerebral bleeding. However, BP medication such as nitroglycerin is avoided due to its vasodilating effects that increase cerebral blood volume and thus increases intracranial pressure.

- **Option A:** Acetaminophen, an antipyretic, prevents increased temperature. A decrease in temperature reduces metabolism, cerebral blood flow, thus decreasing intracranial pressure. It also relieve headache.
- **Option B:** Dexamethasone, a corticosteroids, decreases intracranial pressure by stabilizing the cell membrane and decreases the leakiness in the blood-brain-barrier.
- **Option C:** Mannitol, an osmotic diuretic, lowers intracranial pressure by increasing intravascular pressure to draw fluid from the interstitial spaces and from the brain cells.
- **Option D:** Phenytoin, an anticonvulsant, is given as prophylaxis to prevent seizures. Seizures increase metabolic rate and cerebral blood flow, and volume that may result in increased intracranial pressure.

48. When taking a health history, the nurse screens for manifestations suggestive of diabetes type 1. Which of the following manifestations are considered the primary manifestations of type 1 diabetes mellitus and would be most suggestive and require follow-up investigation?

- A. Excessive intake of calories, rapid weight gain, and difficulty losing weight
- B. An increase in three areas: thirst, intake of fluids, and hunger
- C. Poor circulation, wound healing, and leg ulcers
- D. Lack of energy, weight gain, and depression

Correct Answer: B. An increase in three areas: thirst, intake of fluids, and hunger

The primary manifestations of diabetes type 1 are polyuria (increased urine output), polydipsia (increased thirst), polyphagia (increased hunger). Patients most commonly present hyperglycemic with polydipsia, polyuria, and polyphagia. Polyuria is secondary to osmotic diuresis, which is caused by hyperglycemia. Young children may present with nocturnal enuresis. Polydipsia is related to hyperosmolality and dehydration from increased urination.

- **Option A:** Obesity is the result of an imbalance between daily energy intake and energy expenditure resulting in excessive weight gain. Obesity is a multifactorial disease, caused by a myriad of genetic, cultural, and societal factors.
- **Option C:** People with uncontrolled diabetes may develop poor circulation. As circulation slows down, blood moves more slowly, which makes it more difficult for the body to deliver nutrients to wounds. As a result, the injuries heal slowly, or may not heal at all.
- **Option D:** People with type 1 diabetes are at a heightened risk for mental health issues, including diabetes distress, depression, anxiety, and disordered eating. However, these are all treatable disorders.

49. Nurse Skye is assigned to the cardiac unit caring for four clients. He is preparing to do initial rounds. Which client should the nurse assess first?

- A. A client scheduled for cardiac ultrasound this morning.
- B. A client with syncope being discharged today.
- C. A client with chronic bronchitis on nasal oxygen.
- D. A client with diabetic foot ulcer that needs a dressing change.

Correct Answer: C. A client with chronic bronchitis on nasal oxygen.

A client with airway problems should be attended first. When the nurse needs to prioritize patients, Maslow's hierarchy of needs theory is used to decide which patient is to be seen first. A part of Maslow's hierarchy of needs is airway, breathing, and circulation (ABC), which are physiological elements that are needed for the body to survive and help determine one's level of health. Observing ABCs is a rapid assessment of life-threatening conditions in order of priority.

- **Option A:** Clinical judgment and prioritization of patient care is built on the nursing process. Nurses learn the steps of the nursing process in their foundational nursing course and utilize it throughout their academic and clinical career to direct patient care and determine priorities. Analysis (interpreting what is going on with the patient through reviewing lab work, diagnostic testing, patient history, complaints and observations) comes after assessment.
- **Option B:** The client who was discharged today is not a priority because he is stable enough to be sent home. Maslow's Hierarchy of Needs identifies the physiological or biological needs, including the ABCs, the safety/psychological/emotional needs, the need for love and belonging, the needs for self-esteem and the esteem by others and the self-actualization needs in that order of priority.
- **Option D:** The client needing a dressing change for her pressure ulcer belongs to Maslow's physical and biological needs. Some physical needs include the need for the ABCs of airway, breathing and cardiovascular function, nutrition, sleep, fluids, hygiene and elimination.

50. When should ambulation be initiated in the client who has sustained a major burn?

- A. When all full-thickness areas have been closed with skin grafts
- B. When the client's temperature has remained normal for 24 hours
- C. As soon as possible after wound debridement is complete
- D. As soon as possible after the resolution of the fluid shift

Correct Answer: D. As soon as possible after the resolution of the fluid shift

Regular, progressive ambulation is initiated for all burn clients who do not have contraindicating concomitant injuries as soon as the fluid shift resolves. Clients can be ambulated with extensive dressings, open wounds, and nearly any type of attached lines, tubing, and other equipment.

- **Option A:** The consistent finding in the literature is that early ambulation can be safely initiated after lower extremity skin grafting without compromising graft take if external compression is applied.
- **Option B:** Following thermal injury, the innate immune system responds immediately by stimulating localized and systemic inflammatory reactions. The innate immune response participates in activating the adaptive immune response; however, in so doing it has an adverse effect on the burn

victim's ability to mount a vigorous immune response to invading microorganisms and, therefore, predisposes the burn victim to infectious complications.

- **Option C:** Pain control is obtainable by performing therapies during wound dressing and debridement, if possible. Analgesics should also be administered prior to therapy sessions to encourage participation in movement activities.

51. Amphetamines and amphetamine-like compounds are most commonly used for:

- A. Narcolepsy
- B. Attention deficit disorder
- C. Exogenous obesity
- D. All of the above

Correct Answer: D. All of the above

The most common uses of amphetamines and amphetamine-like compounds are narcolepsy, exogenous obesity, and attention deficit disorder. Amphetamine is FDA-approved for the treatment of attention-deficit/hyperactivity disorder (ADHD) and narcolepsy. It has indications as a first-line agent for ADHD in adults and children six years of age and older. Amphetamine is also a second-line agent for the treatment of narcolepsy.

- **Option A:** Patients with narcolepsy generally benefit from divided doses and may require an early afternoon dose to control daytime sleepiness. Dosages usually range from 5 mg to 40 mg daily and should not exceed 60 mg, which is the maximum dose for certain adults.
- **Option B:** The choice of agent for initial therapy is based on cost, patient preference, and concern for abuse. Dextroamphetamine is the only amphetamine medication FDA-approved for use in children younger than six years, but most current guidelines recommend behavioral therapy alone in preschool-aged children with ADHD symptoms.
- **Option C:** Lisdexamfetamine, a long-acting amphetamine medication, is FDA-approved for the treatment of a binge-eating disorder. Lisdexamfetamine may be preferred if there is increased concern for abuse by the patient or a household member, as its chemically-phased release allows for once-daily dosing and may theoretically deter abuse. Lisdexamfetamine is available as capsules or chewable tablets, and typical daily dosages range from 20 mg to 70 mg.

52. Which age group has the greatest potential to demonstrate regression when they are sick?

- A. Infant
- B. Toddler
- C. Adolescent
- D. Young Adult

Correct Answer: B. Toddler

Regression is most seen among toddlers and it can be caused by stressful situations such as hospitalization, the arrival of a new sibling, or starting a new school. When a child regresses, he or she appears to be going backward in an earlier stage of development where he or she feels comfortable

(e.g. toilet trained toddlers suddenly start wetting their pants when they become sick, thumbsucking).

- **Option A:** Babies are almost entirely dependent on their caregivers. So it should come as no surprise that how parents interact with their babies has a profound effect on both their physical and mental health. Noticing and responding to these signals, whether they are cries, body movements, coos, or even words, helps them learn to trust the people and the world around them.
- **Option C:** There's no doubt the teen years can be a more challenging time to deal with a health condition. In addition to the social pressures to fit in, it's a time of learning about and understanding their bodies. At a time when it's natural to be concerned with body image, it can seem hard to feel different. It's understandable that people can feel just plain sick and tired of dealing with a chronic illness once in a while.
- **Option D:** Regression may happen in this age group but it is more common in toddler years. Struggling in this stage of life can result in loneliness and isolation. Loneliness can affect overall health in other ways. For example, socially isolated people tend to have unhealthier diets, exercise less, experience greater daytime fatigue, and have poorer sleep.

53. When obtaining the health history from a male client with retinal detachment, the nurse expects the client to report:

- A. Light flashes and floaters in front of the eye.
- B. A recent driving accident while changing lanes.
- C. Headaches, nausea, and redness of the eyes.
- D. Frequent episodes of double vision.

Correct Answer: A. Light flashes and floaters in front of the eye.

The sudden appearance of light flashes and floaters in front of the affected eye is characteristic of retinal detachment. Patients with a rhegmatogenous retinal detachment may present with a history of a large number of new-onset floaters. They may also have significant photopsia (flashes of light) in their vision.

- **Option B:** Difficulty seeing cars in another driving lane suggests a gradual loss of peripheral vision, which may indicate glaucoma. Many patients with glaucoma, especially early in the disease, are not aware they have this condition until it is discovered on a routine eye exam. People generally slowly lose peripheral vision but retain central vision until the disease process is severe.
- **Option C:** Headache, nausea, and redness of the eyes are signs of acute (angle-closure) glaucoma. In the acute angle-closure type, patients typically present with severe sudden ocular pain, redness, blurry vision/decreased visual acuity, headache, nausea or vomiting, and may complain of seeing halos of light. Patients will have an unresponsive mid-dilated pupil on examination and a firm feeling eyeball on palpation.
- **Option D:** Double vision is common in clients with cataracts. Diplopia or polyopia, mostly unocular but can be binocular, is due to multiple refractions through clear areas between the opacities. A cataract is a clouding or opacification of the normally clear lens of the eye or its capsule (surrounding transparent membrane) that obscures the passage of light through the lens to the retina of the eye.

54. A 34-year-old woman with a history of asthma is admitted to the emergency department. The nurse notes that the client is dyspneic, with a respiratory rate

of 35 breaths/minute, nasal flaring, and use of accessory muscles. Auscultation of the lung fields reveals greatly diminished breath sounds. Based on these findings, what action should the nurse take to initiate care of the client?

- A. Initiate oxygen therapy and reassess the client in 10 minutes.
- B. Draw blood for an ABG analysis and send the client for a chest x-ray.
- C. Encourage the client to relax and breathe slowly through the mouth.
- D. Administer bronchodilators.

Correct Answer: D. Administer bronchodilators.

In an acute asthma attack, diminished or absent breath sounds can be an ominous sign indicating lack of air movement in the lungs and impending respiratory failure. The client requires immediate intervention with inhaled bronchodilators, intravenous corticosteroids, and possibly intravenous theophylline.

- **Option A:** Administering oxygen and reassessing the client 10 minutes later would delay needed medical intervention. A favorable response to initial treatment of status asthmaticus should be a visible improvement in symptoms that sustains 30 minutes or beyond the last bronchodilator dose and a PEFr greater than 70% of predicted.
- **Option B:** Drawing an ABG and obtaining a chest x-ray would be a delay. The absolute value of PEFr less than 120 L per minute and FEV1 less than 1 L corresponds with the proportional reduction. These absolute numbers should prompt an assessment of arterial blood gas (ABG) immediately. Initial blood gas results indicate respiratory alkalosis with hypoxemia.
- **Option C:** It would be futile to encourage the client to relax and breathe slowly without providing necessary pharmacologic intervention. An initial aggressive treatment trial of beta-agonists, corticosteroids, and anticholinergics has to be tried, followed by adjunct measures, which may not be based on robust guidelines but evidence.

55. When developing a teaching plan for a client with endocarditis, which of the following points is most essential for the nurse to include?

- A. "Report fever, anorexia, and night sweats to the physician."
- B. "Take prophylactic antibiotics after dental work and invasive procedures."
- C. "Include potassium rich foods in your diet."
- D. "Monitor your pulse regularly."

Correct Answer: A. "Report fever, anorexia, and night sweats to the physician."

An essential teaching point is to report signs of relapse, such as fever, anorexia, and night sweats, to the physician. An early manifestation of the disease is mild. Prolonged duration of fever that persists for several months without other manifestations may be the only symptom. On the other hand, the onset can be acute and severe with high, intermittent fever.

- **Option B:** To prevent further endocarditis episodes, prophylactic antibiotics are taken before and sometimes after dental work, childbirth, or GU, GI, or gynecologic procedures. Antibiotic therapy can be adjusted depending on the clinical status of the patient and laboratory findings regarding antibiogram. Antibiotics should be administered intravenously to achieve reliable sustained therapeutic levels.

- **Option C:** A potassium-rich diet is not necessary for patients with endocarditis. In 2007, the AHA modified their infective endocarditis prophylaxis guidelines, and the indications for prophylaxis were reduced for dental procedures, genitourinary, and gastrointestinal tract procedures.
- **Option D:** Daily pulse monitoring isn't necessary for a client with endocarditis. The presence of a new heart murmur or sounds of changing heart murmur is associated with heart failure. Splenomegaly, Roth spots, Janeway lesions, splinter hemorrhage, Osler nodes, and petechial are frequently seen.

56. Nurse Joy is caring for a client with an internal radiation implant. When caring for the client, the nurse should observe which of the following principles?

- A. Remove the dosimeter badge when entering the client's room
- B. Individuals younger than 16 years old may be allowed to go in the room as long as they are 6 feet away from the client
- C. Limit the time with the client to 1 hour per shift
- D. Do not allow pregnant women into the client's room

Correct Answer: D. Do not allow pregnant women into the client's room

- **Options B and D:** Children younger than 16 years of age and pregnant women are not allowed in the client's room to avoid radiation exposure that may harm the children and the developing baby.
- **Option A:** The dosimeter badge must be worn when in the client's room.
- **Option C:** The time that the nurse spends in a room of a client with an internal radiation implant is 30 minutes per 8-hour shift.

57. Which question will critique the auditability of a research project?

- A. Is the strategy used for analysis compatible with the purpose of the study?
- B. Does the researcher document the research process?
- C. Are the researcher's conceptualizations true to the data?
- D. Has adequate time been allowed to fully understand the phenomenon?

Correct Answer: B. Does the researcher document the research process?

This question will critique the auditability of a research project. Understand the purpose and problem, while determining if the design and methodology are consistent with the purpose.

- **Option A:** A research critique is an analysis of a research undertaking that focuses on its strengths and limitations. Critiquing is a systematic process for evaluating research studies and the results reported.
- **Option C:** This question will critique the significance of a research project. "The purpose of a research critique is to determine whether the findings are usable for you" (Brink & Wood, 2001, p. 57).
- **Option D:** This question will critique the credibility of a research project. "The necessary elements in a research critique can be compiled in a series of questions for the process of critiquing research" (Boswell & Cannon, 2009, p. 308).

58. A male client tells the nurse he was involved in a car accident while he was intoxicated. What would be the most therapeutic response from nurse Julia?

- A. "Why didn't you get someone else to drive you?"
- B. "Tell me how you feel about the accident."
- C. "You should know better than to drink and drive."
- D. "I recommend that you attend an Alcoholics Anonymous meeting."

Correct Answer: B. "Tell me how you feel about the accident."

An open-ended statement or question is the most therapeutic response. It encourages the widest range of client responses, makes the client an active participant in the conversation, and shows the client that the nurse is interested in his feelings. mix open-ended questions with focus questions. Open-ended questions may allow the patient to express their thoughts and feelings, and focused questions allow the interviewer to obtain important details with yes or no answers in a more time-efficient manner.

- **Option A:** Asking the client why he drove while intoxicated can make him feel defensive and intimidated. The first question posed in the interview is often open-ended. For example, "What is the main reason you seek medical assistance today?" This provides an opportunity for the interviewer to allow the patient to share their concerns, and the interviewer can show he or she is actively listening. This includes listening without judgment and displaying concern for the patient during communication.
- **Option C:** A judgmental approach isn't therapeutic. During the interview, meaningful questions inquired positively will reduce defensiveness from the patient. Often this can be accomplished by suggesting or sharing a common behavior associated with the actions of the patient. For example, the interviewer may convey the commonality for people to consume alcohol when under stress. It then becomes acceptable to inquire if this is also occurring with the patient. The patient may feel a sense of trust and therefore share pertinent information.
- **Option D:** By giving advice, the nurse suggests that the client isn't capable of making decisions, thus fostering dependency. At the conclusion of the patient interview, an appropriate transition statement to begin the physical exam may be, "Is there anything else that you would like to share with me before I start the physical examination?" This statement serves 2 purposes. First, it elicits any additional information the patient deems necessary, and second, it signals a transition to the physical exam. Lastly, before concluding the interview, it is important to discuss the probable follow-up plan and further treatment. In the outpatient setting, this may include admission to the hospital or going home and returning for a follow-up appointment at a designated time.

59. A client comes into the health clinic 3 years after undergoing resection of the terminal ileum complaining of weakness, shortness of breath, and a sore tongue. Which client statement indicates a need for intervention and client teaching?

- A. "I have been drinking plenty of fluids."
- B. "I have been gargling with warm salt water for my sore tongue."
- C. "I have 3 to 4 loose stools per day."
- D. "I take a vitamin B12 tablet every day."

Correct Answer: D. “I take a vitamin B12 tablet every day.”

Vitamin B12 combines with intrinsic factor in the stomach and is then carried to the ileum, where it is absorbed in the bloodstream. In this situation, vitamin B12 cannot be absorbed regardless of the amount of oral intake of sources of vitamin B12 such as animal protein or vitamin B12 tablets. Vitamin B12 needs to be injected every month, because the ileum has been surgically removed.

- **Option A:** Replacement of fluids and electrolytes is important when the client has continuous multiple loose stools on a daily basis. Massive small bowel resection can lead to short bowel syndrome (SBS), a condition that is characterized by malnutrition and malabsorption secondary to loss of functional small bowel and more rapid intestinal transit. In addition to weight loss and protein-calorie malnutrition, patients suffer from diarrhea, steatorrhea, electrolyte abnormalities, and deficiencies in fat-soluble vitamins.
- **Option B:** Warm salt water is used to soothe sore mucous membranes. Parenteral nutrition, therefore, is a mainstay of early SBS management to limit malnutrition. Early return to enteral feeds once ileus has resolved is advised, even if a diagnosis of SBS is expected. Enteral feeding is thought to stimulate intestinal adaptation by both directly stimulating enterocytes and by inducing endocrine and paracrine effects signaling for hypertrophy of the remaining small bowel mucosa.
- **Option C:** Crohn’s disease and small bowel resection may cause several loose stools a day. Drugs such as loperamide, diphenoxylate and atropine, and opiates will slow gut function, increasing the potential absorptive time of enteral feeds. Reducing gastrointestinal secretion and controlling diarrhea are also important goals for maximizing absorption.

60. The following are considered steps in the qualitative research process, A. Literature review?

- A. Literature review
- B. Hypothesis
- C. Sample
- D. Data collection

Correct Answer: B. Hypothesis

A hypothesis is the tool of quantitative studies and is only found in such studies. A hypothesis states the predictions about what the research will find. It is a tentative answer to a research question that has not yet been tested. A hypothesis is not just a guess — it should be based on existing theories and knowledge. It also has to be testable, which means the researcher can support or refute it through scientific research methods (such as experiments, observations, and statistical analysis of data).

- **Option A:** A literature review is a comprehensive summary of previous research on a topic. The literature review surveys scholarly articles, books, and other sources relevant to a particular area of research. The review should enumerate, describe, summarize, objectively evaluate and clarify this previous research.
- **Option C:** In research terms, a sample is a group of people, objects, or items that are taken from a larger population for measurement. The sample should be representative of the population to ensure that we can generalize the findings from the research sample to the population as a whole.
- **Option D:** This step revolves around obtaining the information that the researcher will need to solve the issue or problem identified. Data collection involves a field force or staff that operates either in the field, as in the case of personal interviewing (in-home, mall intercept, or computer-assisted personal interviewing), from an office by telephone (telephone or

computer-assisted telephone interviewing), or through the mail (traditional mail and mail panel surveys with recruited households).

61. A client is admitted to the psychiatric unit with a tentative diagnosis of psychosis. Her physician prescribes the phenothiazine thioridazine (Mellaril) 50 mg by mouth three times per day. Phenothiazines differ from central nervous system (CNS) depressants in their sedative effects by producing:

- A. Deeper sleep than CNS depressants.
- B. Greater sedation than CNS depressants.
- C. A calming effect from which the client is easily aroused.
- D. More prolonged sedative effects, making the client more difficult to arouse.

Correct Answer: C. A calming effect from which the client is easily aroused.

Shortly after phenothiazine administration, a quieting and calming effect occurs, but the client is easily aroused, alert, and responsive and has good motor coordination. The precise mechanism of action exhibited by phenothiazines is not entirely known. Yet, phenothiazines act primarily through inhibiting the dopamine receptor at the mesolimbic pathway with a selective activity at the D2 receptor. This inhibition antagonizes the hyperactivity of dopamine at the synapse and reduces positive symptoms such as delusions and hallucinations associated with schizophrenia.

- **Option A:** Benzodiazepines are frequently used to treat insomnia; however, there may be a withdrawal syndrome with rapid eye movement (REM) rebound. Two newer benzodiazepine-like agents, zolpidem and zaleplon, have fewer side effects, yet good efficacy. Other agents for insomnia include sedating antidepressants and over-the-counter sleep products (sedating antihistamines).
- **Option B:** Central Nervous System (CNS) depressants are medicines that include sedatives, tranquilizers, and hypnotics. These drugs can slow brain activity, making them useful for treating anxiety, panic, acute stress reactions, and sleep disorders. CNS depressants cause drowsiness; sedatives are often prescribed to treat sleep disorders like insomnia and hypnotics can induce sleep, whereas tranquilizers are prescribed to treat anxiety or to relieve muscle spasms.
- **Option D:** When people overdose on a CNS depressant, their breathing often slows or stops. This can decrease the amount of oxygen that reaches the brain, a condition called hypoxia. Hypoxia can have short- and long-term mental effects and effects on the nervous system, including coma and permanent brain damage.

62. The primary purpose for using a continuous passive motion (CPM) machine for the client with a total knee repair is to help:

- A. Inhibit lactic acid production in the leg muscles
- B. Prevent contractures
- C. Decrease the pain associated with early ambulation
- D. Promote flexion of the artificial joint

Correct Answer: D. Promote flexion of the artificial joint

- Option D: Continuous passive motion (CPM) machine is an equipment used as part of the rehabilitation process following joint or hip surgery. The primary purpose of the continuous passive-motion machine is to promote the flexion of the artificial joint. The device should be placed at the foot of the client's bed.

63. Benztropine (Cogentin) is used to treat the extrapyramidal effects induced by antipsychotics. This drug exerts its effect by:

- A. Decreasing the anxiety causing muscle rigidity.
- B. Blocking the cholinergic activity in the central nervous system (CNS).
- C. Increasing the level of acetylcholine in the CNS.
- D. Increasing norepinephrine in the CNS.

Correct Answer: B. Blocking the cholinergic activity in the central nervous system (CNS).

This is the action of Cogentin. Benztropine antagonizes acetylcholine and histamine receptors. In the CNS and smooth muscles, benztropine exerts its action through competing with acetylcholine at muscarinic receptors. Consequently, it reduces central cholinergic effects by blocking muscarinic receptors that appear to improve the symptoms of Parkinson disease. Thus, benztropine blocks the cholinergic muscarinic receptor in the central nervous system. Therefore, it reduces the cholinergic effects significantly during Parkinson disease which becomes more pronounced in the nigrostriatal tract because of reduced dopamine concentrations.

- **Option A:** Anxiety doesn't cause extrapyramidal effects. Benztropine belongs to the synthetic class of muscarinic receptor antagonists (anticholinergic drug). Thus, it has a structure similar to that of diphenhydramine and atropine. However, it is long-acting so that its administration can be with less frequency than diphenhydramine. It also induces less CNS stimulation effect compared to that of trihexyphenidyl, making it a preferable drug of choice for geriatric patients.
- **Option C:** Overactivity of acetylcholine and lower levels of dopamine are the causes of extrapyramidal effects. It is also useful for drug-induced extrapyramidal symptoms and the prevention of dystonic reactions and acute treatment of dystonic reactions. Furthermore, benztropine has further off-label use as it can treat chronic sialorrhea occurring in developmentally-disabled patients. Also, several clinical studies worked on using benztropine in managing intractable hiccups.
- **Option D:** Benztropine doesn't increase norepinephrine in the CNS. Benztropine overdose can cause an anticholinergic toxidrome, which, in its role, may require supportive care. Commonly, the risk assessment for benztropine overdose can take place as soon as 6 hours after overdose ingestion, and toxicity effects may last variably between 12 hours to 5 days at most. The most crucial step of proper detection of benztropine overdose starts from carrying out intensive and inclusive investigations. For example, ECG can be an essential assessment tool using 12 leads during testing. Also, monitoring the acetaminophen concentrations as well as blood glucose concentrations can become a useful method for toxicity investigations if the toxicant is unknown.

64. During the warfarin (Coumadin) administration, the nurse can expect that the initial extension of PT occurs within how many hours after therapy begins?

- A. 1 to 2
- B. 4 to 6

- C. 8 to 12
- D. 12 to 24

Correct Answer: C. 8 to 12.

Initial extension of PT occurs within 8 to 12 hours after warfarin therapy begins. Warfarin is an oral anticoagulant commonly used to treat and prevent blood clots. Warfarin has multiple FDA-approved and off-label clinical uses.

- **Option A:** Warfarin competitively inhibits the vitamin K epoxide reductase complex 1 (VKORC1), which is an essential enzyme for activating the vitamin K available in the body. Through this mechanism, warfarin can deplete functional vitamin K reserves and therefore reduce the synthesis of active clotting factors. The hepatic synthesis of coagulation factors II, VII, IX, and X, as well as coagulation regulatory factors protein C and protein S, require the presence of vitamin K. Vitamin K is an essential cofactor for the synthesis of all of these vitamin K-dependent clotting factors.
- **Option B:** Warfarin is a once-daily oral medication. Warfarin administration can be at any time during the day, but recommendations are for administration in the afternoon or evening. By instructing patients to take warfarin later in the day, healthcare providers can have the opportunity to individualize a patient's warfarin dose the same day based on their most current lab values.
- **Option D:** Patients receiving treatment with warfarin should have close monitoring to ensure the safety and efficacy of the medication. Periodic blood testing is the recommendation to assess the patient's prothrombin time (PT) and the international normalized ratio (INR).

65. A 25-year-old patient is inquiring about the methods or ways to detect cancer earlier. The nurse least likely identifies this method by stating:

- A. Yearly physical and blood examination
- B. Annual digital rectal examination for persons over age 40
- C. Annual Pap smear for sexually active women only
- D. Annual chest x-ray

Correct Answer: C. Annual Pap smear for sexually active women only

- **Option C:** Pap smear should be done yearly for sexually active women. All women should have an annual pap smear by age 40 and up whether sexually active or not.
- **Options A, B, and D:** Early detection of cancer is promoted by annual oral examination, monthly BSE from age 20, annual chest x-ray, yearly digital rectal examination for persons over age 40, annual Pap smear from age 40 and annual physical and blood examination.

66. The community nurse is speaking to a group of new mothers as part of a primary prevention program. Which self-measures would be most helpful as a strategy to decrease the occurrence of mood disorders?

- A. Keeping busy, so as not to confront problem areas.
- B. Medication with antidepressants.
- C. Use of crisis intervention services.
- D. Verbalizing rather than internalizing feelings.

Correct Answer: D. Verbalizing rather than internalizing feelings.

Individuals who develop mood disorders often have difficulty expressing feelings, especially feelings of anger toward significant others. Internalizing those feelings can contribute to loss of self-esteem and guilt, and therefore negative cognitions and depression.

- **Option A:** Ignoring problems is not a helpful strategy. Recognizing problems and using problem-solving methods will contribute to mental health. The nurse can direct their need for movement into socially acceptable, large motor activities such as arranging chairs for a community meeting or walking.
- **Option B:** Antidepressants are certainly necessary in the treatment of the mood disorder of depression; however, they are not used in primary prevention. Decreasing environmental stimulation may assist the client to relax; the nurse must provide a quiet environment without noise, television, and other distractions; finger foods or things the client can eat while moving around are the best options to improve nutrition.
- **Option C:** Crisis intervention would be a useful strategy in handling the immediate needs of someone experiencing a crisis; it is not a tool of primary prevention. A primary nursing responsibility is to provide a safe environment for the client and others; for clients who feel out of control, the nurse must establish external controls emphatically and nonjudgmentally.

67. A female client exhibits purplish bruises to the skin after a fall. The nurse would document this finding most accurately using which of the following terms?

- A. Purpura
- B. Petechiae
- C. Ecchymosis
- D. Erythema

Correct Answer: C. Ecchymosis

Ecchymosis is a type of purpuric lesion and also is known as a bruise. It happens when blood leaks out of the vessels into the underlying subcutaneous tissues.

- **Option A:** Purpura is an umbrella term that incorporates ecchymoses and petechiae.
- **Option B:** Petechiae are pinpoint hemorrhages and are another form of purpura.
- **Option D:** Erythema is an area of redness on the skin.

68. Mandy, an adolescent girl is admitted to an acute care facility with severe malnutrition. After a thorough examination, the physician diagnoses anorexia nervosa. When developing the plan of care for this client, the nurse is most likely to include which nursing diagnosis?

- A. Hopelessness
- B. Powerlessness
- C. Chronic low self-esteem
- D. Deficient knowledge

Correct Answer: C. Chronic low self-esteem

Young women with chronic low self-esteem — are at the highest risk for anorexia nervosa because they perceive being thin as a way to improve their self-confidence. Anorexia nervosa is an illness of starvation, brought on by severe disturbance of body image and a morbid fear of obesity. People with anorexia nervosa attempt to maintain a weight that's far below normal for their age and height.

- **Option A:** Hopelessness is an inappropriate nursing diagnosis because clients with anorexia nervosa seldom feel hopeless; instead, they use food to control their desire to be thin and hope that restricting food intake will achieve this goal. Feelings of personal ineffectiveness, low self-esteem, and perfectionism are often part of the problem.
- **Option B:** Major physical and psychological changes in adolescence can contribute to the development of eating disorders. Feelings of powerlessness and loss of control of feelings (in particular sexual sensations) lead to an unconscious desire to desexualize self. The patient often believes that these fears can be overcome by taking control of bodily appearance, development, and function.
- **Option D:** Anorexia nervosa doesn't result from a knowledge deficit, such as one regarding good nutrition. The patient sees herself as weak-willed, even though part of a person may feel a sense of power and control (dieting, weight loss). The patient feels helpless to change and requires assistance to problem-solve methods of control in life situations.

69. In a nuanced neonatal clinical evaluation, a nurse is performing a postnatal assessment on a newborn who has just been delivered via vaginal birth. Amidst the myriad of physiological adaptations occurring in the transition from intrauterine to extrauterine life, which of the following clinical findings would be least expected in a healthy neonate?

- A. The neonate's heart rate is recorded at 80 beats per minute.
- B. The neonate exhibits an uneven head shape, also known as molding.
- C. The neonate's respirations are observed to be irregular and abdominal, ranging between 30-60 breaths per minute.
- D. The neonate demonstrates a positive Moro reflex upon examination.
- E. The neonate has a bluish tint to the extremities, known as acrocyanosis.
- F. The neonate's skin is coated with a white, cheesy substance known as vernix caseosa.

Correct Answer: A. The neonate's heart rate is recorded at 80 beats per minute.

A heart rate of 80 bpm is considered bradycardia in a newborn. The normal range for a neonate's heart rate is between 120 to 160 bpm when awake and can be as low as 80 bpm during deep sleep, but a sustained rate of 80 bpm, especially in the immediate postnatal period, could be indicative of underlying issues and warrants further investigation.

- **Option B:** An uneven head shape, or molding, is a common and expected finding in newborns delivered vaginally. The cranial bones can overlap and shift to facilitate passage through the birth canal. This condition is usually temporary and resolves on its own.
- **Option C:** Irregular and predominantly abdominal respirations ranging between 30-60 breaths per minute are normal for a newborn. Infants typically have irregular breathing patterns, which can include periodic breathing.

- **Option D:** The Moro reflex, or startle reflex, is a normal reflex present in newborns. It is an indication of healthy neurological function and typically disappears around 4 to 6 months of age.
- **Option E:** Acrocyanosis, a bluish discoloration of the extremities, is a common finding in the first few days of life as the newborn's circulation adapts. It is generally benign and transient.
- **Option F:** Vernix caseosa is a white, cheesy substance found coating the skin of newborns. It provides protection in the uterine environment and is typically washed off after birth. Its presence is a normal finding, especially in preterm infants.

70. Which of the following is the most appropriate activity for a 5-year-old child?

- A. Squeeze toy
- B. Board games
- C. Play-Doh
- D. Computer games

Correct Answer: C. Play-Doh

In the preschooler, play is simple and imaginative that includes activities such as puppets, play-doh, and coloring books. While the kids are molding play dough into different shapes, they are actually building up strength in their tiny hands. The acts of squishing, rolling, flattening, and more help your children develop muscles used in their hands for fine motor movements useful in the future, such as holding a pencil or using scissors.

- **Option A:** Easy and safe to hold toys such as squeeze toys are appropriate for infants. Infants are fascinated with movement, sounds, and simple black and white visuals. They are discovering their own bodies, working on eye-hand coordination, reaching, and grasping.
- **Option B:** Toys that require concentration such as board games are appropriate for the school-age child. In addition to teaching them about teamwork, patience, and how to win and lose gracefully, board games can actually benefit kids' brains and language development.
- **Option D:** A play that requires problem-solving techniques like computer games is appropriate for an adolescent. Some games might improve kids' hand-eye coordination and problem-solving skills. Video games that require kids to actually move or manipulate the game through their own physical movement can even get sedentary kids moving.

71. During a class discussion, the 50-year-old professor suddenly feels left-sided chest pain, dizziness, and diaphoresis. What is the priority action when he arrives in the ED triage area?

- A. Supply oxygen via nasal cannula
- B. Place intravenous (IV) access
- C. Notify the ED physician
- D. Set the client on continuous electrocardiographic monitoring

Correct Answer: A. Supply oxygen via nasal cannula

Increasing myocardial oxygenation is the priority goal. Place the patient on a cardiac monitor, establish intravenous (IV) access, give 162 mg to 325 mg chewable aspirin, clopidogrel, or ticagrelor

(unless bypass surgery is imminent), control pain and consider oxygen (O₂) therapy.

- **Option B:** Intravenous opioids (e.g., morphine) are the analgesics most commonly used for pain relief (Class IIa). The results from CRUSADE quality improvement initiative have shown that the use of morphine may be associated with a higher risk of death and adverse clinical outcomes.
- **Option C:** After providing initial treatment, the physician should be notified. Patients with non-ST elevation myocardial infarction (NSTEMI) and unstable angina should be admitted for cardiology consultation and workup. Patients with stable angina may be appropriate for outpatient workup.
- **Option D:** The other actions are also appropriate and should be done immediately. Electrocardiogram (ECG) preferably in the first 10 min of arrival, (consider serial ECGs). Patients with ST-elevation on ECG patients should receive immediate reperfusion therapy either pharmacologic (thrombolytics) or transfer to the catheterization laboratory for percutaneous coronary intervention (PCI).

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

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

Correct Answer: D. Acute renal failure

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

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

73. A client with myocardial infarction is receiving tissue plasminogen activator, alteplase (Activase, tPA). While on the therapy, the nurse plans to prioritize which of the following?

- A. Observe for neurological changes.
- B. Monitor for any signs of renal failure.
- C. Check the food diary.
- D. Observe for signs of bleeding.

Correct Answer: D. Observe for signs of bleeding.

Bleeding is the priority concern for a client taking thrombolytic medication.

- **Options A & B:** Neurological changes and signs of renal failure are monitored but are not the primary concern.
- **Option C:** Checking the food diary is not related to the use of medication.

74. Which assessment data should the nurse include when obtaining a review of body systems?

- A. Brief statement about what brought the client to the health care provider.
- B. Client complaints of chest pain, dyspnea, or abdominal pain.
- C. Information about the client's sexual performance and preference.
- D. The client's name, address, age, and phone number.

Correct Answer: B. Client complaints of chest pain, dyspnea, or abdominal pain.

Client complaints about chest pain, dyspnea, or abdominal pain are considered part of the review of body systems. This portion of the assessment elicits subjective information on the client's perceptions of major body system functions, including cardiac, respiratory, and abdominal. Critical thinking skills applied during the nursing process provide a decision-making framework to develop and guide a plan of care for the patient incorporating evidence-based practice concepts.

- **Option A:** A brief statement about what brought the client to the health care provider is the chief complaint. The CC is the reason for the visit as stated in the patient's own words. This must be present for each encounter, and should reference a specific condition or complaint (e.g., patient complains of abdominal pain).
- **Option C:** Information about the client's sexual performance and preference addresses past health status. Understanding the client's current and past health is important and may provide an explanation or rationale for the client's current health status. Furthermore, these data can provide insight into health promotion needs and co-morbidities. It is helpful to understand the current and past health profiles before assessing other aspects of health, as the information will inform subsequent questions.
- **Option D:** The client's name, address, age, and phone number are biographical data. "Introductory Information" refers to the demographic and biographic data that you collect from the client. This data provides you with basic characteristics about the client, such as their name, contact information, birth date and age, gender and preferred pronouns, allergies, languages spoken and preferred language, relationship status, occupation, and resuscitation status.

76. When reviewing the admission assessment, the nurse notes that a patient was admitted to the mental health unit involuntarily. Based on this type of admission, the nurse should provide which intervention for this patient?

- A. Monitor closely for harm to self or others.
- B. Assist in completing an application for admission
- C. Supply the patient with written information about their mental illness.
- D. Provide an opportunity for the family to discuss why they felt the admission was needed.

Correct Answer: A. Monitor closely for harm to self or others.

Involuntary admission is necessary when a person is a danger to himself or others or is in need of psychiatric treatment regardless of the patient's willingness to consent to the hospitalization. The person must pose a "clear and present danger" to self or others based upon statements and behavior that occurred in the past 30 days.

- **Option B:** A written request is a component of voluntary admission. Involuntary admission to an acute inpatient psychiatric hospital occurs when the patient does not agree to hospitalization on a locked inpatient psychiatric unit, but a mental health professional evaluates the patient and believes that, as a result of mental illness, the patient is at risk of harming self or others, or is unable to care for self.
- **Option C:** Providing written information regarding the illness is likely premature initially. The decision to discharge the patient or request a longer commitment is made by the treatment team based on concerns for the safety of the patient or others.
- **Option D:** The family may have had no role to play in the patient's admission. However, any person (including police and doctors) can petition or request an involuntary psychiatric evaluation for another person. The person requesting the evaluation is known as the "petitioner." A request for an evaluation can be made by going to any CRC or by calling a mobile crisis team to come to the petitioner's home.

77. When caring for a client with total parenteral nutrition (TPN), what is the most important action on the part of the nurse?

- A. Record the number of stools per day.
- B. Maintain strict intake and output records.
- C. Sterile technique for dressing change at IV site.
- D. Monitor for cardiac arrhythmias.

Correct Answer: C. Sterile technique for dressing change at IV site.

Clients receiving TPN are very susceptible to infection. The concentrated glucose solutions are a good medium for bacterial growth. Strict sterile technique is crucial in preventing infection at IV infusion sites. Catheter-related sepsis rates have decreased since the introduction of guidelines that emphasize sterile techniques for catheter insertion and skin care around the insertion site. The increasing use of dedicated teams of physicians and nurses who specialize in various procedures including catheter insertion also has accounted for a decrease in catheter-related infection rates.

- **Option A:** Progress of patients with a TPN line should be followed on a flowchart. An interdisciplinary nutrition team, if available, should monitor patients. Weight, complete blood count, electrolytes, and blood urea nitrogen should be monitored often (eg, daily for inpatients). Plasma glucose should be monitored every 6 hours until patients and glucose levels become stable. Fluid intake and output should be monitored continuously. When patients become stable, blood tests can be done much less often.

- **Option B:** Volume overload (suggested by > 1 kg/day weight gain) may occur when patients have high daily energy requirements and thus require large fluid volumes.
- **Option D:** Forty-one percent of procedures resulted in atrial arrhythmias and 25% produced some degree of ventricular ectopy, 30% of these were ventricular couplets or greater. Ventricular ectopy was significantly more common in shorter patients and when the catheter was inserted from the right subclavian position (43% ventricular ectopy vs 10% at the other sites). Other variables such as age, cardiac history, serum potassium, type of procedure, and catheter brand were not significant.

78. A nurse is planning care for a child with acute bacterial meningitis. Based on the mode of transmission of this infection, which of the following would be included in the plan of care?

- A. No precautions are required as long as antibiotics have been started.
- B. Maintain enteric precautions.
- C. Maintain respiratory isolation precautions for at least 24 hours after the initiation of antibiotics.
- D. Maintain neutropenic precautions.

Correct Answer: C. Maintain respiratory isolation precautions for at least 24 hours after the initiation of antibiotics

A major priority of nursing care for a child suspected of having meningitis is to administer the prescribed antibiotic as soon as it is ordered. The child is also placed on respiratory isolation for at least 24 hours while culture results are obtained and the antibiotic is having an effect. Antibiotics are given to treat the underlying causes of inflammation and thus prevent the occurrence of seizure activity.

- **Option A:** Assess neurologic status to include VS pattern, changes in consciousness, behavior patterns and pupillary/ocular responses appropriate for age (measure head circumference in infant) (specify when). Administer antibiotics as prescribed (specify) as soon as ordered based on analysis of CSF, throat cultures.
- **Option B:** Enteric precautions are taken to prevent infections that are transmitted primarily by direct or indirect contact with fecal material. They're indicated for patients with known or suspected infectious diarrhea or gastroenteritis. Clostridium difficile is the most common cause of hospital-acquired infectious diarrhea.
- **Option D:** Neutropenic precautions are steps one can take to prevent infections if they have moderate to severe neutropenia. Neutropenia is a condition that causes the client to have low neutrophils in the blood. Neutrophils are a type of white blood cell that helps the body fight infection and bacteria. Ask a healthcare provider for more information on neutropenia.

79. A new RN nurse is about to insert a nasogastric tube into a client with Guillain-Barre Syndrome. To determine the accurate measurement of the length of the tube to be inserted, the nurse should:

- A. Place the tube at the tip of the nose, and measure by extending the tube to the earlobe and then down to the top of the sternum.
- B. Place the tube at the tip of the nose and measure by extending the tube to the earlobe and then down to the xiphoid process.

C. Place the tube at the tip of the nose, and measure by extending the tube down to the chin and then down to the top of the xiphoid process.

D. Place the tube at the base of the nose and measure by extending the tube to the earlobe and then down to the top of the sternum.

Correct Answer: B. Place the tube at the tip of the nose, and measure by extending the tube to the earlobe and then down to the xiphoid process.

Estimate the length of insertion by measuring the distance from the tip of the nose, around the ear, and down to just below the left costal margin. This point can be marked with a piece of tape on the tube. When using the Salem sump NG tube (Kendall, Mansfield, MA) in adults, the estimated length usually falls between the second and third preprinted black lines on the tube.

- **Option A:** Apart from the nose-to-ear-to-xiphisternum (NEX) method, several other methods for determining the length of the tube have been described. Among the various options, a formula based on gender, weight, and nose-to-umbilicus measurement while lying flat was found to be safer and more accurate in a study by Santos et al.
- **Option C:** While the stomach is a highly distensible structure and therefore, can vary in length, the empty stomach is generally around 25 cm long. Thus if one intended to place a tube through the nares and place it in the middle of the stomach, then approximately 55 cm of the tube should be inserted.
- **Option D:** There are several methods to estimate the depth that an NG should be placed. All methods for estimation will have some margin of error. A common pre-procedure maneuver is to loop the tube over one of the patient's ears and place the tip at the patient's xiphoid process and use this as an estimate for the length of the tube that should be inserted.

80. Which route of administration is preferred if immediate analgesia and rapid titration are necessary?

- A. Intraspinal
- B. Patient-controlled analgesia (PCA)
- C. Intravenous (IV)
- D. Sublingual

Correct Answer: C. Intravenous (IV)

The IV route is preferred as the fastest and most amenable to titration. Medications may be given as repeated intermittent bolus doses or by continuous infusion. Intravenous provides almost immediate analgesia; subcutaneous may require up to 15 minutes for effect. Bolus IV dosing provides a shorter duration of action than other routes.

- **Option A:** Intraspinal administration requires special catheter placement and there are more potential complications with this route. Intraspinal and intraventricular administration are options if maximal doses of opioids and adjuvants administered through other routes are ineffective or produce intolerable side effects {e.g., nausea/vomiting, excessive sedation, confusion}. Opioids can be administered via indwelling percutaneous or tunneled catheters into the epidural or intrathecal space.
- **Option B:** A PCA bolus can be delivered; however, the pump will limit the dosage that can be delivered unless the parameters are changed. Patient-controlled analgesia (PCA) devices can be used to combine continuous infusion with intermittent bolus doses, allowing more flexible pain

control. It is recommended that the hourly SQ volume limit not exceed 5 cc. Medications can be concentrated to maintain SQ volume limits; maximal concentrations: fentanyl 50 ug/ml, morphine 50 mgs/ml, hydromorphone 50 mgs/ml.

- **Option D:** Sublingual is reasonably fast, but not a good route for titration, medication variety in this form is limited. An alkaline pH microenvironment that favors the unionized fraction of opioids increased sublingual drug absorption. Although absorption was found to be independent of drug concentration, it was contact time dependent for methadone and fentanyl but not for buprenorphine. These results indicate that although the sublingual absorption and apparent sublingual bioavailability of morphine are poor, the sublingual absorption of methadone, fentanyl, and buprenorphine under controlled conditions is relatively high.

81. Isotonic FVD can result from:

- A. GI fluid loss through diarrhea.
- B. Insensible water loss during prolonged fever.
- C. Inadequate ingestion of fluids and electrolytes.
- D. Impaired thirst regulation.

Correct Answer: C. Inadequate ingestion of fluids and electrolytes.

Isotonic FVD may result from inadequate intake of fluids and electrolytes that can occur secondary to an inability to ingest orally. Isotonic dehydration is a condition in which both water and sodium are lost proportionally and the serum sodium concentration maintains normal serum osmolality. Serum osmolality determines the movement of fluids and electrolytes across membranes. The normal serum osmolality is 285–295 mOsm/kg.

- **Option A:** GI fluid loss through diarrhea is an etiology of hypotonic FVD. Hypotonic dehydration occurs when sodium loss is greater than water loss, resulting in a decrease in serum osmolality. This causes a shift of water from the extracellular space into the intracellular space. The cells swell and cerebral edema may occur.
- **Option B:** Insensible water loss during prolonged fever is a cause of hypertonic FVD. Fever will increase the respiratory rate and therefore, water loss. Sweating also increases to lower the body temperature. Water intake is commonly decreased during a fever which will aggravate dehydration.
- **Option D:** Impaired thirst regulation is a cause of hypertonic FVD. Hypertonic dehydration occurs when water excretion from the body exceeds that of sodium excretion, resulting in increased sodium concentration in the extracellular fluid (hypernatremia). Blood osmolality is increased, causing water to shift from the intracellular to the extracellular space.

82. A male client is admitted to a psychiatric facility by court order for evaluation for antisocial personality disorder. This client has a long history of initiating fights and abusing animals and recently was arrested for setting a neighbor's dog on fire. When evaluating this client for the potential for violence, nurse Perry should assess for which behavioral clues?

- A. A rigid posture, restlessness, and glaring
- B. Depression and physical withdrawal
- C. Silence and noncompliance

D. Hypervigilance and talk of past violent acts

Correct Answer: A. A rigid posture, restlessness, and glaring

Behavioral clues that suggest the potential for violence include a rigid posture, restlessness, glaring, a change in usual behavior, clenched hands, overtly aggressive actions, physical withdrawal, noncompliance, overreaction, hostile threats, recent alcohol ingestion or drug use, talk of past violent acts, inability to express feelings, repetitive demands and complaints, argumentativeness, profanity, disorientation, inability to focus attention, hallucinations or delusions, paranoid ideas or suspicions, and somatic complaints.

- **Option B:** Before performing a comprehensive psychiatric assessment of the patient, a careful history and physical examination is necessary. "The DSM-5 diagnostic criteria for Antisocial Personality Disorder. A pervasive pattern of disregard for and violation of the rights of others, since age 15 years, as indicated by three (or more) of the following: failure to conform to social norms concerning lawful behaviors, such as performing acts that are grounds for arrest; deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit; Impulsivity or failure to plan; Irritability and aggressiveness, often with physical fights or assaults; reckless disregard for the safety of self or others; consistent irresponsibility, failure to sustain consistent work behavior, or honor monetary obligations; lack of remorse, being indifferent to or rationalizing having hurt, mistreated, or stolen from another person.
- **Option C:** Of those children with conduct disorder, 25% of girls and 40% of boys will meet the diagnostic criteria for antisocial personality disorder. Boys exhibit symptoms earlier than girls, who often only elicit these symptoms in puberty. Children who do not develop conduct disorder and progress to the age of 15 without antisocial behaviors will not develop ASPD.
- **Option D:** Antisocial personality disorder, although a chronic condition with a lifelong presentation, has had moderations shown with advancing ages, with the mean remitted age of 35 years old. Those with less baseline symptomatology showed better-remitted rates. Studies in the past revealed remission rates of 12 to 27% and 27 to 31% rates of improvement, but not remitted. Crime rates and severity reflect this relation as well, with peak crime statistics in late teens and higher severity of crimes at younger ages.

83. A female client begins to experience alcoholic hallucinosis. Nurse Joy is aware that the best nursing intervention at this time?

- A. Keeping the client restrained in bed.
- B. Checking the client's blood pressure every 15 minutes and offering juices.
- C. Providing a quiet environment and administering medication as needed and prescribed.
- D. Restraining the client and measuring blood pressure every 30 minutes.

Correct Answer: C. Providing a quiet environment and administering medication as needed and prescribed.

Manifestations of alcoholic hallucinosis are best treated by providing a quiet environment for reducing stimulation and administering prescribed central nervous system depressants in dosages that control symptoms without causing oversedation. Encourage the patient to rest by controlling minimal interpersonal contact with the patient. Decrease environmental stimuli with controlled lighting, and provide a calm, quiet private room. The individualized, symptom-triggered approach to benzodiazepine use satisfies the need to use medication only when needed and may also reduce inpatient hospital stays. Benzodiazepines stimulate GABA receptors causing a decrease in neuronal activity resulting in sedation.

- **Option A:** Although bed rest is indicated, restraints are unnecessary unless the client poses a danger to himself or others. Also, restraints may increase agitation and make the client feel trapped and helpless when hallucinating. Present reality without challenging or escalating the patient's anxiety and thought disturbances. Build a therapeutic rapport with the patient by providing relief from his or her symptoms and meeting physiologic and safety needs. Meet the patient's needs promptly to reduce the risk of violence or aggression. Do not approach the patient with loose items that the patient could grab if he or she becomes agitated, such as a clipboard or dangling ID badge or phone.
- **Option B:** Offering juice is appropriate, but measuring blood pressure every 15 minutes would interrupt the client's rest. The nurse also documents the patient's vital signs, looking for an upward trend indicating increased withdrawal symptoms. On a scale of 0 (none) to 3 (severe), the nurse then rates key signs and symptoms such as nausea/vomiting; tremors; diaphoresis; anxiety; agitation; tactile, auditory, and visual disturbances; headache; and orientation.
- **Option D:** To avoid overstimulating the client, the nurse should check blood pressure every 2 hours. As direct caregivers, nurses are ideally positioned to improve patient outcomes by using the symptom-triggered approach. Based on an objective withdrawal severity scale, a symptom-triggered approach provokes faster and more-effective relief of withdrawal symptoms than treatment based on clinicians' subjective judgment alone.

84. A patient has partial-thickness burns to both legs and portions of his trunk. Which of the following I.V. fluids are given first?

- A. Albumin
- B. D5W
- C. Lactated Ringer's solution
- D. 0.9% sodium chloride solution with 2 mEq of potassium per 100 ml

Correct Answer: C. Lactated Ringer's solution

Lactated Ringer's solution replaces lost sodium and corrects metabolic acidosis, both of which commonly occur following a burn.

- **Option A:** Albumin is used as an adjunct therapy, not a primary fluid replacement.
- **Option B:** Dextrose isn't given to burn patients during the first 24 hours because it can cause pseudodiabetes.
- **Option D:** The patient is hyperkalemic from the potassium shift from the intracellular space to the plasma, so potassium would be detrimental.

85. The personality type of Ryan is:

- A. Conforming
- B. Dependent
- C. Perfectionist
- D. Masochistic

Correct Answer: B. Dependent

A client with a dependent personality is predisposed to develop asthma. At the heart of dependent personality is a lack of self-efficacy. Individuals with dependent personality believe they are incapable of being independent and may feel unable to make even simple decisions without outside input. They often avoid expressing any type of disagreement for fear of losing their support.

- **Option A:** The conforming non-assertive client is predisposed to develop hypertension because of the tendency to repress rage. Conformity describes the adaptation of behavior that occurs in response to unspoken group pressure. It differs from compliance, which is adaptation of behavior resulting from overt pressure. Individuals conform to or comply with group behavior in an attempt to “fit in” or to follow the norms of the social group.
- **Option C:** The perfectionist and compulsive tend to develop a migraine. Perfectionism is often seen as a positive trait that increases the chances of success, but it can lead to self-defeating thoughts or behaviors that make it harder to achieve goals. It may also cause stress, anxiety, depression, and other mental health issues. People who strive for perfection out of feelings of inadequacy or failure may find it helpful to speak with a therapist; this can often help people manage excessive self-criticism.
- **Option D:** The masochistic, self-sacrificing type is prone to develop rheumatoid arthritis. Masochism may be a means of escaping from high-level awareness of self as a symbolically mediated, temporally extended identity. Such awareness is replaced by a focus on the immediate present and on bodily sensations, and sometimes by a low-level awareness of self as an object.

86. The nurse is preparing to discharge a patient with chronic low back pain. Which statement by the patient indicates that additional teaching is necessary?

- A. “I will avoid exercise because the pain gets worse.”
- B. “I will use heat or ice to help control the pain.”
- C. “I will not wear high-heeled shoes at home or work.”
- D. “I will purchase a firm mattress to replace my old one.”

Correct Answer: A. “I will avoid exercise because the pain gets worse.”

Exercises are used to strengthen the back, relieve pressure on compressed nerves and protect the back from re-injury. Doing exercises to strengthen the lower back can help alleviate and prevent lower back pain. It can also strengthen the core, leg, and arm muscles. According to researchers, exercise also increases blood flow to the lower back area, which may reduce stiffness and speed up the healing process.

- **Option B:** Ice and heat application are appropriate interventions for back pain. Applying ice or a reusable gel pack constricts blood vessels and reduces swelling around the injury. This is particularly useful for conditions, like a sprained ankle, that cause significant swelling. Heat has the opposite effect, increasing blood flow to the area. This relaxes muscle fibers, which can help when the client experiences spasms or stiffness.
- **Option C:** People with chronic back pain should avoid wearing high-heeled shoes at all times. The normal s-curve of the spine acts as a cushion or spring, reducing stress on the vertebrae. When wearing high heels, the shape of the spine is altered and the client doesn't get that same shock absorption as she walks, which, over time, can lead to uneven wear on the cartilage discs, joints and ligaments of the back.
- **Option D:** A firm mattress prevents lower back pain. Sleeping on a mattress that is too firm can cause aches and pains on pressure points. A medium-firm mattress may be more comfortable because it allows the shoulder and hips to sink in slightly. Patients who want a firmer mattress for

back support can get one with thicker padding for greater comfort.

87. Which goal of the client's care should take priority during the first days of hospitalization for an exacerbation of ulcerative colitis?

- A. Promoting self-care and independence.
- B. Managing diarrhea.
- C. Maintaining adequate nutrition.
- D. Promoting rest and comfort.

Correct Answer: B. Managing diarrhea

Diarrhea is the primary symptom in an exacerbation of ulcerative colitis, and decreasing the frequency of stools is the first goal of treatment. Observe and record stool frequency, characteristics, amount, and precipitating factors. The other goals are ongoing and will be best achieved by halting the exacerbation. The client may receive antidiarrheal medications, antispasmodic agents, bulk hydrophilic agents, or anti-inflammatory drugs.

- **Option A:** Include patient and SO in team conferences to develop an individualized program. Promotes continuity of care and enables the patient and SO to feel a part of the plan, imparting a sense of control and increasing cooperation with the therapeutic regimen.
- **Option C:** Identify and restrict foods and fluids that precipitate diarrhea (vegetables and fruits, whole-grain cereals, condiments, carbonated drinks, milk products). Avoiding intestinal irritants promotes intestinal rest and reduces intestinal workload.
- **Option D:** Encourage use of stress management skills, (relaxation techniques, visualization, guided imagery, deep-breathing exercises). Refocuses attention, promotes relaxation, and enhances coping abilities.

88. Older adults who take long-acting sedatives or hypnotics are likely to experience:

- A. Hallucinations
- B. Ataxia
- C. Alertness
- D. Dyspnea

Correct Answer: B. Ataxia

If longer-acting barbiturates are used in older adults, these clients may experience daytime sedation, ataxia, and memory deficits. Long-acting barbiturates have an effect of longer than 6 hours and include barbital and phenobarbital. Barbiturate classification is according to the duration of their action, IV formulations of thiopental and methohexital are in the ultra short-acting class.

- **Option A:** Age-related changes have been demonstrated in pharmacokinetics due to slower intercompartmental clearance in the elderly, resulting in higher serum concentrations with smaller drug doses.
- **Option C:** Thiopental and thiamylal have been shown to release histamine, while methohexital and pentobarbital have minimal histamine release. Withdrawal symptoms may occur: nervousness,

tremor, agitation, and hypotension may develop 2 to 8 days after the abrupt discontinuation of barbiturates. Additionally, the patient may develop delirium or grand mal seizures.

- **Option D:** When given in IV anesthetics, barbiturates will produce a reduction in blood pressure and an increase in heart rate. Respiratory depression and apnea may occur. Absolute contraindications for any barbiturate include status asthmaticus and acute and intermittent variegate porphyria.

89. Five hours after birth, a neonate is transferred to the nursery, where the nurse intervenes to prevent hypothermia. What is a common source of radiant heat loss?

- A. Low room humidity
- B. Cold weight scale
- C. Cool incubator walls
- D. Cool room temperature

Correct Answer: C. Cools incubator walls

A common source of radiant heat loss includes cool incubator walls and windows. Radiant heat loss constitutes the transfer of heat from an infant's warm skin, via infrared electromagnetic waves, to the cooler surrounding walls that absorb heat.

- **Option A:** Low room humidity promotes evaporative heat loss. Evaporative heat loss occurs through the skin and the respiratory system. The driving force behind evaporation is the vapor pressure difference between the body surface and the environment.
- **Option B:** When the skin directly contacts a cooler object, such as a cold weight scale, conductive heat loss may occur. Heat loss can occur by conduction of heat from the skin to the layer of still air around the body.
- **Option D:** A cool room temperature may lead to convective heat loss. Convective heat loss is the transfer of heat from a body to moving molecules such as air or liquid.

90. The school guidance counselor refers a family with an 8-year-old child to the mental health clinic because of the child's frequent fighting in school and truancy. Which of the following data would be a priority to the nurse doing the initial family assessment?

- A. The child's performance in school
- B. Family education and work history
- C. The family's perception of the current problem
- D. The teacher's attempt to solve the problem

Correct Answer: C. The family's perception of the current problem

The family's perception of the problem is essential because change in any one part of a family system affects all other parts and the system as a whole. Each member of the family has been affected by the current problems related to the school system and the nurse would be interested in the data. Research indicates at-risk youth are more likely to experience emotional and psychological problems. Young

people who are often truant from school represent a group of at-risk youth, but one for which mental health issues are understudied.

- **Option A:** The child's performance in school and the teacher's attempts to solve the problem are relevant and may be assessed; however, priority would be given to the family's perception of the problem. Truancy is a serious problem that affects most school districts in the U.S. Research on truancy can be challenging because there is not a uniform definition of truancy and statistics on truancy rates are lacking and/or inconsistently reported across school districts. Psychological research reports a high prevalence of mental health problems among youths characterized as school refusers. School refusers demonstrate symptoms of mood disorders such as depression and dysthymia, anxiety disorders such as generalized anxiety, separation anxiety, and panic disorder, and disruptive behavior disorders such as oppositional defiant, attention deficit hyperactivity disorder (ADHD) and conduct disorders.
- **Option B:** The family education and work history may be relevant, but are not a priority. Generally, truancy is defined as unauthorized, intentional absence from compulsory schooling. It is estimated that thousands of youth in the U.S. are absent from school each day. For example, recent statistics on truancy in Los Angeles County and Colorado indicate truancy rates greater than 10 percent, with the highest rates in urban high schools. Comparable statistics corroborating high rates of truancy can also be found in other jurisdictions.
- **Option D:** Truancy appears to be a risk factor for a life-course trajectory toward more negative behaviors. As Garry observed, truancy may be the beginning of a lifetime of problems among students who routinely skip school, including poor standardized test performance, high school dropout, a stressed family life, difficulties in emotional/psychological functioning, drug use, and progression to both juvenile delinquency and adult criminal offending. Related research has also documented a link between truancy and later problems with employment, adult crime and incarceration.

91. A nurse in a provider's office is assessing a client who reports losing control of urine whenever she coughs, laughs, or sneezes. The client relates a history of three vaginal births, but no serious accidents or illnesses. Which of the following interventions are appropriate for helping to control or eliminate the clients incontinence? Select all that apply.

- A. Limit total daily fluid intake
- B. Decrease or avoid caffeine
- C. Increase the intake of calcium supplements
- D. Avoid the intake of alcohol
- E. Use Crede maneuver

Correct Answer: B and D

Caffeine and alcohol are bladder irritants and can worsen stress incontinence. Alcohol is a bladder irritant and can worsen stress incontinence. Quitting smoking, losing excess weight, or treating a chronic cough will lessen the risk of stress incontinence and improve the symptoms. Stress incontinence is different from urgency incontinence and overactive bladder (OAB). If the client has urgency incontinence or OAB, the bladder muscle contracts, causing a sudden urge to urinate before he can get to the bathroom. Stress incontinence is much more common in women than in men.

- **Option A:** Because stress incontinence results from weak pelvic muscles and other structures, limiting fluid will not resolve the problem. The doctor may recommend how much and when one

should consume fluids during the day and evening. However, don't limit what the client drinks so much that he becomes dehydrated.

- **Option B:** Lifestyle changes should be made such as reducing caffeine intake (including green tea), stopping smoking, and losing weight.
- **Option C:** Calcium has no effect on stress incontinence. Bladder training involves learning techniques to increase the length of time between feeling the need to urinate and passing urine. The course usually lasts for at least six weeks and can be combined with the Kegel exercises. Some individuals may find that timed toileting is helpful, particularly for people with a learning disability or cognitive impairment.
- **Option D:** The doctor may also suggest that the client avoid caffeinated, carbonated, and alcoholic beverages, which may irritate and affect bladder function in some people. If he finds that using fluid schedules and avoiding certain beverages significantly improves leakage, the client will have to decide whether making these changes in the diet are worth it.
- **Option E:** The Crede maneuver helps manage reflex incontinence, not stress incontinence. Pelvic floor muscle training is a technique that strengthens the pelvic floor muscles and is an effective treatment for stress incontinence, especially if the muscle has been damaged.

92. A patient undergoing external radiation has developed a dry desquamation of the skin in the treatment area. The nurse knows that teaching about management of the skin reaction has been effective when the patient says

- A. "I can use ice packs to relieve itching in the treatment area."
- B. "I can buy a steroid cream to use on the itching area."
- C. "I will expose the treatment area to a sun lamp daily."
- D. "I will scrub the area with warm water to remove the scales."

Correct Answer: B. "I can buy a steroid cream to use on the itching area"

- **Option B:** Steroid (over-the-counter [OTC] hydrocortisone) cream may be used to reduce itching in the area.
- **Options A and C:** Extreme heat or cold temperatures may injure the skin.
- **Option D:** Treatment areas should be cleaned gently to avoid further injury.

93. A client has been taking prednisone (Deltasone) 20 mg once a day to treat severe seborrheic dermatitis. Which of the following assessment findings is of most concern?

- A. Complaints of epigastric pain.
- B. Blood pressure 145/90 mm Hg.
- C. Blood glucose level 129 mg/dL.
- D. Complaints of increase appetite.

Correct Answer: A. Complaints of epigastric pain.

Complaints of epigastric pain indicate that the client might be suffering from peptic ulcers, which require the addition of the use of antacid such as proton pump inhibitor (Nexium).

- **Options B, C, and D:** These are symptoms related to the use of prednisone but are not clinically significant when steroids are used for limited periods and do not require treatment.

94. Capillary glucose monitoring is being performed every 4 hours for a client diagnosed with diabetic ketoacidosis. Insulin is administered using a scale of regular insulin according to glucose results. At 2 p.m., the client has a capillary glucose level of 250 mg/dl for which he receives 8 U of regular insulin. Nurse Mariner should expect the dose's:

- A. Onset to be at 2 p.m. and its peak to be at 3 p.m.
- B. Onset to be at 2:15 p.m. and its peak to be at 3 p.m.
- C. Onset to be at 2:30 p.m. and its peak to be at 4 p.m.
- D. Onset to be at 4 p.m. and its peak to be at 6 p.m.

Correct Answer: C. Onset to be at 2:30 p.m. and its peak to be at 4 p.m.

Regular insulin, which is a short-acting insulin, has an onset of 15 to 30 minutes and a peak of 2 to 4 hours. Because the nurse gave the insulin at 2 p.m., the expected onset would be from 2:15 p.m. to 2:30 p.m. and the peak from 4 p.m. to 6 p.m.

- **Option A:** 2 p.m. is when the insulin was given; onset does not occur at the same time as the medication was given
- **Option B:** The peak starts 2 to 4 hours after the insulin was given, which will be at 4 p.m.
- **Option D:** Onset of 4 p.m. is very late; 15 to 30 minutes is the expected onset of insulin. Peak should start at 4 p.m.

95. Ethical dilemmas often arise over a conflict of opinion. Once the nurse has determined that the dilemma is ethical, a critical first step in negotiating the difference of opinion would be to:

- A. Consult a professional ethicist to ensure that the steps of the process occur in full.
- B. Gather all relevant information regarding the clinical, social, and spiritual aspects of the dilemma.
- C. List the ethical principles that inform the dilemma so that negotiations agree on the language of the discussion.
- D. Ensure that the attending physician has written an order for an ethics consultation to support the ethics process.

Correct Answer: B. Gather all relevant information regarding the clinical, social, and spiritual aspects of the dilemma

Each step in the processing of an ethical dilemma resembles steps in critical thinking. The nurse begins by gathering information and moves through assessment, identification of the problem, planning, implementation, and evaluation.

- **Option A:** To address health inequity factors, nurses are encouraged to be aware of health disparities that could impair treatment outcomes. They can then refer patients to social workers, case managers, and other healthcare team members for additional services. Nurses should be mindful of the social and economic factors that affect patient and community health.
- **Option C:** Nurses make decisions based on the information available to them in the current situation. The more relevant information they have, the more likely their decision will have a positive outcome. When a nurse's decision leads to a negative outcome, the question becomes: What critical pieces of information were lacking at the time of the decision? Nurses must take responsibility for their decisions and strive to understand why some decisions have negative outcomes.
- **Option D:** Even the most extensive code of ethics can't account for all the potential dilemmas that nurses may encounter in their work. That's the reason that one of the duties stated in the nursing code of ethics is to seek the advice and counsel of others whenever a nurse is uncertain about a medical decision's ethical aspects.

96. Aluminum hydroxide gel (Amphojel) is prescribed for the client with chronic renal failure to take at home. What is the purpose of giving this drug to a client with chronic renal failure?

- A. To relieve the pain of gastric hyperacidity.
- B. To prevent Curling's stress ulcers.
- C. To bind phosphorus in the intestine.
- D. To reverse metabolic acidosis.

Correct Answer: C. To bind phosphorus in the intestine.

A client in renal failure develops hyperphosphatemia that causes a corresponding excretion of the body's calcium stores, leading to renal osteodystrophy. To decrease this loss, aluminum hydroxide gel is prescribed to bind phosphates in the intestine and facilitate their excretion.

- **Option A:** Gastric hyperacidity is not necessarily a problem associated with chronic renal failure. Aluminum hydroxide can also serve as a phosphate binder in patients with chronic renal disease. However, its use in this manner is infrequent due to the risk of adverse effects.
- **Option B:** Antacids will not prevent Curling's stress ulcers. Aluminum hydroxide $[Al(OH)_3]$ dissociates into Al^{3+} and OH^- in the stomach. The freed hydroxide groups then bind to free protons, ultimately producing water and insoluble aluminum salts, mostly $Al(OH)_3$, within the stomach. The proton binding serves to increase the overall pH of the stomach, i.e., less acidic, reducing the symptoms of indigestion.
- **Option D:** Antacids will not affect metabolic acidosis. Prolonged administration should not be considered in a patient with renal impairment or a patient on dialysis, as impaired clearance of excess aluminum may precipitate the drug's adverse effects.

97. When administering codeine, the nurse should be aware that:

- A. Codeine produces more sedation than other opiates.
- B. Codeine causes diarrhea, so the client must take an additional drug to prevent this.
- C. Codeine is very constipating.

D. Codeine is antitussive in high doses.

Correct Answer: C. Codeine is very constipating.

Codeine is very constipating, so the client's diet should include foods that fight constipation, such as water, fruits, and vegetables. Constipation is one of the most common adverse effects of codeine. Most patients report some constipation following the initiation of therapy or increases in dose. With continued exposure, the resolution of constipation does not occur. The clinician should advise stool softeners along with codeine.

- **Option A:** Clouded mentation or sedation following codeine initiation tends to fade over time. During initiation or increasing doses, patients should receive counsel about considering precautions at work and restrictions with driving. They should also understand the effects and risks with concomitant exposure to other substances and drugs with sedating effects.
- **Option B:** Constipation is one of the most common adverse effects of codeine. Most patients report some constipation following the initiation of therapy or increases in dose. With continued exposure, the resolution of constipation does not occur.
- **Option D:** 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.

98. A patient comes to the emergency department with abdominal pain. Work-up reveals the presence of a rapidly enlarging abdominal aortic aneurysm. Which of the following actions should the nurse expect?

- A. The patient will be admitted to the medicine unit for observation and medication.
- B. The patient will be admitted to the day surgery unit for sclerotherapy.
- C. The patient will be admitted to the surgical unit and resection will be scheduled.
- D. The patient will be discharged home to follow-up with his cardiologist in 24 hours.

Correct Answer: C. The patient will be admitted to the surgical unit and resection will be scheduled.

A rapidly enlarging abdominal aortic aneurysm is at significant risk of rupture and should be resected as soon as possible. No other appropriate treatment options currently exist.

- **Option A:** Admitting the patient for observation will be a delay and may result in the rupture of the aneurysm. Immediate surgery is the only recommended management.
- **Option B:** Sclerotherapy, in which a solution is injected into a vein, causing it to collapse, scar, and fade, remains the primary treatment for the small-vessel varicose disease of the lower extremities.
- **Option D:** The patient should not be discharged because the abdominal aneurysm may rupture at any time and place the patient's life at risk.

99. Which histamine-2 antagonist is associated with the most drug interactions?

- A. ranitidine
- B. cimetidine

- C. Prilosec
- D. nizatidine

Correct Answer: B. cimetidine

Cimetidine was the first histamine-2 antagonist developed and is associated with the most toxic drug interactions of the group. High doses of cimetidine (over 5 g/day) can cause reversible impotence or gynecomastia. This effect appears to be the result of the antiandrogenic potential of cimetidine, which depends on an increase in prolactin levels secondary to histamine H2 receptor blockade. Also, cimetidine has non-specific actions that stimulate prolactin secretion, causing galactorrhea in men in a dose-related pattern. The effects could also be related to a blockade of the 2-hydroxylation of estradiol. However, gynecomastia in men is not an adverse effect with the other H2 receptor blockers (ranitidine, famotidine, and nizatidine).

- **Option A:** Severe toxicity to ranitidine is rare, and there currently is no antidote for ranitidine overdose. Patients may present with CNS depression or severe hypotension. Supportive treatment and monitoring based on the presenting symptoms may be warranted.
- **Option C:** Omeprazole is considered a benign drug; however, the primary adverse effects of omeprazole include headache, abdominal pain, nausea, diarrhea, vomiting, and flatulence in adults. The major adverse effects in the pediatric population are similar to adults; the most frequent events were reportedly fever and respiratory. Proton pump inhibitors (PPI) therapy may correlate with an increased risk of *Clostridioides difficile* (C. diff) associated diarrhea.
- **Option D:** H2RAs are generally well-tolerated. Mild side effects may include headache, drowsiness, fatigue, abdominal pain, constipation, or diarrhea. The use of H2RAs in patients with renal impairment, hepatic impairment, or who are over 50 years of age has correlated with central nervous system side effects such as delirium, confusion, hallucinations, or slurred speech.

100. When discharging a client after treatment for a dystonic reaction, the emergency department nurse must ensure that the client understands which of the following?

- A. Results of treatment are rapid and dramatic but may not last.
- B. Although uncomfortable, this reaction isn't serious.
- C. The client shouldn't buy drugs on the street.
- D. The client must take benztropine (Cogentin) as prescribed to prevent a return of symptoms.

Correct Answer: D. The client must take benztropine (Cogentin) as prescribed to prevent a return of symptoms.

An oral anticholinergic agent such as benztropine (Cogentin) is commonly prescribed to control and prevent the return of symptoms. Benztropine is FDA approved as adjunctive therapy of all forms of parkinsonism. It is also useful for drug-induced extrapyramidal symptoms and the prevention of dystonic reactions and acute treatment of dystonic reactions. Benztropine antagonizes acetylcholine and histamine receptors. In the CNS and smooth muscles, benztropine exerts its action through competing with acetylcholine at muscarinic receptors. Consequently, it reduces central cholinergic effects by blocking muscarinic receptors that appear to improve the symptoms of Parkinson disease.

- **Option A:** Dystonic reactions are typically acute and reversible. 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.

- **Option B:** Dystonic reactions can be life-threatening when airway patency is compromised. Anticholinergic agents and benzodiazepines are the most commonly used agents to reverse or reduce symptoms in acute dystonic reaction. Acute dystonic reactions are often transient but can cause significant distress to the patient. Although rare, laryngeal dystonia can cause life-threatening airway obstruction.
- **Option C:** Lecturing the client about buying drugs on the street isn't appropriate. Antipsychotic and antiemetic agents are among the most commonly described causative agents of acute dystonic reactions. Other agents including anti-malarial, antidepressants, antihistamines, and anticonvulsants have also been implicated in cases of acute dystonic reaction. Antipsychotic agents with a dopamine-blocking mechanism are commonly used to treat acute psychosis, acute agitation, bipolar mania, and many other psychiatric conditions. All currently known antipsychotic medications carry a risk of causing an acute dystonic reaction.