

Kevin's Review - 100 NCLEX Practice Questions

1. Nurse Melinda is caring for an elderly bedridden adult. To prevent pressure ulcers, which intervention should the nurse include in the plan of care?

- A. Turn and reposition the client at least once every 8 hours.
- B. Vigorously massage lotion into bony prominences.
- C. Post a turning schedule at the client's bedside.
- D. Slide the client, rather than lifting, when turning.

Correct Answer: C. Post a turning schedule at the client's bedside.

A turning schedule with a signing sheet will help ensure that the client gets turned and, thus, help prevent pressure ulcers. Set goals with the patient or significant other for cooperation in activities or exercise and position changes. This enhances a sense of anticipation of progress or improvement and gives some sense of control or independence.

- **Option A:** Turning should occur every 1 to 2 hours — not every 8 hours — for clients who are in bed for prolonged periods. Keep limbs in functional alignment with one or more of the following: pillows, sandbags, wedges, or prefabricated splints. This avoids footdrop and too much plantar flexion or tightness. Maintain feet in dorsiflexed position.
- **Option B:** The nurse should apply lotion to keep the skin moist but should avoid vigorous massage, which could damage capillaries. Assess the skin over bony prominences (sacrum, trochanters, scapulae, elbows, heels, inner and outer malleolus, inner and outer knees, back of the head). These areas at highest risk for breakdown resulting from tissue ischemia from compression against a hard surface.
- **Option D:** When moving the client, the nurse should lift — rather than slide — the client to avoid shearing. Assess client's ability to move (shift weight while sitting, turn over in bed, move from the bed to a chair). Immobility is a huge risk factor for pressure ulcer development among adult hospitalized clients.

2. A male client who is recovering from surgery has been advanced from a clear liquid diet to a full liquid diet. The client is looking forward to the diet change because he has been "bored" with the clear liquid diet. The nurse would offer which full liquid item to the client?

- A. Tea
- B. Gelatin
- C. Custard
- D. Popsicle

Correct Answer: C. Custard

Full liquid food items include items such as plain ice cream, sherbet, breakfast drinks, milk, pudding, and custard, soups that are strained, and strained vegetable juices. A clear liquid diet consists of foods that are relatively transparent. A patient prescribed a full liquid diet follows a specific diet type requiring all liquids and semi-liquids but no forms of solid intake.

- **Option A:** Tea is included in the clear liquid diet. Unlike a clear liquid diet, which includes only liquids and semi-liquids that are non-opaque, a full liquid diet is more inclusive, as it allows all types of liquids.

- **Option B:** A clear liquid diet is a specific dietary plan that only includes liquids that are fully transparent at room temperature. Some items that may be allowed include water, ice, fruit juices without pulp, sports drinks, carbonated drinks, gelatin, tea, coffee, clear broths, and clear ice pops.
- **Option D:** A popsicle is included in the clear liquid diet. The clear liquid diet assists in maintaining hydration, it provides electrolytes and calories, and offers some level of satiety when a full diet is not appropriate, but may struggle to provide adequate caloric needs if employed for more than five days.

3. The nurse is teaching a group of prenatal clients about the effects of cigarette smoke on fetal development. Which characteristic is associated with babies born to mothers who smoked during pregnancy?

- A. Low birth weight
- B. Large for gestational age
- C. Preterm birth, but appropriate size for gestation
- D. Growth retardation in weight and length

Correct Answer: A. Low birth weight

Infants of mothers who smoke are often low in birth weight. Smoking during pregnancy increases the risk of health problems for developing babies, including preterm birth, low birth weight, and birth defects of the mouth and lip. Smoking during and after pregnancy also increases the risk of sudden infant death syndrome (SIDS).

- **Option B:** Infants who are large for gestational age are associated with diabetic mothers. The reason for excessive growth of the fetus varies but primarily results from an abundance of nutrients combined with hormones in the fetus that stimulate growth. In pregnant women who have diabetes, a large amount of sugar (glucose) crosses the placenta (the organ that provides nourishment to the fetus), resulting in high levels of glucose in the fetus's blood. The high levels of glucose trigger the release of increased amounts of the hormone insulin from the fetus's pancreas. The increased amount of insulin results in accelerated growth of the fetus, including almost all organs except the brain, which grows normally.
- **Option C:** Preterm births are associated with smoking, but not with appropriate size for gestation. Mothers who smoke are more likely to deliver their babies early. Preterm delivery is a leading cause of death, disability, and disease among newborns. One in every five babies born to mothers who smoke during pregnancy has low birth weight.
- **Option D:** Growth retardation is associated with smoking, but this does not affect the infant length. Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke. Babies whose mothers smoke are about three times more likely to die from SIDS.

4. Nurse Benjamin, who works at Little Stars Pediatric Hospital, has been assigned to care for 4-year-old Mia. Mia has been admitted for a corrective surgery related to her cleft palate. While reviewing Mia's medical history, Nurse Benjamin observes that Mia has had multiple instances of otitis media in the past year. Remembering his pediatric nursing training and understanding the interrelation between cleft palate and otitis media, Nurse Benjamin anticipates

the potential reasons behind Mia's recurrent ear infections. He is preparing to discuss these with Mia's parents, to help them understand the risks and possible preventative measures. When assessing a child like Mia with a cleft palate, the nurse understands that the child is at risk for more frequent episodes of otitis media due to which of the following reasons?

- A. Lowered resistance from malnutrition.
- B. Ineffective functioning of the Eustachian tubes.
- C. Plugging of the Eustachian tubes with food particles.
- D. Associated congenital defects of the middle ear.
- E. Nasal congestion leading to impaired drainage.
- F. Chronic exposure to upper respiratory tract infections.

Correct Answer: B. Ineffective functioning of the Eustachian tubes.

Children with cleft palate often have altered muscle function which affects the Eustachian tube function. This can result in poor drainage of fluid from the middle ear, increasing the risk of otitis media. Understanding the link between cleft palate and ineffective functioning of the Eustachian tubes will help Nurse Benjamin educate Mia's parents about her increased risk and discuss preventative measures to reduce future occurrences.

- **Option A:** While children with cleft palate can face feeding difficulties which may lead to malnutrition, it isn't the direct cause of increased otitis media in these children.
- **Option C:** Food particles don't typically enter the Eustachian tubes. However, children with cleft palate are at risk of aspirating food into the airways, not the ears.
- **Option D:** Some children with cleft palate may have associated middle ear defects, but this isn't the primary reason for the increased risk of otitis media in most children with cleft palate.
- **Option E:** While nasal congestion can contribute to otitis media, it's not directly related to the presence of a cleft palate.
- **Option F:** Children with frequent respiratory infections can have an increased risk of otitis media, but this is not a direct correlation with having a cleft palate.

5. The cyanosis that accompanies bacterial pneumonia is primarily caused by which of the following?

- A. Decreased cardiac output.
- B. Pleural effusion.
- C. Inadequate peripheral circulation.
- D. Decreased oxygenation of the blood.

Correct Answer: D. Decreased oxygenation of the blood.

A client with pneumonia has less lung surface available for the diffusion of gases because of the inflammatory pulmonary response that creates lung exudate and results in reduced oxygenation of the blood. The client becomes cyanotic because blood is not adequately oxygenated in the lungs before it enters the peripheral circulation. It is evident that the cyanosis of pneumonia patients is due to the incomplete saturation of venous blood with oxygen in the lungs, and that the various shades of blue

observed in the distal parts are caused by an admixture of reduced hemoglobin and oxyhemoglobin in the superficial capillaries.

- **Option A:** With expansion of blood volume in the acute phase of pneumonia, all patients showed an increase in cardiac output, a decrease in arteriovenous oxygen difference, and a decrease in peripheral vascular resistance; however, the percentage change in the hypodynamic patients was not as great as occurred in the patients with normal hemodynamics nor as great as occurred when restudied in convalescence.
- **Option B:** Pleural effusions are common in patients who develop pneumonia. At least 40-60% of patients with bacterial pneumonia will develop a pleural effusion of varying severity. Today, these parapneumonic effusions are not common because of prompt antibiotic therapy.
- **Option C:** The inadequate response to pneumonia is most consistent with depressed myocardial function, but the possibility of decreased intravascular volume as a contributory factor could not be excluded. The arteriovenous oxygen difference was used to assess the adequacy of the circulation to meet peripheral tissue perfusion, and a spectrum of arteriovenous oxygen differences was noted.

6. The client experiencing eighth cranial nerve damage will most likely report which of the following symptoms?

- A. Vertigo
- B. Facial paralysis
- C. Impaired vision
- D. Difficulty swallowing

Correct Answer: A. Vertigo

The eighth cranial nerve is the vestibulocochlear nerve, which is responsible for hearing and equilibrium. Streptomycin can damage this nerve. Ototoxicity and vestibular impairment are often thought to be the hallmark of streptomycin toxicity. In extreme cases, deafness may occur due to ototoxicity, thus caution must be exercised when combining streptomycin with other potentially ototoxic drugs. Vestibular impairment usually manifests during the course of treatment and is typically permanent.

- **Option B:** Isoniazid can cause pyridoxine deficiency that may lead to peripheral neuropathy in patients. The patient can supplement vitamin B6 to prevent this from happening. Neuropathy symptoms are usually sensory which include numbness, tingling, burning sensation in all the extremities. Rarely seen are central features like ataxia, nystagmus.
- **Option C:** The manifestation of EMB-induced optic neuropathy appears to be from EMB's chelation of copper. A study with 60 patients undergoing treatment with ethambutol monitored their serum copper levels. Statistical analysis confirmed there was a significant change in copper concentration, supporting the copper chelation effect by EMB.
- **Option D:** Aminoglycoside-induced nephrotoxicity is reversible when stopping the medication. Renal toxicity depends on the patient if any underlying renal disease is present, and on the dose of the medication being administered. Renal insufficiency is avoidable in most patients.

7. The lungs participate in acid-base balance by:

- A. Reabsorbing bicarbonate.
- B. Splitting carbonic acid in two.
- C. Using CO₂ to regulate hydrogen ions.
- D. Sending hydrogen ions to the renal tubules.

Correct Answer: C. Using CO₂ to regulate hydrogen ions

The lungs use carbon dioxide to regulate hydrogen ion concentration. The carbon dioxide formed during cellular respiration combines with water to create carbonic acid. Carbonic acid then dissociates into bicarbonate and a hydrogen ion. This reaction is one of the many buffer systems in the human body; it resists dramatic changes in pH to allow a person to remain within the narrow physiological pH range.

- **Option A:** The renal system affects pH by reabsorbing bicarbonate and excreting fixed acids. Whether due to pathology or necessary compensation, the kidney excretes or reabsorbs these substances which affect pH. The nephron is the functional unit of the kidney. Blood vessels called glomeruli transport substances found in the blood to the renal tubules so that some can be filtered out while others are reabsorbed into the blood and recycled.
- **Option B:** This reaction can and does occur without an enzyme; however, carbonic anhydrase is an enzyme that assists with this process. It catalyzes the first reaction above to form carbonic acid which can then freely dissociate into bicarbonate and a hydrogen ion. Carbonic anhydrase is located in red blood cells, renal tubules, gastric mucosa, and pancreatic cells.
- **Option D:** If bicarbonate is reabsorbed and/or acid is secreted into the urine, the pH becomes more alkaline (increases). When bicarbonate is not reabsorbed or acid is not excreted into the urine, pH becomes more acidic (decreases). The metabolic compensation from the renal system takes longer to occur: days rather than minutes or hours.

8. Nurse Arya assesses for evidence of positive symptoms of schizophrenia in a newly admitted client. Which of the following symptoms are considered positive evidence? Select all that apply.

- A. Anhedonia
- B. Delusions
- C. Flat affect
- D. Hallucinations
- E. Loose associations
- F. Social withdrawal

Correct Answers: B, D, E

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

- **Option A:** In Greek, an means “without” and hedone means “pleasure,” so in simple terms, anhedonia is a state where you are unable to feel pleasure. For people with schizophrenia, this can

mean a lack of enthusiasm for activities, hobbies, passions, and pleasures once enjoyed.

- **Option B:** Delusions are ideas that are not true. For example, people with schizophrenia might believe that the secret service is out to get them, or that TV anchors are transmitting coded messages, or their food is poisoned—and without any evidence. A fairly common type of delusion in schizophrenia is paranoia, which can cause a person with schizophrenia to feel followed, under close monitoring and surveillance, or afraid of ongoing plots or threats.
- **Option C:** This limits a person's ability to convey his or her emotions, causing diminished facial and emotional expressions. A blunted affect is less severe than flat affect, in which a person has an extremely limited range of emotions; for instance, not even being able to crack a smile or laugh during a time of great joy.
- **Option D:** Schizophrenia causes a surplus of mental experiences (thoughts, feelings, behaviors). For example, hallucinations, which are not part of the normal, day-to-day experience for most people, are classified as positive symptom for people with schizophrenia. People with schizophrenia can experience a variety of hallucinations, but the most common are auditory hallucinations (or hearing noises and voices). This can include clicks and knocks, full conversations between people, or voices that talk to them directly. The voices can be good, but more often they are bad, dismissive, and mean. At times, the voices can be in the form of commands.
- **Option E:** Disorganized thinking can be extremely frustrating, making it nearly impossible for people with schizophrenia to keep their thoughts straight or express what's on their minds. This positive symptom causes a series of disjointed thoughts, making it hard to follow or make sense of what a loved one with schizophrenia is trying to say. Loose associations refer to illogical thinking or disconnected thoughts.
- **Option F:** Other terms used to describe asociality are nonsocial, unsocial, social disinterest, or a lack of social drive. Asociality causes a lack of involvement in social relationships or an increased desire to spend time alone. This is different from a person who isolates him or herself after hearing voices or experiencing feelings of paranoia.

9. Which of the following is the first priority in preventing infections when providing care for a client?

- A. Wearing gowns and goggles
- B. Using a barrier between client's furniture and nurse's bag
- C. Handwashing
- D. Wearing gloves

Correct Answer: C. Handwashing

Handwashing remains the most effective way to avoid spreading infection. However, too often nurses do not practice good handwashing techniques and do not teach families to do so. Nurses need to wash their hands before and after touching the client and before entering the nursing bag.

- **Option A:** Isolation gowns are generally the preferred PPE for clothing but aprons occasionally are used where limited contamination is anticipated. If contamination of the arms can be anticipated, a gown should be selected. Goggles provide barrier protection for the eyes; personal prescription lenses do not provide optimal eye protection and should not be used as a substitute for goggles.
- **Option B:** In terms of airflow blocking, a barrier height of at least 40 cm above the desk level (at 80 cm) is recommended to prevent the coughing flow of an infected person, considering an unknown location in the open office and subject to a modified ventilation mode.

- **Option D:** Gloves are the most common type of PPE used in healthcare settings. However, gloves should never replace the practice of handwashing. The nurse should learn to work from clean to dirty. This is a basic principle of infection control. In this instance, it refers to touching clean body sites or surfaces before you touch dirty or heavily contaminated areas.

10. After administering bethanechol to a patient with urine retention, the nurse in charge monitors the patient for adverse effects. Which is most likely to occur?

- A. Decreased peristalsis
- B. Increase heart rate
- C. Dry mucous membranes
- D. Nausea and Vomiting

Correct Answer: D. Nausea and Vomiting

Bethanechol will increase GI motility, which may cause nausea, belching, vomiting, intestinal cramps, and diarrhea. Bethanechol directly stimulates cholinergic receptors in the parasympathetic nervous system while stimulating the ganglia to a lesser extent.

- **Option A:** Peristalsis is increased rather than decreased. Stimulation of muscarinic receptors in the GI tract restores peristalsis, increases motility, and increases the resting lower esophageal sphincter pressure.
- **Option B:** With high doses of bethanechol, cardiovascular responses may include vasodilation, decreased cardiac rate, and decreased the force of cardiac contraction, which may cause hypotension.
- **Option C:** Salivation or sweating may gently increase because of its cholinergic effects.

11. Niklaus was born with hypospadias; which of the following should be avoided when a child has such condition?

- A. Surgery
- B. Circumcision
- C. Intravenous pyelography (IVP)
- D. Catheterization

Correct Answer: B. Circumcision

Hypospadias refers to a condition in which the urethral opening is located below the glans penis or anywhere along the ventral surface (underside) of the penile shaft. The ventral foreskin is lacking, and the distal portion gives an appearance of a hood. Early recognition is important so that circumcision is avoided; the foreskin is used for surgical repair.

- **Option A:** Surgery is the procedure of choice to improve the child's ability to stand when urinating, improve the appearance of the penis, and preserve sexual adequacy. Patients diagnosed with hypospadias should be referred for surgical evaluation within the first weeks of life. If parents want circumcisions for their newborns, the presence of any penile abnormality should contraindicate the procedure, given that the foreskin is used in arthroplasties.

- **Option C:** IVP is contraindicated if the child has an allergy to iodine or shellfish. Intravenous pyelography (IVP), or intravenous urography, is a diagnostic test that involves the administration of intravenous contrast and X-ray imaging of the urinary tract.
- **Option D:** Catheterization may be used to ensure urinary elimination. Hypospadias is the most frequent anatomical variant of the penis and occurs during development when hormonal triggers malfunction and the urethra does not properly tubularize. The urethral meatus can be found anywhere along the glans, penile shaft, scrotum, or perineum, leading to a difficult catheterization.

12. Before giving a postpartum (PP) client the rubella vaccine, which of the following facts should the nurse include in client teaching?

- A. The vaccine is safe in clients with egg allergies.
- B. Breastfeeding isn't compatible with the vaccine.
- C. Transient arthralgia and rash are common adverse effects.
- D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects.

Correct Answer: D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects.

The client must understand that she must not become pregnant for 3 months after the vaccination because of its potential teratogenic effects. Women who are planning to become pregnant should check with their doctor to make sure they are vaccinated before they get pregnant. Because MMR vaccine is an attenuated (weakened) live virus vaccine, pregnant women who are not vaccinated should wait to get MMR vaccine until after they have given birth. Adult women of childbearing age should avoid getting pregnant for at least four weeks after receiving an MMR vaccine.

- **Option A:** The rubella vaccine is made from duck eggs so an allergic reaction may occur in clients with egg allergies. Vaccines that contain small quantities of egg protein can cause hypersensitivity reactions in some people with egg allergy. Adverse reactions are more likely with vaccines, such as yellow fever and influenza vaccines, that are grown in embryonated eggs.
- **Option B:** The virus is not transmitted into the breast milk, so clients may continue to breastfeed after the vaccination. Early studies found no transmission of rubella virus to breastfed infants. None of 18 infants who were breastfed after maternal vaccination with rubella vaccine (various strains) had detectable antibodies in one study. A study of mothers vaccinated with the Cendehill strain of live, attenuated rubella virus found no transmission of the live virus to their breastfed infants. However, rubella vaccine virus can appear in breastmilk and result in infections in some infants.
- **Option C:** Transient arthralgia and rash are common adverse effects of the vaccine. Transient joint manifestations, ranging from mild arthralgia to severe extensive polyarthritis are a troublesome feature of rubella. These complaints, described as early as 1906 in Osler's textbook, have been a source of considerable concern in the past, since they may simulate the picture of acute rheumatoid polyarthritis.

13. A nurse is working in the hematology ward and is administering a blood transfusion to a 40-year-old patient with chronic anemia due to a genetic condition. The patient, who is a biology teacher, is curious about the physiology of red blood cells and asks, "Considering the turnover and production of red blood cells in my body, how long does a typical red blood cell

live?" Given the patient's background and the context, which of the following responses is accurate?

- A. "The average lifespan of a red blood cell (RBC) is about 45 days, after which it is broken down."
- B. "Red blood cells typically survive for around 60 days in the circulatory system."
- C. "Most red blood cells have a life span of approximately 90 days before they are replaced."
- D. "A red blood cell generally has a lifespan of 120 days in the body."
- E. "The longevity of red blood cells can vary, but it's usually around 150 days."
- F. "Red blood cells continuously regenerate and can live indefinitely in the body."

Correct Answer: D. "A red blood cell generally has a lifespan of 120 days in the body."

Red blood cells (RBCs), or erythrocytes, have a typical life span of about 120 days in the human body. After this period, they are removed from the circulation and broken down in the spleen and liver. The components are then recycled to produce new RBCs in the bone marrow. This continuous process ensures that the body has an adequate supply of fresh RBCs to transport oxygen to tissues.

14. The nurse understands that the following clinical findings are indications for dialysis. Select all that apply.

- A. Volume overload
- B. BUN 18 mg/dL
- C. K 5.2 mEq/L
- D. Decreased creatinine clearance.
- E. Metabolic acidosis
- F. Cr 5.0 mg/dL

Correct Answer: A, C, E, and F.

Indications for dialysis include volume overload, weight gain, hyperkalemia, metabolic acidosis, and rising BUN (normally 10-20 mg/dL) and Cr (normally 0.5-1.5 mg/dL) levels, along with decreased urinary creatinine clearance.

- **Option A:** Hemodialysis initiation is needed for acute illness associated with AKI, life-threatening hyperkalemia, refractory acidosis, hypervolemia causing end-organ complications (e.g., pulmonary edema), or any toxic ingestion. Patients with CKD and heart failure experience fluid retention, which leads to worsening of heart failure and pulmonary edema.
- **Option B:** The BUN is normal. The decision to initiate dialysis should not be based on the level of kidney function in an asymptomatic individual. In renal failure patients, elevated urea levels can also lead to uremic pericarditis.
- **Option C:** The potassium level is hyperkalemic. The decision to initiate maintenance dialysis should be based on an assessment of signs and symptoms of renal failure (pruritus, acid-base or electrolyte abnormalities, serositis), volume or BP dysregulation, a progressive deterioration in nutritional status despite dietary intervention or impairment in cognition.
- **Option D:** It is not advisable to assign an arbitrary urea nitrogen or creatinine level for dialysis initiation due to individual variability in uremia symptom severity and renal function.

- **Option E:** Potassium abnormalities arise from acidosis (due to intracellular shift) and decreased renal excretion in chronic kidney disease or renal failure patients.
- **Option F:** The National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI) recommends that patients who reach CKD stage 4 (GFR, 30 mL/min/1.73 m²), and those with an imminent need for maintenance dialysis during the initial assessment, should be counseled about renal failure and the treatment options (kidney transplantation, hemodialysis at home or in-center, PD) and conservative treatment.

15. Nurse Casey is studying insulin administration. She should be knowledgeable that regular insulin:

- A. Is slow acting
- B. Is used IV
- C. Is a suspended insulin
- D. Peaks in 6 to 12 hours

Correct Answer: B. Is used IV

Regular insulin is the only insulin preparation that can be administered IV. When administered intravenously, U-100 administration should be with close monitoring of serum potassium and blood glucose. Do not use if the solution is viscous or cloudy; administration should only take place if it is colorless and clear.

- **Option A:** Regular insulin is rapid-acting. In patients with DM (mainly type 1 but also can be in type 2) and on an insulin regimen, blood glucose should be monitored between meals to prevent hypoglycemia. Additionally, weight measurements are necessary due to insulin-associated weight gain. Insulin regular onset of effect is 1 hour.
- **Option C:** It is a crystalline zinc preparation. For intravenous infusions, to minimize insulin adsorption to plastic IV tubing, flush the intravenous tube with priming infusion of 20 mL from a 100 mL-polyvinyl chloride bag insulin, every time a new intravenous tubing is added to the insulin infusion container.
- **Option D:** It peaks in 2 to 4 hours. Insulin regular onset of effect is 1 hour, peaks at 2 to 4 hours, and the duration of the effect lasts 4-hours.

16. Nurse Sophia is teaching the parents of a child with pervasive developmental disorder about how to deal with the child when his behavior escalates and he begins throwing things and screaming. Which guideline would be most helpful for the parents to deal with the situation?

- A. Accept the child's limitations and ignore this behavior
- B. Decrease stimulation in the environment and provide a time-out
- C. Seek help when feeling overwhelmed by the child's behavior
- D. Tell the child to calm down, and encourage quiet activity

Correct Answer: B. Decrease stimulation in the environment, and provide a time-out.

A child with a pervasive developmental disorder can have bizarre responses to environmental stimuli. By decreasing that stimulating effect and providing a time-out, the child can more readily de-escalate the behaviors.

- **Option A:** Escalating behaviors, such as those described, require intervention to promote safety. It is inappropriate to ignore this. The situation requires immediate intervention. Regular health checkups, diagnostics, health promotion teaching, and emergency situations require more time while maintaining a controlled environment with a focus on specific communication.
- **Option C:** The parents should seek help when overwhelmed, but they must intervene when safety is an issue. With counseling, support groups, behavioral therapy, physical and occupational therapies, and ongoing reading of current literature, family members can work together to communicate honestly, accept their circumstances, and rejoice with each moment of progress.
- **Option D:** The response in option D is inadequate; the child will not be able to calm down without assistance. In most social situations, people with ASD may interpret language literally. An example is when directing a patient to “open your mouth and say ‘ah.’” Patients with ASD may open their mouth, say “ah,” and close it. These patients need direct instruction, preferably with a demonstration, describing how you want to look at their throat, so they should keep their mouth open and say “ah” while you look.

17. Which of the following types of asthma involves an acute asthma attack brought on by an upper respiratory infection?

- A. Emotional
- B. Extrinsic
- C. Intrinsic
- D. Mediated

Correct Answer: C. Intrinsic

Intrinsic asthma doesn't have an easily identifiable allergen and can be triggered by the common cold. In intrinsic asthma, IgE is usually only involved locally, within the airway passages. Unlike extrinsic asthma, which is triggered by commonly known allergens, intrinsic asthma may be triggered by a wide range of non-allergy-related factors. Unlike people with extrinsic asthma, those with intrinsic asthma usually have a negative allergy skin test, so they often won't benefit from allergy shots or allergy medications.

- **Option A:** Asthma caused by emotional reasons is considered to be in the extrinsic category. Strong emotions and stress are well-known triggers of asthma. There is evidence of a link between asthma, anxiety, and depression, though the outcomes are sometimes not consistent. Anxiety and depression may be associated with poor asthma control.
- **Option B:** Extrinsic asthma is caused by dust, molds, and pets; easily identifiable allergens. Extrinsic asthma is simply asthma caused by an allergic reaction, especially a chronic one. If the asthma is allergic, the client will have higher levels of IgE (Immunoglobulin E) present in the blood test.
- **Option D:** Mediated asthma doesn't exist. When airflow is obstructed as a result of exercise, it's known as exercise-induced bronchoconstriction (EIB), which is a subcategory of asthma. EIB was previously known as exercise-induced asthma; however, exercise-induced asthma incorrectly implies that exercise is the underlying cause of asthma when it is actually its trigger, not the cause.

18. The clinic nurse is assessing the skin of a white client who is diagnosed with psoriasis. Which of the following characteristics is associated with this skin disorder?

- A. Clear, thin nail beds.
- B. Red-purplish scaly lesions.
- C. Oily skin and no episodes of pruritus.
- D. Silvery-white scaly patches on the scalp, elbow, knees, and sacral regions.

Correct Answer: D. Silvery-white scaly patches on the scalp, elbow, knees, and sacral regions.

Psoriatic patches are covered with silvery-white scales. Affected areas include the scalp, elbows, knees, shins, trunk, and sacral area. Psoriasis presents as well-defined erythematous plaques covered with silvery scales commonly over the scalp, extensors of extremity particularly over knees and elbows, and lumbosacral region. Psoriasis is classified into two types. Type 1 psoriasis, which has a positive family history, starts before age 40 and is associated with HLA-Cw6; while type 2 psoriasis does not show a family history, presents after age 40, and is not associated with HLA-Cw6.

- **Option A:** Nail changes in psoriasis are seen as pitting, oil spots, subungual hyperkeratosis, nail dystrophy, and ankylosis. Psoriasis can present with different morphology in the form of plaque, guttate, rupioid, erythrodermic, pustular, inverse, elephantine, and psoriatic arthritis. Variation in a site is seen with the involvement of scalp, palmoplantar region, genitals, and nails.
- **Option B:** Guttate psoriasis also called as eruptive psoriasis is commonly seen in children after an upper respiratory tract infection with the streptococcal organism. It presents with erythematous and scaly raindrop-shaped lesions mainly over the trunk and back. It is the type of psoriasis having the best prognosis.
- **Option C:** Plaque psoriasis typically presents as erythematous plaques with silvery scales most commonly over extensors of extremities, i.e., on the elbows, knees, scalp, and back. It is the most common type of psoriasis which affects 85% to 90% of patients. On successive removal of psoriatic scales pinpoint bleeding points are seen. This is called the Auspitz sign which is used to confirm the diagnosis clinically.

19. The nurse has been assigned a group of cardiac clients. What would be the most important information for the nurse to check on the initial evaluation of each client? Select all that apply.

- A. Presence of cardiac pain.
- B. Medications taken before hospitalizations.
- C. Presence of jugular vein distention.
- D. Heart sounds and apical rate.
- E. Presence of diaphoresis.
- F. History of difficulty breathing.

Correct Answer: A, C, D, and E.

A focused cardiac assessment is directed towards assessing physiological symptoms (cardiac pain, JVD, heart sounds and rate, and presence of diaphoresis) that provide immediate information regarding

the client's condition, which is appropriate for the nurse to do at the beginning of each shift. After the physiological parameters have been evaluated the nurse can determine history of SOB and meds.

- **Option A:** The hallmark of cardiac disease, however, it can also result from pulmonary, GI, and musculoskeletal disorders. A detailed history is imperative to differentiate cardiac anginal chest pain from the rest. The typical description of angina is retrosternal and diffuse.
- **Option B:** A thorough history and review of systems can help diagnose specific cardiac diseases and can help differentiate it from diseases of other organ systems.
- **Option C:** Abnormalities in the jugular venous pulse can lead clinicians towards diseases such as atrial fibrillation, tricuspid regurgitation, tricuspid stenosis, pulmonary artery hypertension, pulmonic stenosis, and cardiac tamponade. Looking for jugular venous distention and performing the hepatojugular reflex can give a rough estimation of right-sided heart pressures.
- **Option D:** Palpitations is defined as a fluttering, uncomfortable sensation in the chest that is usually associated with arrhythmias. It feels as if the "heart has skipped a beat." When palpating the arterial pulse, the examiner should be able to gather the rate, rhythm, and characteristics.
- **Option E:** The skin can display many clues about cardiac disease. Inspect the temperature of the skin, cool skin points towards poor perfusion, which is many times due to reduced cardiac output.
- **Option F:** Paroxysmal nocturnal dyspnea and dyspnea on exertion are usually the results of congestive heart failure.

20. Immediately following a thoracentesis, which clinical manifestations indicate that a complication has occurred and the physician should be notified?

- A. Serosanguineous drainage from the puncture site.
- B. Increased temperature and blood pressure.
- C. Increased pulse and pallor.
- D. Hypotension and hypothermia.

Correct Answer: C. Increased pulse and pallor

Increased pulse and pallor are symptoms associated with shock. A compromised venous return may occur if there is a mediastinal shift as a result of excessive fluid removal. Usually, no more than 1 L of fluid is removed at one time to prevent this from occurring.

- **Option A:** Complications include bleeding, pain, and infection at the point of needle entry. If the approach is made too high in the intercostal space damage to the coastal vasculature and nerve injury is possible.
- **Option B:** If too much fluid is removed or if the fluid is removed too rapidly (eg using negative pressure chambers) re-expansion (aka post-expansion) pulmonary edema may occur. Removal of significant fluid volumes may also induce vasovagal physiology.
- **Option D:** If the procedural needle/catheter is passed through diseased tissue prior to entering the chest cavity, that process can be extended into the chest space. For example, passing the needle through thoracic or pleural tumor can seed the thoracic cavity or passing the needle through a chest wall abscess or otherwise infected tissue can result in empyema.

21. Sheila tells the community nurse that her boyfriend has been abusive and she is afraid of him, but she doesn't want to leave. The client asks the nurse for

**assistance. Which nursing interventions are appropriate in this situation?
Select all that apply.**

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

Correct Answer: A, C, D, F

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

- **Option A:** Initiate referral to a social worker, public health nurse, psychological counselor before discharge to home. Provides support to the client and family, and monitors behaviors following discharge. A considerable body of empirical data (cited earlier) indicates that women's readiness to act in ways that help them achieve nonviolence is shaped by (a) the level of violence they experience, (b) the supports and resources available to them, and (c) their appraisals of the nature of the abuse and the costs and benefits of taking action.
- **Option B:** Nurses can raise women's awareness that they are in abusive relationships and that they do not deserve to be in them by expressing concern for women's (and their children's) safety and pointing out the degree of vulnerability and danger they face. It can be useful in this context to note Walker's concept of "the cycle of violence, in which periods of violence alternate with periods of reconciliation" (1979).
- **Option C:** In the third stage, preparation, Brown (1997) claimed that women realize the abuse is not their fault and become determined to end the violence. Many acknowledge the loss of the relationship, begin to let go of the hope that abuse will end, and start to work through the associated grief. At this point, women may shift from reevaluating the violent components of the relationship to reevaluating the entire relationship and its meaning for them (Mills, 1985).
- **Option D:** Health care providers in most states cannot intervene directly to prevent women's partners' use of violence (the exceptions are a few states where reporting is mandatory and could lead to the arrest of an abusive partner). Nevertheless, they can intervene in ways that "shore up" women's resources, modify their appraisals of abuse, and help them consider taking actions that may prove beneficial in their quest for nonviolence. Ultimately, it is the responsibility of nurses to help women themselves determine what strategies will work best to achieve nonviolence in their specific situations and then provide support for those actions.
- **Option E:** Barriers to change may include fears related to retaliation from the intimate partner and loss of child custody, employment, or financial support and housing. Each setting should have a plan for assisting women in immediate danger, social service resources for dealing with economic issues, and protocols for providing effective safety planning. Women's past safety strategies should be assessed, and planning should build on strategies they have found effective.
- **Option F:** Self-liberation involves supporting women's own plans to achieve safety in their lives by listening to their deliberations about the meaning of change, identifying resources that will support

change, discussing means for removing barriers to change, and providing safety planning. All health care settings should have a list of resources that are available to victims of IPV; these include hot lines, shelters, legal advisors, as well as counselors with experience in IPV.

22. The client complains of fever, perineal pain, and urinary urgency, frequency, and dysuria. To assess whether the client's problem is related to bacterial prostatitis, the nurse would look at the results of the prostate examination, which should reveal that the prostate gland is:

- A. Tender, indurated, and warm to the touch
- B. Soft and swollen
- C. Tender and edematous with ecchymosis
- D. Reddened, swollen, and boggy

Correct Answer: A. Tender, indurated, and warm to the touch

The client with prostatitis has a prostate gland that is swollen and tender, but that is also warm to the touch, firm, and indurated. Systemic symptoms include fever with chills, perineal and low back pain, and signs of urinary tract infection (which often accompany the disorder).

- **Option B:** Patients with ABP typically complain of fever, malaise, myalgias, dysuria, urinary frequency/hesitancy, and pelvic pain. On physical exam, the prostate is often enlarged and exquisitely tender to palpation.
- **Option C:** Vigorous manipulation of the prostate gland should not be performed in ABP as this may acutely exacerbate the patient's condition. The patient should also be evaluated for signs and symptoms of urinary retention, which may present with suprapubic tenderness and suprapubic fullness.
- **Option D:** Patients suspected of having ABP should also be assessed for CVA tenderness, as pyelonephritis is an important differential. The prostate is not acutely inflamed on the exam but may be tender to palpation. Men with CBP may also present with sexual dysfunction.

23. Kellan, a high school student is referred to the school nurse for suspected substance abuse. Following the nurse's assessment and interventions, what would be the most desirable outcome?

- A. The student discusses conflicts over drug use.
- B. The student accepts a referral to a substance abuse counselor.
- C. The student agrees to inform his parents of the problem.
- D. The student reports increased comfort with making choices.

Correct Answer: B. The student accepts a referral to a substance abuse counselor

All of the outcomes stated are desirable; however, the best outcome is that the student would agree to seek the assistance of a professional substance abuse counselor. The basic goal for a client in any substance abuse treatment setting is to reduce the risk of harm from continued use of substances. The greatest degree of harm reduction would obviously result from abstinence, however, the specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered.

- **Option A:** Primary care providers find many brief intervention techniques effective in addressing the substance abuse issues of clients who are unable or unwilling to access specialty care. Examples of brief interventions include asking clients to try nonuse to see if they can stop on their own, encouraging interventions directed toward attending a self-help group (e.g., Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]), and engaging in brief, structured, time-limited efforts to help pregnant clients stop using.
- **Option C:** The clinician can use brief interventions to motivate particular behavioral changes at each stage of this process. For example, in the contemplation stage, a brief intervention could help the client weigh the costs and benefits of change. In the preparation stage, a similar brief intervention could address the costs and benefits of various change strategies (e.g., self-change, brief treatment, intensive treatment, self-help group attendance). In the action stage, brief interventions can help maintain motivation to continue on the course of change by reinforcing personal decisions made at earlier stages.
- **Option D:** To consider change, clients at the precontemplation stage must have their awareness raised. To resolve their ambivalence, clients in the contemplation stage must be helped to choose positive change over their current circumstances. Clients in the preparation stage need help in identifying potential change strategies and choosing the most appropriate ones. Clients in the action stage need help to carry out and comply with the change strategies.

24. The client on Haldol has pill rolling tremors and muscle rigidity. He is likely manifesting:

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

Correct Answer: B. Pseudoparkinsonism

Pseudoparkinsonism is a side effect of antipsychotic drugs characterized by mask-like faces, pill-rolling tremors, muscle rigidity. Patients with this disorder have apraxic slowness, paratonic rigidity, frontal gait disorder, and elements of akinesia that, taken together, may be mistaken for true parkinsonism. Pseudoparkinsonism appears to be common and is most often due to Alzheimer's disease or vascular dementia.

- **Option A:** Tardive dyskinesia is manifested by lip-smacking, wormlike movement of the tongue. Tardive dyskinesia (TD) is a syndrome that includes a group of iatrogenic movement disorders caused due to a blockade of dopamine receptors. The movement disorders include akathisia, dystonia, buccolingual stereotypy, myoclonus, chorea, tics, and other abnormal involuntary movements which are commonly caused by the long-term use of typical antipsychotics.
- **Option C:** Akinesia is characterized by a feeling of weakness and muscle fatigue. The term akinesia refers to the inability to perform a clinically perceivable movement. It can present as a delayed response, freezing mid-action, or even total abolition of movement. Akinesia occurs when movement is not perceived either because the amplitude of the movement is small or because the time taken to initiate the reaction is significantly increased.
- **Option D:** Dystonia is manifested by torticollis and rolling back of the eyes. Dystonia is defined by involuntary maintained contraction of agonist and antagonist muscles yielding abnormal posturing, twisting, and repetitive movements or tremulous and can be initiated or worsened by attempted movement.

25. A 40-year-old woman with a recent diagnosis of rheumatoid arthritis (RA) is seen in the outpatient rheumatology clinic. She reports significant joint pain, particularly in her hands, that has been affecting her ability to perform daily tasks. Due to the aggressive nature of her disease, her rheumatologist prescribes methotrexate as part of her treatment regimen. As the nurse prepares to provide education about this medication, the patient expresses concern, having heard that methotrexate is a powerful drug. The nurse responds, "Methotrexate is indeed a potent medication and there are some essential instructions you should be aware of." Which instruction should the nurse prioritize?

- A. "It is important to avoid pregnancy while taking methotrexate."
- B. "Take methotrexate on an empty stomach to enhance absorption."
- C. "Increase your intake of vitamin C while on methotrexate."
- D. "Expect immediate relief from joint pain after starting methotrexate."

Correct Answer: A. "It is important to avoid pregnancy while taking methotrexate."

This statement is correct. Methotrexate is teratogenic, meaning it can cause harm to a developing fetus. Women of childbearing age should be counseled to use effective contraception while on methotrexate and to avoid becoming pregnant due to the risk of fetal abnormalities. Given the patient's age and potential for pregnancy, and the risks associated with methotrexate, this is the most critical instruction for the nurse to prioritize.

- **Option B:** While absorption can be influenced by food, the main emphasis for methotrexate is to take it consistently, either always with food or always without. The recommendation is often to take methotrexate with or after meals to reduce stomach upset. This option can be misleading.
- **Option C:** There is no specific recommendation to increase vitamin C intake while on methotrexate. This instruction is not related to the use of methotrexate in RA patients. In fact, patients should be cautious about starting any new supplements while on methotrexate without discussing with their healthcare provider.
- **Option D:** Methotrexate does not provide immediate relief. It may take several weeks to months for patients to notice a decrease in their symptoms. This is because methotrexate works by modifying the course of the disease, not by directly addressing pain or inflammation.

26. A nurse is developing a plan of care for a PP woman with a small vulvar hematoma. The nurse includes which specific intervention in the plan during the first 12 hours following the delivery of this client?

- A. Assess vital signs every 4 hours.
- B. Inform health care providers of assessment findings.
- C. Measure fundal height every 4 hours.
- D. Prepare an ice pack for application to the area.

Correct Answer: D. Prepare an ice pack for application to the area.

- **Option D:** Application of ice will reduce swelling caused by hematoma formation in the vulvar area. During labor, a vulvar hematoma can result from either direct or indirect injury to the soft tissue. Examples of causes of direct injuries include episiotomy, vaginal laceration repairs, or instrumental deliveries, while indirect injury can result from extensive stretching of the birth canal during vaginal delivery.

27. You are conducting a comprehensive assessment of a 38-year-old female patient in the outpatient psychiatric clinic. She mentions that she has been struggling with both depression and an anxiety disorder for several years. She hints at being on medication but doesn't remember the name. As you review her medication list, you notice a drug that is commonly prescribed for such conditions. Based on her described symptoms, which of the following medications on her list would she most likely be taking for her depression and anxiety?

- A. Amitriptyline (Elavil)
- B. Calcitonin
- C. Pergolide mesylate (Permax)
- D. Verapamil (Calan)

Correct Answer: A. Amitriptyline (Elavil)

Amitriptyline (Elavil) is a tricyclic antidepressant and used to treat symptoms of depression.

- **Option B:** Calcitonin is used to treat osteoporosis in women who have been in menopause. Calcitonin is a hormone that is produced in humans by the parafollicular cells (commonly known as C-cells) of the thyroid gland. Calcitonin is involved in helping to regulate levels of calcium and phosphate in the blood, opposing the action of the parathyroid hormone.
- **Option C:** Permax (pergolide mesylate) is indicated as adjunctive treatment to levodopa/carbidopa in the management of the signs and symptoms of Parkinson's disease.
- **Option D:** Verapamil is used to treat high blood pressure and to control angina (chest pain). The immediate-release tablets are also used alone or with other medications to prevent and treat irregular heartbeats. Verapamil is in a class of medications called calcium-channel blockers. It works by relaxing the blood vessels so the heart does not have to pump as hard. It also increases the supply of blood and oxygen to the heart and slows electrical activity in the heart to control the heart rate.

28. Which factor is least important in the decision regarding whether a victim of family violence can safely remain in the home?

- A. The availability of appropriate community shelters.
- B. The non-abusing caretaker's ability to intervene on the client's behalf.
- C. The client's possible response to relocation.
- D. The family's socioeconomic status.

Correct Answer: D. The family's socioeconomic status

Socioeconomic status is not a reliable predictor of abuse in the home so that it would be the least important consideration in deciding issues of safety for the victim of family violence. Family and domestic violence (including child abuse, intimate partner abuse, and elder abuse) is a common problem in the United States. Family and domestic health violence are estimated to affect 10 million people in the United States every year. It is a national public health problem, and virtually all healthcare professionals will at some point evaluate or treat a patient who is a victim of some form of domestic or family violence.

- **Option A:** Unfortunately, each form of family violence begets interrelated forms of violence, and the “cycle of abuse” is often continued from exposed children into their adult relationships, and finally to the care of the elderly. Domestic and family violence includes a range of abuse including economic, physical, sexual, emotional, and psychological toward children, adults, and elders. If the patient elects to leave their current situation, information for referral to a local domestic violence shelter to assist the victim should be given.
- **Option B:** The ability of the non-abusing caretaker to intervene on the client’s behalf are important factor when making safety decisions. Patients that have suffered domestic violence may or may not want a referral. Many are fearful of their lives and financial well-being and hence may be weighing the tradeoff in leaving the abuser leading to loss of support and perhaps the responsibility of caring for children alone. The healthcare provider needs to assure the patient that the decision is voluntary and that the provider will help regardless of the decision. The goal is to make resources accessible, safe, and to enhance support.
- **Option C:** The client’s response to possible relocation (if the client is a competent adult) would be the most important factor to consider; feelings of empowerment and being treated as a competent person can help a client feel less like a victim. If the patient does not want to go to a shelter, provide telephone numbers for domestic violence or crisis hotlines and support services for potential later use. Provide the patient with instructions but be mindful that written materials may pose a danger once the patient returns home.

29. The nurse is assessing a newborn who had undergone vaginal delivery. Which of the following findings is least likely to be observed in a normal newborn?

- A. uneven head shape
- B. respirations are irregular, abdominal, 30-60 bpm
- C. (+) Moro reflex
- D. heart rate is 80 bpm

Correct Answer D. Heart rate is 80 bpm

Normal heart rate of the newborn is 120 to 160 bpm. The high heart rate (120 to 160 beats per minute) seen in newborn infants can be attributed to the high metabolic rate of activity to main breathing, feeding, and thermogenesis.

- **Option A:** Uneven head shape is molding. Starting with the head, look for the presence of hematomas, subcutaneous swelling, overriding of sutures, and patency of anterior and posterior fontanelles.
- **Option B:** In the newborn, the work of breathing is usually labored (i.e., using accessory muscles, costal retractions, grunting) to overcome the high surface tension. As the fluid leaves the alveoli in the lungs, the effort of breathing is reduced. This is also one of the reasons why newborns have an increased respiratory rate (30 to 60 breaths per minute).

- **Option C:** The Moro reflex is a normal primitive, infantile reflex. The Moro reflex is an involuntary protective motor response against abrupt disruption of body balance or extremely sudden stimulation. It can be seen as early as 25 weeks postconceptional age and usually is present by 30 weeks postconceptional age. The reflex is present in full-term infants and begins to disappear by 12 weeks with complete disappearance by six months.

30. You're preparing for urinary catheterization of a trauma patient and you observe bleeding at the urethral meatus. Which action has priority?

- A. Irrigate and clean the meatus before catheterization.
- B. Check the discharge for occult blood before catheterization.
- C. Heavily lubricate the catheter before insertion.
- D. Delay catheterization and notify the doctor.

Correct Answer: D. Delay catheterization and notify the doctor.

Bleeding at the urethral meatus is evidence that the urethra is injured. Because catheterization can cause further harm, consult with the doctor. Urethral trauma can occur due to pelvic and perineal injuries or iatrogenic trauma to the urethra. Urethral bleeding as one of the complications of urethral trauma is not usually life-threatening, nevertheless it can be very embarrassing.

- **Option A:** Traditionally, direct pressure on the bleeding site is the standard way to control hemorrhage. Putting pressure on the perineum is the only way we can reach this goal. In the perineum, applying a pressure dressing over a solid object which is fixed with adhesive bands to the lower abdomen is the conventional method.
- **Option B:** The second method to control traumatic or non-traumatic urethral bleeding is to apply intermittent penile ligation. This intervention does not permit bleeding through the urethra, increases pressure at the bleeding site and helps homeostasis.
- **Option C:** Intermittent penile and continuous perineal compression are methods that are taught but not mentioned in the literature directly. Sometimes these methods are ineffective and difficult to tolerate. In applying this method, providing direct pressure on the distal end of the urethra and also corpus spongiosum and urethral arteries ceases the bleeding.

31. A client is admitted to the psychiatric unit of a local hospital with chronic undifferentiated schizophrenia. During the next several days, the client is seen laughing, yelling, and talking to herself. This behavior is characteristic of:

- A. Delusion
- B. Looseness of association
- C. Illusion
- D. Hallucination

Correct Answer: D. Hallucination

Auditory hallucination, in which one hears voices when no external stimuli exist, is common in schizophrenic clients. Such behaviors as laughing, yelling, and talking to oneself suggest such a hallucination. Auditory hallucinations are the sensory perceptions of hearing voices without an external stimulus. This symptom is particularly associated with schizophrenia and related psychotic disorders

but is not specific to it. Auditory hallucinations are one of the major symptoms of psychosis.

- **Option A:** Delusions, also common in schizophrenia, are false beliefs or ideas that arise without external stimuli. Jaspers (1883-1969) was amongst the first to describe and classify delusions. In his book *General Psychopathology* (1913), he suggests that a delusion is a “perverted view of reality, incorrigibly held.” These perversions are enigmatically derived, held with extraordinary certainty, and absolutely unamenable. He further emphasized that these false beliefs exist along a continuum of thought disturbance, increasing in severity of distortion from normal thinking patterns to ‘true’ delusions. One hundred years later, Jaspers’ postulation remains a leading candidate in the investigation of delusion morphology.
- **Option B:** Clients with schizophrenia may exhibit looseness of association, a pattern of thinking and communicating in which ideas aren’t clearly linked to one another. A thought disturbance demonstrated by speech that is disconnected and fragmented, with the individual jumping from one idea to another unrelated or indirectly related idea. It is essentially equivalent to derailment.
- **Option C:** Illusion is a less severe perceptual disturbance in which the client misinterprets actual external stimuli. Illusions are rarely associated with schizophrenia. Illusion, a misrepresentation of a “real” sensory stimulus—that is, an interpretation that contradicts objective “reality” as defined by general agreement. For example, a child who perceives tree branches at night as if they are goblins may be said to be having an illusion.

32. A mother asks the nurse if her child’s iron deficiency anemia is related to the child’s frequent infections. The nurse responds based on the understanding of which of the following?

- A. Little is known about iron-deficiency anemia and its relationship to infection in children.
- B. Children with iron deficiency anemia are more susceptible to infection than are other children.
- C. Children with iron-deficiency anemia are less susceptible to infection than are other children.
- D. Children with iron-deficient anemia are equally as susceptible to infection as are other children.

Correct Answer: B. Children with iron deficiency anemia are more susceptible to infection than are other children.

Children with iron-deficiency anemia are more susceptible to infection because of marked decreases in bone marrow functioning with microcytosis. Iron deficiency may, apart from leading to anemia, increase the susceptibility to infection by suppressing the immunological response to pathogens. Anemia is a global public health problem, especially affecting young children with prevalence up to 70% in some populations (World Health Organisation, 2005).

- **Option A:** Iron deficiency is thought to impair immunity by negatively influencing cell-mediated immunity and components of the human innate immune system. For example, iron deficiency has also been associated with thymic atrophy, the depression of T-lymphocytes, decreased neutrophil function, a decrease in the microbicidal qualities of macrophages (Kumar & Choudhry, 2010; Drakesmith & Prentice, 2012) and reduced interleukin-2 production by activated lymphocytes (Galan et al, 1992).
- **Option C:** Besides being an essential element for human metabolism, iron is also an important nutrient for pathogenic microorganisms. Pathogens are able to sequester iron from the host, depending on the preferred iron source and whether the pathogen adopts a predominantly intracellular or extracellular lifestyle (Cassat & Skaar, 2013).

- **Option D:** Several studies have examined the relationship between susceptibility to infections and the host iron status and/or iron supplementation. Where some authors found adverse effects of iron supplementation and/or a protective effect of iron-deficient status, others reported a decreased risk of infections after iron supplementation.

33. You are a pediatric nurse working in a community clinic which primarily serves low-income, high-risk populations. Your day is typically filled with prenatal consultations, well-baby checkups, and parent education sessions. Today, you have been discussing sudden infant death syndrome (SIDS) prevention with new parents. Several parents have come with their infants for well-baby checkups and you observed the different sleep positions and environments for each infant. You are to assess which infant is least likely to develop SIDS based on the provided background information. Given the following information, choose the infant least likely to develop SIDS:

- A. Baby Angela, who was born prematurely at 32 weeks gestation and has since been on apnea monitoring.
- B. A sibling of Baby Angie, whose family has already tragically lost a child to SIDS a year ago.
- C. Baby Gabriel, whose mother admitted to using illicit substances during pregnancy.
- D. Baby Gabby, whose parents have attended your SIDS prevention class and now consistently practices safe sleep guidelines by placing him on his back to sleep, free of soft bedding, toys, and bumper pads.
- E. Baby Dexter, who often sleeps on his stomach in a crib filled with soft toys and plush blankets.
- F. Baby Bella, who shares a bed with her parents and two older siblings.

Correct Answer: D. Baby Gabby who sleeps on his back.

Sleeping on the back is the safest sleep position to reduce the risk of SIDS. The parents' adherence to safe sleep guidelines significantly reduces Baby Gabby's risk. Given the circumstances, Baby Gabby, who sleeps on his back and whose parents follow safe sleep guidelines, is the least probable among the mentioned infants to develop SIDS.

- **Option A:** Prematurity and the need for apnea monitoring place Baby Angela at a higher risk for SIDS.
- **Option B:** The family history of a previous child dying from SIDS increases the risk for subsequent children.
- **Option C:** Prenatal drug exposure has been associated with a higher risk of SIDS due to potential neurological and respiratory system compromise.
- **Option E:** Sleeping on the stomach and a sleep environment with soft bedding and toys significantly increases the risk of SIDS.
- **Option F:** Bed-sharing, especially with multiple people, is associated with a higher risk of SIDS and other sleep-related infant deaths.

34. When she presents the nursing procedures to be followed, she refers to what type of standards?

- A. Process
- B. Outcome
- C. Structure
- D. Criteria

Correct Answer: A. Process

Process standards include care plans, the nursing procedures to be done to address the needs of the patients. Process standards focus on the practitioner and the activities carried out in delivering care. The development of standards and related criterion measures are then guided by the basic principles.

- **Option B:** Outcome standards focus on the end result of the nursing services and activities carried out and the changes which occurred. This approach is based on the belief that structure, process, and outcome are interdependent.
- **Option C:** Structure standards focus on the settings and environment in which nursing is practiced. This approach may be most suitable for standards developed at the local operational level and written within the framework of the broader standards developed at the national level.
- **Option D:** Criteria is the plural of criterion—a standard or principle for judging, evaluating, or selecting something. Criteria are the ideals or requirements on which a judgment, evaluation, or selection is based.

35. The nurse is preparing to teach a client with microcytic hypochromic anemia about the diet to follow after discharge. Which of the following foods should be included in the diet?

- A. Eggs
- B. Lettuce
- C. Citrus fruits
- D. Cheese

Correct Answer: A. Eggs

One of the microcytic, hypochromic anemias is iron-deficiency anemia. A rich source of iron is needed in the diet, and eggs are high in iron. Other foods high in iron include organ and muscle (dark) meats; shellfish, shrimp, and tuna; enriched, whole-grain, and fortified cereals and breads; legumes, nuts, dried fruits, and beans; oatmeal; and sweet potatoes.

- **Option B:** Lettuce is low in calories, fat and sodium. It is a good source of fiber, iron, folate, and vitamin C. Lettuce is also a good source of various other health-beneficial bioactive compounds. An adult human being requires 1 mg to 2 mg per day of iron. The normal western diet contains approximately 10 mg to 20 mg of iron. Iron from animal sources is in the form of Heme iron which has a bioavailability of 10% to 20% compared to non-heme iron which has a limited bioavailability of 1% to 5%.
- **Option C:** Dark green leafy vegetables and citrus fruits are good sources of vitamin C. An average male contains 6grams of iron while a female contains 2.5 gm of iron. This diet is usually sufficient to maintain a healthy iron pool. Ingested iron is freed from other food constituents by gastric HCL while ascorbic acid (vitamin C) prevents precipitation of ferric.
- **Option D:** Cheese is a good source of calcium. Cheese is a great source of calcium, fat, and protein. It also contains high amounts of vitamins A and B-12, along with zinc, phosphorus, and

riboflavin. Cheese made from the milk of 100 percent grass-fed animals is the highest in nutrients and also contains omega-3 fatty acids and vitamin K-2.

36. Exercise has which of the following effects on clients with asthma, chronic bronchitis, and emphysema?

- A. It enhances cardiovascular fitness.
- B. It improves respiratory muscle strength.
- C. It reduces the number of acute attacks.
- D. It worsens respiratory function and is discouraged.

Correct Answer: A. It enhances cardiovascular fitness.

Exercise can improve cardiovascular fitness and help the client tolerate periods of hypoxia better, perhaps reducing the risk of heart attack. People with long-term lung conditions can help improve their symptoms through regular exercise. It can be tempting to avoid exercise because one may think it will make them breathless, but if the client does less activity he becomes less fit, and daily activities will become even harder.

- **Option B:** Most exercise has little effect on respiratory muscle strength, and these clients can't tolerate the type of exercise necessary to do this. Intermittent exercises can help deal with shortness of breath. In this case, the client alternates brief exercise, lasting 1–2 minutes, with moments of rest (or slower exercise). This is called interval training.
- **Option C:** Exercise won't reduce the number of acute attacks. Having asthma should not restrict the ability to exercise or be physically active. If the client feels uncomfortable during or after exercise, he should ask his doctor to investigate whether the management of his condition could be improved. In fact, many athletes have asthma and are able to compete at the highest level when their condition is well-controlled.
- **Option D:** In some instances, exercise may be contraindicated, and the client should check with his physician before starting any exercise program. It is best to ask the guidance of a doctor or physiotherapist before one begins exercising, to ensure that the exercise plans are in line with the body's capacity and are safe. All exercise programs must be built up over time to allow the body to adapt.

37. When developing a plan of care for a hospitalized child, nurse Mary knows that children in which age group is most likely to view illness as a punishment for misdeeds?

- A. Infancy
- B. Preschool age
- C. School age
- D. Adolescence

Correct Answer: B. Preschool age

Preschool-age children are most likely to view illness as a punishment for misdeeds. When children in this age group become seriously ill, they may think it's punishment for something they did or thought about. They don't understand how their parents could not have protected them from this illness.

- **Option A:** Separation anxiety, although seen in all age groups, is most common in older infants. Keeping a consistent routine is important for a baby and their caregivers. Because babies can't talk about their needs, fear is often expressed by crying.
- **Option C:** Fear of the unknown, loss of control, and separation from family and friends can be the school-aged child's main sources of anxiety and fear related to death. They may fear their own death because of the uncertainty of what happens to them after they die.
- **Option D:** Fear of death is typical of adolescents. Adolescents also fear mutilation. Most teens are starting to establish their identity, independence, and relation to peers. The main theme in teens is feeling immortal or being exempt from death. Their realization of their own death threatens all of these objectives.

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

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

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

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

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

39. The nurse is caring for the mother of a newborn. The nurse recognizes that the mother needs more teaching regarding cord care because she

- A. Keeps the cord exposed to the air
- B. Washes her hands before sponge bathing her baby
- C. Washes the cord and surrounding area well with water at each diaper change
- D. Checks it daily for bleeding and drainage

Correct Answer: C. Washes the cord and surrounding area well with water at each diaper change.

Washing the surrounding area is fine but wetting the umbilical cord predisposes it to infection. The cord is kept dry and it will eventually fall off within one to three weeks after birth. Parents were once instructed to swab the stump with rubbing alcohol after every diaper change. Researchers now say this might kill bacteria that can help the cord dry and separate.

- **Option A:** Exposure to air helps dry the cord. Expose the stump to air to help dry out the base. Keep the front of the baby's diaper folded down to avoid covering the stump.
- **Option B:** Good hand washing is the prime mechanism for preventing infection. While there's no harm in getting the stump wet, sponge baths might make it easier to keep the stump dry.
- **Option D:** It is important to check for complications of bleeding and drainage that might occur. Contact the baby's doctor if the umbilical area oozes pus, the surrounding skin becomes red and swollen, or the area develops a pink moist bump. These could be signs of an umbilical cord infection.

40. Khaleesi is admitted to the hospital due to having a lower than normal potassium level in her bloodstream. Her medical history reveals vomiting and diarrhea prior to hospitalization. Which foods should the nurse instruct the client to increase?

- A. Whole grains and nuts
- B. Milk products and green, leafy vegetables
- C. Pork products and canned vegetables
- D. Orange juice and bananas

Correct Answer: D. Orange juice and bananas

The client with hypokalemia needs to increase the intake of foods high in potassium. Orange juice and bananas are high in potassium, along with raisins, apricots, avocados, beans, and potatoes. Encourage high potassium diet such as oranges, bananas, tomatoes, coffee, red meat, and dried fruits. Discuss the use of potassium chloride salt substitutes for a client receiving long-term diuretics. Potassium may be replaced and level maintained through the diet when the client is allowed oral food and fluids.

- **Option A:** Whole grains and nuts would be encouraged for the client with hypomagnesemia. Encourage intake of dairy products, meat, fish, green leafy vegetables, and whole grains. Provides an oral replacement for mild magnesium deficits; may prevent a recurrence.
- **Option B:** Milk products and green, leafy vegetables are good sources of calcium for the client with hypocalcemia. Encourage the client to eat foods high in calcium such as dark leafy greens, cheese, low-fat milk, yogurt, eggs, oranges, green beans, and sardines. Avoid intake of phosphorus-rich foods such as bran, chocolates, nuts, whole wheat, and barley.

- **Option C:** Pork products and canned vegetables are high in sodium and are encouraged for the client with hyponatremia. Encourage fluids and foods high in sodium such as meat, milk, beets, celery, eggs, and carrots. Use fruit juices and bouillon instead of water. Unless sodium deficit causes serious symptoms requiring immediate IV replacement, the client may benefit from slower replacement by oral method or removal of previous salt restriction.

41. When assessing the adequacy of sperm for conception to occur, which of the following is the most useful criterion?

- A. Sperm count
- B. Sperm motility
- C. Sperm maturity
- D. Semen volume

Correct Answer: B. Sperm motility

Although all of the factors listed are important, sperm motility is the most significant criterion when assessing male infertility. To reach and fertilize an egg, sperm must move — wriggling and swimming through a woman’s cervix, uterus, and fallopian tubes. This is known as motility. Males are most likely to be fertile if at least 40% of their sperm are moving.

- **Option A:** A normal sperm count ranges from 15 million sperm to more than 200 million sperm per milliliter (mL) of semen. Anything less than 15 million sperm per milliliter, or 39 million sperm per ejaculate, is considered low.
- **Option C:** Sperm cells are continually being produced by the testes, but not all areas of the seminiferous tubules produce sperm cells at the same time. One immature germ cell takes as long as 74 days to reach final maturation, and during this growth process, there are intermittent resting phases.
- **Option D:** According to the International Society for Sexual Medicine, the average semen volume per ejaculate ranges from 1.25 to 5 milliliters (ml). This amount is the equivalent of one-quarter to 1 teaspoon of semen. It is important to note that semen volumes can vary from one time to another.

42. Tamisha will be having her exam in pharmacology tomorrow. She should be aware that antitussive is indicated to:

- A. Encourage removal of secretions through coughing
- B. Relieve rhinitis
- C. Control a productive cough
- D. Relieve a dry cough

Correct Answer: D. Relieve a dry cough

An antitussive is a cough suppressant. Antitussives constitute a heterogeneous class of compounds that inhibit cough through either a central or a peripheral mechanism, or a mixture of the two. Antitussives are cough suppressants. There are two ways to inhibit coughing: centrally and peripherally. Choices A and C describe the action of an expectorant.

- **Option A:** Expectorant is a medication that helps bring up mucus and other material from the lungs, bronchi, and trachea. An example of an expectorant is guaifenesin, which promotes

drainage of mucus from the lungs by thinning the mucus, and also lubricates the irritated respiratory tract.

- **Option B:** Decongestants are a type of medicine that can provide short-term relief for a blocked or stuffy nose (nasal congestion). They can help ease the symptoms of conditions such as colds and flu, hay fever and other allergic reactions, catarrh and sinusitis. They work by reducing the swelling of the blood vessels in the nose, which helps to open the airways.
- **Option C:** An expectorant is a type of cough medicine that thins and loosens mucus. These medications are typically used for managing the effects of chest congestion, especially when symptoms are caused by persistent mucus. Expectorants are designed to thin the respiratory secretions in the airways so that one can cough up excessive mucus more effectively. These medications do this by lubricating the airway passages.

43. The following statements appear on a nursing care plan for a client after a mastectomy: Incision site approximated; absence of drainage or prolonged erythema at the incision site; and the client remains afebrile. These statements are examples of:

- A. Nursing interventions
- B. Short-term goals
- C. Long-term goals
- D. Expected outcomes

Correct Answer: D. Expected outcomes

Goals or desired outcomes describe what the nurse hopes to achieve by implementing the nursing interventions and are derived from the client's nursing diagnoses. One overall goal is determined for each nursing diagnosis. The terms goal, outcome, and expected outcome are oftentimes used interchangeably.

- **Option A:** Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis.
- **Option B:** Short-term goals can act as stepping stones to achieving longer-term targets. For example, a client may have the long-term goal of being able to groom herself, including cleaning her teeth, washing her face, combing her hair, and applying her make-up on her own. A short-term goal for this client might be to be able to clean her teeth.
- **Option C:** Long-term goals are often used for clients who have chronic health problems or who live at home, in nursing homes, or extended-care facilities. Long-term goal indicates an objective to be completed over a longer period, usually over weeks or months.

44. Nurse April is teaching a client who suspects that she has a lump in her breast. The nurse instructs the client that a diagnosis of breast cancer is confirmed by:

- A. Breast self-examination
- B. Mammography

- C. Fine needle aspiration
- D. Chest X-ray

Correct Answer: C. Fine needle aspiration

- **Option C:** Fine needle aspiration and biopsy provide cells for histologic examination to confirm a diagnosis of cancer. During the procedure, a needle is inserted into the lump and a sample of tissue is taken for examination.
- **Option A:** A breast self-examination, if done regularly, is the most reliable method for detecting breast lumps early.
- **Option B:** Mammography is used to detect tumors that are too small to palpate.
- **Option D:** Chest X-rays can be used to pinpoint rib metastasis.

45. Claudication is a well-known effect of peripheral vascular disease. Which of the following facts about claudication is correct? Select all that apply.

- A. It results when oxygen demand is greater than oxygen supply.
- B. It is characterized by pain that often occurs during rest.
- C. It is a result of tissue hypoxia.
- D. It is characterized by cramping and weakness.
- E. It is relieved after a short rest.

Correct Answer: A, C, D, & E.

Claudication describes the pain experienced by a patient with peripheral vascular disease when oxygen demand in the leg muscles exceeds the oxygen supply. This most often occurs during activity when demand increases in muscle tissue, and usually relieved after rest. The tissue becomes hypoxic, causing cramping, weakness, and discomfort.

- **Option A:** Intermittent claudication (IC) typically refers to lower extremity skeletal muscle pain that occurs during exercise. IC presents when there is insufficient oxygen delivery to meet the metabolic requirements of the skeletal muscles.
- **Option B:** Pain occurs during activity when demand increases in muscle tissues, not when at rest. IC is commonly localized to the thigh, hip, buttock, and calf muscles. Pain within these muscle groups is reproducibly induced by walking and relieved with rest. The severity of pain can sometimes correlate with the degree of stenosis or blockage in arteries supplying the lower extremities.
- **Option C:** The key feature of intermittent claudication is that the muscle discomfort is reproducible. The pain usually comes on during physical activity and subsides after a period of rest. The key reason for the pain is inadequate blood flow.
- **Option D:** Physical examination of these patients may show evidence of arterial insufficiency. The affected limb may feel cool and have diminished pulses. The physical examination should include an assessment of femoral, popliteal, dorsalis pedis, and posterior tibial artery pulses.
- **Option E:** Structured walking programs improve pain-free walking distance better than pharmacologic therapy alone. It is important to note that continued smoking with walking therapy restricts improvement in these patients.

46. Serious adverse effects of oral contraceptives include:

- A. Increase in skin oil followed by acne.
- B. Headache and dizziness.
- C. Early or mid-cycle bleeding.
- D. Thromboembolic complications.

Correct Answer: D. Thromboembolic complications.

Oral contraceptives have been associated with an increased risk of stroke, myocardial infarction, and deep vein thrombosis. If the patient has other risk factors significant for increased risk of venous thromboembolism one may consider using a prophylactic anticoagulant medication temporarily.

- **Option A:** Increased skin oil and acne are the effects of progestin excess. Progestin-only methods such as the implant, hormonal IUD, or shot may worsen acne, hirsutism, or hair loss in some people.
- **Option B:** Headache and dizziness are effects of estrogen excess. These risks are increased in women who smoke. If a patient takes too many oral contraceptive pills at one time the most likely complications will be severe headaches and nausea or vomiting. There is no antidote to treat this condition, just treatment of the symptoms with antiemetics and analgesics.
- **Option C:** Early or mid-cycle bleeding are effects of estrogen deficiency. Most side effects of OCP's are mild and disappear with continued use or switching to another pill formulation. The most common adverse effect of combined oral contraceptive pills is breakthrough bleeding.

47. Which of the following tasks should be included in the immediate postoperative management of a client who has undergone gastric resection?

- A. Monitoring gastric pH to detect complications.
- B. Assessing for bowel sounds.
- C. Providing nutritional support.
- D. Monitoring for symptoms of hemorrhage.

Correct Answer: D. Monitoring for symptoms of hemorrhage.

The client should be monitored closely for signs and symptoms of hemorrhage, such as bright red blood in the nasogastric tube suction, tachycardia, or a drop in blood pressure. Identify signs and symptoms requiring medical evaluation such as persistent nausea and vomiting or abdominal fullness; weight loss; diarrhea; foul-smelling fatty or tarry stools; bloody or coffee-ground vomitus or presence of bile, fever. Instruct the patient to report changes in pain characteristics.

- **Option A:** Gastric pH may be monitored to evaluate the need for histamine-2 receptor antagonists. Caution the patient to read labels and avoid products containing ASA, ibuprofen. This can cause gastric irritation and bleeding. Review medication purpose, dosage, and schedule, and possible side effects.
- **Option B:** Bowel sounds may not return for up to 72 hours postoperatively. Auscultate for resumption of bowel sounds and note passage of flatus. Peristalsis can be expected to return about the third postoperative day, signaling readiness to resume oral intake.

- **Option C:** Nutritional needs should be addressed soon after surgery. Monitor tolerance to fluid and food intake, noting abdominal distension, reports of increased pain, cramping, nausea, and vomiting. Avoid milk and high-carbohydrate foods in the diet because this may trigger dumping syndrome.

48. Norma asks for information about osteoarthritis. Which of the following statements about osteoarthritis is correct?

- A. Osteoarthritis is rarely debilitating.
- B. Osteoarthritis is a rare form of arthritis.
- C. Osteoarthritis is the most common form of arthritis.
- D. Osteoarthritis affects people over 60.

Correct Answer: C. Osteoarthritis is the most common form of arthritis

Osteoarthritis is the most common form of arthritis and can be extremely debilitating. It can afflict people of any age, although most are elderly.

- **Option A:** Osteoarthritis is an extremely debilitating disease. The cartilage within a joint begins to break down and the underlying bone begins to change.
- **Option B:** It is the most common form of arthritis. It affects over 32.5 million US adults.
- **Option D:** Osteoarthritis can affect people of any age, but are most common among the elderly. Women are more likely to develop OA than men, especially after the age of 50.

49. Before giving a repeat dose of magnesium sulfate to a pre-eclamptic patient, the nurse should assess the patient's condition. Which of the following conditions will require the nurse to temporarily suspend a repeat dose of magnesium sulfate?

- A. 100 cc. urine output in 4 hours
- B. Knee jerk reflex is (+)2
- C. Serum magnesium level is 10mEq/L.
- D. Respiratory rate of 16/min

Correct Answer: A. 100 cc. urine output in 4 hours

The minimum urine output expected for a repeat dose of MgSO₄ is 30 cc/hr. If in 4 hours the urine output is only 100 cc this is low and can lead to poor excretion of Magnesium with a possible cumulative effect, which can be dangerous to the mother.

- **Option B:** As the plasma levels increase the muscle weakness becomes more pronounced and there is a marked reduction and then loss of deep tendon reflexes eventually leading to flaccid paralysis and respiratory arrest.
- **Option C:** Magnesium sulfate is the ideal drug for the prevention and treatment of eclampsia, and, indeed, its universal use is recommended by the World Health Organization. Nevertheless, the best regimen remains to be established and there is still no evidence that serum magnesium levels between 4 and 7mEq/L, established in a retrospective study and still considered therapeutic, represent a guarantee that pregnant women with hypertensive disorders are protected against

eclampsia.

- **Option D:** Magnesium sulfate has CNS and respiratory depressant effects. It acts peripherally, causing vasodilation; moderate doses cause flushing and sweating, whereas high doses cause hypotension. It prevents or controls seizures by blocking neuromuscular transmission.

50. When attending a client with a head and neck trauma following a vehicular accident, the nurse's initial action is to?

- A. Provide oxygen therapy
- B. Initiate intravenous access
- C. Immobilize the cervical area
- D. Do oral and nasal suctioning

Correct Answer: C. Immobilize the cervical area

Clients with suspected or possible cervical spine injury must have their neck immobilized until formal assessment occurs. Maintain cervical spine spinal immobilization and minimize neck movement particularly during transport. Beware that absence of neurologic findings does not eliminate the possibility of spinal cord injury.

- **Option A:** Immediate measures are necessary to maintain breathing and hemodynamic stability, such as oxygen therapy. Hyperbaric oxygen (HBO) therapy has also been shown to exert neuroprotective effects when administered before or after SCI. Experimental studies have revealed various mechanisms that contribute to these neuroprotective effects, including improved spinal cord oxygen tension, decreased apoptosis, reduced inflammation, attenuation of oxidative stress, and improved angiogenesis and autophagy.
- **Option B:** Rapid infusion as quickly as possible of large volumes of crystalloids to restore blood volume and blood pressure is now the standard treatment for patients with combined traumatic brain injury and hemorrhagic shock. The final goal of fluid management is to optimize the circulatory system to ensure the sufficient delivery of oxygen to organs.
- **Option D:** Suctioning is also done after the cervical spine is immobilized. Patients with known or suspected cervical spine injury may require emergent intubation for airway protection and ventilatory support or elective intubation for surgery with or without rigid neck stabilization (i.e., halo).

51. When caring for a patient who has started anticoagulant therapy with warfarin (Coumadin), the nurse knows not to expect therapeutic benefits for:

- A. At least 12 hours
- B. The first 24 hours
- C. 2-3 days
- D. 1 week

Correct Answer: C. 2-3 days

The onset of action is typically 24 to 72 hours. A peak therapeutic effect is seen 5 to 7 days after initiation. However, the patient's international normalized ratio (INR) may increase within 36 to 72 hours after initiating treatment. 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 A:** The dose-response of warfarin among patients is highly variable and depends on interpatient differences. Patient-specific factors such as drug metabolism, the presence of a vitamin K enriched diet, genetics, quantity of vitamin K-dependent clotting factors, concurrent disease states, binding proteins, concomitant drug interactions, laboratory testing, and medication adherence requires assessment when dosing warfarin.
- **Option B:** The half-life of warfarin is generally 20 to 60 hours (mean: 40 hours). However, it is highly variable among individuals. The duration of action is 2 to 5 days. Hepatic metabolism, primarily through the CYP2C9 enzyme. Other minor enzymatic pathways for metabolism include CYP2C8, 2C18, 2C19, 1A2, and 3A4. Warfarin is primarily eliminated as metabolites by glomerular filtration in the kidney (92% via urine).
- **Option D:** 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.

52. When performing an assessment on a neonate, which assessment finding is most suggestive of hypothermia?

- A. Bradycardia
- B. Hyperglycemia
- C. Metabolic alkalosis
- D. Shivering

Correct Answer: A. Bradycardia.

- **Option A:** Hypothermic neonates become bradycardic proportional to the degree of core temperature. Hypoglycemia is seen in hypothermic neonates.

53. During an internal medicine clerkship, medical students are assigned to the care of a 55-year-old patient with a recent organ transplant who is now showing signs of transplant rejection. The clinical team explains the underlying immunologic mechanism of transplant rejection, emphasizing the role of cell-mediated immunity. The students are engaged in a discussion on how certain immune cells are pivotal in recognizing and attacking the transplanted tissue, leading to graft rejection. Later during an immunology lecture recap, the professor delves deeper into cell-mediated immunity and the immune cells central to this process. Given the clinical scenario of transplant rejection and the theoretical discussion, which of the following cells are primarily responsible for cell-mediated immunity?

- A. B cells

- B. Memory B cells
- C. Cytotoxic T cells
- D. Helper T cell

Correct Answer: C. Cytotoxic T cells

Cytotoxic T cells (also known as CD8+ T cells) are the primary effector cells in cell-mediated immunity. They have the capability to directly recognize and kill cells that are infected with viruses or are otherwise damaged or dysfunctional, as in the case of transplant rejection.

- **Option A:** B cells are central to humoral immunity rather than cell-mediated immunity. They function by producing antibodies that neutralize pathogens, which is distinct from the direct cell-to-cell combat characteristic of cell-mediated immunity.
- **Option B:** Memory B cells, like B cells, are associated with humoral immunity by holding the immunological memory of previously encountered antigens. They do not play a primary role in cell-mediated immunity.
- **Option D:** Helper T cells (CD4+ T cells) assist in the activation of other immune cells, including cytotoxic T cells and B cells, by releasing cytokines. While they play a supporting role in cell-mediated immunity, the primary executors of cell-mediated immune responses are the cytotoxic T cells.

54. A patient admitted to a mental health unit for treatment of psychotic behavior spends hours at the locked exit door shouting. "Let me out. There's nothing wrong with me. I don't belong here." What defense mechanism is the patient implementing?

- A. Denial
- B. Projection
- C. Regression
- D. Rationalization

Correct Answer: A. Denial.

Denial is a refusal to admit to a painful reality, which was treated as if it does not exist. It involves blocking external events from awareness. If some situation is just too much to handle, the person refuses to experience it. This is a primitive and dangerous defense – no one disregards reality and gets away with it for long! It can operate by itself or, more commonly, in combination with other, more subtle mechanisms that support it.

- **Option B:** In projection, a person unconsciously rejects emotionally unacceptable features and attributes them to other persons, objects, or situations. Projection is a psychological defense mechanism proposed by Anna Freud in which an individual attributes unwanted thoughts, feelings, and motives onto another person.
- **Option C:** Regression allows the patient to return to an earlier, more comforting, although less mature, way of behaving. This is a movement back in psychological time when one is faced with stress. Regression functions as a form of retreat, enabling a person to psychologically go back in time to a period when the person felt safer.
- **Option D:** Rationalization is justifying illogical or unreasonable ideas, actions, or feelings by developing acceptable explanations that satisfy the teller and the listener. Rationalization is a

defense mechanism proposed by Anna Freud involving a cognitive distortion of “the facts” to make an event or an impulse less threatening.

55. The best explanation of what Title VI of the Civil Rights Act mandates is the freedom to:

- A. Pick any physician and insurance company despite one's income.
- B. Receive free medical benefits as needed within the county of residence.
- C. Have equal access to all health care regardless of race and religion.
- D. Have basic care with a sliding scale payment plan from all healthcare facilities.

Correct Answer: C. Have equal access to all health care regardless of race and religion.

Title VI of the Civil Rights Act of 1964 states that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

- **Option A:** The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new “Patient’s Bill of Rights” gives the American people the stability and flexibility they need to make informed choices about their health. Through this bill, the client may choose the primary care physician he wants from his plan’s network.
- **Option B:** Since the Patient’s Bill of Rights was enacted, the Affordable Care Act has provided additional rights and protections. The health care law covers preventive care at no cost. Clients may be eligible for recommended preventive health services without a copayment.
- **Option D:** Under the Patient’s Bill of Rights, a client’s premium dollars are ensured to be spent on primary healthcare, not on administrative costs. Also, the bill removes insurance company barriers to emergency services that are outside of their health plan’s network.

56. Which of the following symptoms usually signifies rapid expansion and impending rupture of an abdominal aortic aneurysm?

- A. Abdominal pain
- B. Absent pedal pulses
- C. Angina
- D. Lower back pain

Correct Answer: D. Lower back pain

Lower back pain results from the expansion of an aneurysm. The expansion applies pressure in the abdominal cavity, and the pain is referred to the lower back.

- **Option A:** Abdominal pain is the most common symptom resulting from impaired circulation. The most typical manifestation of rupture is abdominal or back pain with a pulsatile abdominal mass. However, the symptoms may be vague, and the abdominal mass may be missed.
- **Option B:** Absent pedal pulses are a sign of no circulation and would occur after a ruptured aneurysm or in peripheral vascular disease.
- **Option C:** Angina is associated with atherosclerosis of the coronary arteries.

57. 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.

58. When teaching parents about typical toddler eating patterns, which of the following should be included?

- A. Food "jags."
- B. Preference to eat alone
- C. Consistent table manners
- D. Increase in appetite

Correct Answer: A. Food "jags."

Toddlers become picky eaters, experiencing food jags, and eating large amounts one day and very little the next. A toddler's food jags express a preference for the ritualism of eating one type of food for several days at a time.

- **Option B:** Toddlers typically enjoy socialization and limiting others at mealtime.
- **Option C:** Toddlers prefer to feed themselves and thus are too young to have table manners.
- **Option D:** A toddler's appetite and the need for calories, protein, and fluid decrease due to the dramatic slowing of growth rate.

59. A client with acute pancreatitis is experiencing severe abdominal pain. Which of the following orders should be questioned by the nurse?

- A. Meperidine 100 mg IM q 4 hours PRN pain
- B. Mylanta 30 ccs q 4 hours via NG
- C. Cimetidine 300 mg PO q.i.d.
- D. Morphine 8 mg IM q 4 hours PRN pain

Correct Answer: D. Morphine 8 mg IM q 4 hours PRN pain

Morphine is contraindicated in clients with gallbladder disease and pancreatitis because morphine causes spasms of the Sphincter of Oddi. GI obstruction is another important contraindication. It is also considered by many as a contraindication to provide opioids to individuals that have a history of substance misuse, especially if a patient has had a history of abusing opioids.

- **Option A:** Clinicians use meperidine is used for the treatment of moderate to severe pain. It has intramuscular, subcutaneous, intravenous injection, syrup, and tablet forms. In the 20th century, it was the drug of choice amongst the opioids in the management of acute pain by most of the physicians and the management of some patients with chronic pain.
- **Option B:** Antacids are a group of drugs that have been on the market for many years. They were initially first-line defense against peptic ulcer disease; however, the discovery of proton pump inhibitors revolutionized the treatment of peptic ulcer disease. Currently, antacid use is restricted to the relief of mild intermittent gastroesophageal reflux disease (GERD) associated heartburn.
- **Option C:** Cimetidine is ordered for pancreatitis, making answer C incorrect. Cimetidine is a gastric acid reducer used in the short-term treatment of duodenal and gastric ulcers. The drug is effective in managing gastric hypersecretion, and therefore, used for the management of reflux esophagitis disease and in the prevention of stress ulcers. With the development of proton pump inhibitors, such as omeprazole, approved for the same indications, cimetidine is available as an over the counter formulation for the prevention of heartburn or acid indigestion, along with the other H2-receptor antagonists.

60. The mother of a child with hemophilia asks the nurse which over-the-counter medication is suitable for her child's joint discomfort. The nurse should tell the mother to purchase:

- A. Aspirin (acetylsalicylic acid)
- B. Naproxen (Naprosyn)
- C. Tylenol (acetaminophen)
- D. Advil (ibuprofen)

Correct Answer: C. Tylenol (acetaminophen)

- **Option C:** The nurse should recommend acetaminophen for the child's joint discomfort because it will have no effect on the bleeding time.
- **Options A, B, and D:** Aspirin, Naproxen, and Advil are all nonsteroidal anti-inflammatory medications that can prolong bleeding time; therefore, they are not suitable for the child with

hemophilia.

61. A 28-year-old woman, in her second pregnancy, visits the prenatal clinic. During her first pregnancy, she did not receive any postnatal Rhogam shots. Her medical records indicate that she is RH negative. The father of the child, however, is RH positive. Given the potential risks associated with Rh incompatibility and the importance of preventive care, under which circumstances would Rhogam most likely be administered to the mother to prevent hemolytic disease in the infant?

- A. When the mother is RH positive and the infant is RH positive.
- B. When the mother is RH positive and the infant is RH negative.
- C. When the mother is RH negative and the infant is RH positive.
- D. When the mother is RH negative and the infant is RH negative.
- E. When both the mother and the infant have an unknown RH status.
- F. When the mother has previously received Rhogam in a prior pregnancy.

Correct Answer: C. When the mother is RH negative and the infant is RH positive.

Rhogam (Rho(D) immune globulin) is given to RH negative mothers to prevent the development of antibodies against RH positive blood. This is crucial when an RH negative mother has an RH positive infant, as the mother's body may see the baby's RH positive red blood cells as foreign and develop antibodies against them, leading to hemolytic disease in the infant. Rhogam is administered to prevent this immune response.

62. Acids have no hydrogen ions and are able to bind in a solution.

- A. True
- B. False
- C. Acid is a substance that is not capable of donating hydrogen ions.
- D. Acids and bases have nothing to do with hydrogen ions.

Correct Answer: B. False

Acids are substances having one or more hydrogen ions that can be liberated into a solution.

Bases are substances that can bind hydrogen ions in a solution.

63. Which of the following will Nurse Dory use when communicating with a client who has cognitive impairment?

- A. Complete explanations with multiple details.
- B. Pictures or gestures instead of words.
- C. Stimulating words and phrases to capture the client's attention.
- D. Short words and simple sentences.

Correct Answer: D. Short words and simple sentences.

Short words and simple sentences minimize client confusion and enhance communication. Assess the patient's ability to speak, language deficit, cognitive or sensory impairment, presence of aphasia, dysarthria, aphonia, dyslalia, or apraxia. Presence of psychosis, and/or other neurologic disorders affecting speech. This identifies problem areas and speech patterns to help establish a plan of care.

- **Option A:** Use simple, direct questions requiring one-word answers. Repeat and reword questions if misunderstanding occurs. This promotes self-confidence of the patient who is able to achieve some degree of speech or communication. Encourage the patient to breathe prior to speaking, pause between words, and use the tongue, lips, and jaw to speak. Encourage the patient to control the length and rate of phrases, over articulate words, and separate syllables, emphasizing consonants.
- **Option B:** Although pictures and gestures may be helpful, they would not substitute for verbal communication. When communicating with the patient, face the patient and maintain eye contact, speaking slowly and enunciating clearly in a moderate or low-pitched tone. Clarity, brevity, and time provided for responses promote the opportunity for successful speech by allowing patient time to receive and process the information.
- **Option C:** Complete explanations with multiple details and stimulating words and phrases would increase confusion in a client with short attention span and difficulty with comprehension. Remove competing stimuli, and provide a calm, unhurried atmosphere for communication. This reduces unnecessary noise and distraction and allows patient time to decrease frustration.

64. Develop a teaching care plan for Angie who is about to undergo a liver biopsy. Which of the following points do you include?

- A. "You'll need to lie on your stomach during the test."
- B. "You'll need to lie on your right side after the test."
- C. "During the biopsy, you'll be asked to exhale deeply and hold it."
- D. "The biopsy is performed under general anesthesia."

Correct Answer: B. "You'll need to lie on your right side after the test."

After a liver biopsy, the patient is placed on the right side to compress the liver and to reduce the risk of bleeding or bile leakage. The risk of fatal hemorrhage in patients without malignant disease is 0.04%, and the risk of nonfatal hemorrhage is 0.16%. In those with malignancy, the risk of nonfatal hemorrhage is 0.4% and 0.57% for nonfatal hemorrhage.

- **Option A:** The patient is usually kept in the right decubitus position. The duration of observation varies across centers ranging from 1 hour to 6 hours. The American Association for the Study of Liver Diseases guidelines recommends observation for 2 to 4 hours. The vital signs are monitored every 15 minutes for the first hour, every 30 minutes for the next hour, and hourly till discharge.
- **Option C:** The patients are made to lie in a comfortable supine position. The right hand is placed under the head in a neutral position. By percussion, the area of maximum dullness is identified over the right hemithorax. This is typically between the 6 and 9 intercostal spaces between the anterior and the midclavicular line.
- **Option D:** The skin is prepped and draped in a sterile fashion. The overlying skin is anesthetized using 1% lidocaine. The peritoneum is also anesthetized by inserting the needle along the upper border of the rib avoiding vascular structures.

65. A nurse is suctioning fluids from a female client through an endotracheal tube. During the suctioning procedure, the nurse notes on the monitor that the heart rate is decreasing. Which of the following is the appropriate nursing intervention?

- A. Continue to suction.
- B. Notify the physician immediately.
- C. Stop the procedure and reoxygenate the client.
- D. Ensure that the suction is limited to 15 seconds.

Correct Answer: C. Stop the procedure and reoxygenate the client.

During suctioning, the nurse should monitor the client closely for side effects, including hypoxemia, cardiac irregularities such as a decrease in heart rate resulting from vagal stimulation, mucosal trauma, hypotension, and paroxysmal coughing. If side effects develop, especially cardiac irregularities, the procedure is stopped and the client is reoxygenated.

- **Option A:** Suction gently and intermittently, use proper catheter size and technique. Clears airway and pool of secretions without injury to the trachea, prolonged suctioning causes vagal stimulation and bradycardia and high pressure may damage the mucosa of the trachea.
- **Option B:** Monitor arterial blood gasses and oxygen saturation. Pulse oximetry is a useful tool to detect early changes in oxygen saturation. Oxygen saturation should be kept at 90% or greater. Increasing PaCo₂ and decreasing PaO₂ are signs of hypoxemia and respiratory acidosis.
- **Option D:** Brief, 10-second suction duration is usually recommended to avoid mucosal damage and prolonged hypoxia. Hypoxia can be profound from occlusion, interruption of oxygen supply, and prolonged suctioning.

66. Which of the following statements by the parents of a child with school phobia would indicate the need for further teaching?

- A. "We'll keep him at home until the phobia subsides."
- B. "We'll work with his teachers and counselors at school."
- C. "We'll try to encourage him to talk about his problem."
- D. "We'll discuss possible solutions with him and his counselor."

Correct Answer: A. "We'll keep him at home until the phobia subsides."

The parents need more teaching if they state that they will keep the child home until the phobia subsides. Doing so reinforces the child's feelings of worthlessness and dependency.

- **Option B:** The child should attend school even during resolution of the problem.
- **Option C:** Allowing the child to verbalize helps the child to ventilate feelings and may help to uncover causes and solutions.
- **Option D:** Collaboration with the teachers and counselors at school may lead to uncovering the cause of the phobia and to the development of solutions. The child should participate and play an active role in developing possible solutions.

67. To avoid fecal impaction, psyllium (Metamucil) should be administered with at least how many ounces of fluid?

- A. 4
- B. 6
- C. 8
- D. 10

Correct Answer: C. 8

Bulk-forming laxatives must be given with at least 8 ounces of liquid plus additional liquid each day to prevent intestinal obstruction. Bulk-forming laxatives retain fluid in the stool and increase stool weight and consistency. Psyllium, dietary fiber, carboxymethylcellulose, and methylcellulose are common examples. It is important to take ample amounts of water for bulk-forming agents to work. Lack of water, in turn, leads to bloating and can cause bowel obstruction.

- **Option A:** Most laxatives are safe when used appropriately and in patients without contraindications. Bulk-forming agents like lactulose can have adverse effects like bloating, nausea, vomiting, and diarrhea. With prokinetic agents, adverse effects like a headache, nausea, and diarrhea have been described.
- **Option B:** Stimulant laxatives are known to cause abdominal pain. Cisapride and tegaserod were withdrawn from the market after cardiovascular adverse effects, including prolonged QT interval that increases the risk for Torsades de Pointes. Mineral oil can cause aspiration and lipid pneumonia.
- **Option D:** Osmotic agents like magnesium can cause metabolic disturbances, especially in the presence of renal involvement. Also, magnesium excretion depends on renal function, and its use requires caution in renal impairment. Osmotic agents result in volume load and should be used with caution in renal or cardiac dysfunction.

68. A 72-year-old retired ballet dancer, with a long-standing history of osteoarthritis (OA) affecting her right hip, is admitted to the orthopedic ward for an upcoming total hip replacement surgery. Over the years, conservative treatments have become less effective, and her mobility has significantly declined, prompting the decision for surgical intervention. As the surgery date approaches, the nurse plans a preoperative intervention to optimize the patient's readiness for the procedure. Which preoperative nursing intervention should be implemented?

- A. Administering prophylactic antibiotics as prescribed
- B. Encouraging active range of motion exercises for the affected joint
- C. Applying cold packs to the affected joint to reduce inflammation
- D. Teaching the patient about postoperative pain management techniques

Correct Answer: A. Administering prophylactic antibiotics as prescribed.

Prophylactic antibiotics are often prescribed prior to certain surgeries, including joint replacements, to reduce the risk of postoperative infections. While this is an important measure, the decision and timing of antibiotic administration are usually very specific and directed by the surgical team or protocol, often

closer to the time of the actual surgery.

- **Option B:** While exercise is crucial in the management of OA, encouraging active range of motion exercises immediately before a joint replacement surgery may not be the primary focus. The joint is already deteriorated, and the main goal of the surgery is to address this issue. However, exercises might be essential postoperatively to aid in rehabilitation.
- **Option C:** Cold therapy can help in reducing inflammation and alleviating pain. However, in the immediate preoperative phase, the focus is often on preparing the patient for surgery and managing any potential complications, rather than on symptom management which the surgery itself is aiming to address.
- **Option D:** Education about postoperative pain management is crucial before joint replacement surgeries. This ensures that the patient has realistic expectations, understands the methods of pain relief available, and can actively participate in their pain management after the surgery, leading to better outcomes and improved patient satisfaction. Teaching the patient about postoperative pain management techniques is important but is more appropriate for the postoperative period.

69. While planning care for a 2-year-old hospitalized child, which situation would the nurse expect to most likely affect the behavior?

- A. Strange bed and surroundings.
- B. Separation from parents.
- C. Presence of other toddlers.
- D. Unfamiliar toys and games.

Correct Answer: B. Separation from parents

Separation anxiety is most evident from 6 months to 30 months of age. It is the greatest stress imposed on a toddler by hospitalization. If separation is avoided, young children have a tremendous capacity to withstand other stress.

- **Option A:** Most children, even school-aged children, are fearful of a strange bed and new surroundings.
- **Option C:** The presence of other toddlers might help the client calm down and adjust with the environment.
- **Option D:** Unfamiliar toys and games would least likely affect the toddler's behavior.

70. Which of the following types of behavior is expected from a client diagnosed with a paranoid personality disorder?

- A. Eccentric
- B. Exploitative
- C. Hypersensitive
- D. Seductive

Correct Answer: C. Hypersensitive

People with paranoid personality disorders are hypersensitive to perceived threats. While this mistrust is unfounded, their distrust of others makes it difficult to form relationships and can interfere with many

aspects of life including at home, at school, and at work. People with PPD do not see their behaviors as out of the ordinary but are perceived by others as hostile and suspicious.

- **Option A:** Schizotypal personalities appear eccentric and engage in activities others find perplexing. Schizotypal personality disorder is marked by a pervasive pattern of social and interpersonal deficits. Individuals with schizotypal personality disorder have little capacity—and perhaps even need—for close relationships.
- **Option B:** Clients with narcissistic personality disorder are interpersonally exploitative to enhance themselves or indulge in their own desires. Narcissistic personality disorder (NPD) is an enduring pattern of inner experience and behavior characterized by self-centeredness, lack of empathy, and an exaggerated sense of self-importance.
- **Option D:** A client with a histrionic personality disorder can be extremely seductive when in search of stimulation and approval. Histrionic personality disorder, or dramatic personality disorder, is a psychiatric disorder distinguished by a pattern of exaggerated emotionality and attention-seeking behaviors. Histrionic personality disorder falls within the “Cluster B” of personality disorders.

71. The physician has ordered several laboratory tests to help diagnose an infant's bleeding disorder. Which of the following tests, if abnormal, would the nurse interpret as most likely to indicate hemophilia?

- A. Bleeding time
- B. Tourniquet test
- C. Clot retraction test
- D. Partial thromboplastin time (PTT)

Correct Answer: D. Partial thromboplastin time (PTT)

PTT measures the activity of thromboplastin, which is dependent on intrinsic clotting factors. In hemophilia, the intrinsic clotting factor VIII (antihemophilic factor) is deficient, resulting in a prolonged PTT. The PTT could be as prolonged as 2 to 3 times the high normal range. Once PTT is found to be prolonged, it should be followed by a mixing study. In a mixing study, the PTT should normalize if factor deficiency is suspected.

- **Option A:** Bleeding time reflects platelet function. Bleeding time is a clinical laboratory test performed to evaluate platelet function. It involves the creation of a standardized incision and timing the cessation of bleeding. The historical indications were the pre-operative assessment of patients taking aspirin or NSAIDs and screening for von-Willebrand disease.
- **Option B:** The tourniquet test measures vasoconstriction and platelet function. The tourniquet test is part of the new WHO case definition for dengue. The test is a marker of capillary fragility and it can be used as a triage tool to differentiate patients with acute gastroenteritis, for example, from those with dengue.
- **Option C:** Clot retraction test measures capillary fragility. All of these are unaffected in people with hemophilia. Clot retraction is a process driven by outside-in signaling by platelet integrin α IIb β 3 that results in the contraction of the fibrin mesh. The contraction of the fibrin clot results in the blood clot becoming smaller and excess fluid is extruded.

72. You are the pediatric unit charge nurse today and is working with a new RN. Which action by the new RN requires the most immediate action on your part?

- A. The new RN wears goggles to change linens of a client who has diarrhea caused by *C. difficile*.
- B. The new RN places a child who has chemotherapy-induced neutropenia into a negative-pressure room.
- C. The new RN admits a new client with respiratory syncytial virus (RSV) infection to a room with another child who has RSV.
- D. The new RN tells the nursing assistant to use an N95 respirator mask when caring for a child who has pertussis.

Correct Answer: B. The new RN places a child who has chemotherapy-induced neutropenia into a negative-pressure room.

Clients who are neutropenic should be placed in positive-airflow rooms; placement of the child in a negative airflow room will increase the likelihood of infection for this client. Clean, filtered air is constantly pumped into the room. This is done to keep contagious diseases out of the room. With this type of isolation room, the client may be able to feel air blowing out of the room under a closed door.

- **Option A:** Goggles are not needed for changing the linens of clients infected with *C. difficile*; however, these protections do not increase the risk to the clients. Healthcare providers will put on gloves and wear a gown over their clothing while taking care of clients with *C. diff*. Visitors may also be asked to wear a gown and gloves. When leaving the room, hospital providers and visitors remove their gown and gloves and clean their hands.
- **Option C:** Although private rooms are preferred for clients who need droplet precautions, such as clients with RSV infection, they can be placed in rooms with other clients who are infected with the same microorganism.
- **Option D:** The use of an N95 respirator is not necessary for pertussis. Wearing a surgical mask within 3 feet of the client provides protection from the spread of pertussis. Oftentimes, close household contacts are the source of the child's infection; therefore, providers should also wear masks when within 3 feet of symptomatic parents or siblings.

73. Nurse Harry is aware that the following is an appropriate nursing diagnosis for a client with renal calculi?

- A. Ineffective tissue perfusion
- B. Functional urinary incontinence
- C. Risk for infection
- D. Decreased cardiac output

Correct Answer: C. Risk for infection

Infection can occur with renal calculi from urine stasis caused by obstruction. When kidney stones remain inside the body, complications can develop. If they block the tube that connects the kidney to the bladder, urine will not be able to pass out of the body. This dysfunction increases the risk of a UTI or kidney infection.

- **Option A:** Option A isn't appropriate for this diagnosis. The association between nephrolithiasis and subclinical atherosclerosis was recently investigated within the Coronary Adult Risk Development in Young Adults (CARDIA) cohort, which identified a significant association between kidney stones and carotid artery atherosclerosis, even after adjusting for known major atherosclerotic risk factors.

- **Option B:** Retention of urine usually occurs, rather than incontinence. Urinary retention can be attributed to two causes — either obstruction or non-obstruction. If there is an obstruction (for example, bladder or kidney stones), a blockage occurs and urine cannot flow unimpeded through your urinary tract. This is the basis for acute urinary retention and is potentially life-threatening.
- **Option D:** At the root of the pathophysiology of urolithiasis is the physiochemical formation of urinary stones. As the glomerular filtrate passes through the nephron, the urine becomes concentrated with stone-forming salts which, when supersaturated, can precipitate out of solution into crystals that can either be expelled with voided urine or grow and aggregate under the relative influences of various stone-promoting or stone-inhibiting agents, resulting in stone formation.

74. The nurse is teaching the mother regarding treatment for enterobiasis. Which instruction should be given regarding the medication?

- A. Treatment is not recommended for children less than 10 years of age.
- B. The entire family should be treated.
- C. Medication therapy will continue for 1 year.
- D. Intravenous antibiotic therapy will be ordered.

Correct Answer: B. The entire family should be treated.

Enterobiasis, or pinworms, is treated with Vermox (mebendazole) or Antiminth (pyrantel pamoate). The entire family should be treated to ensure that no eggs remain. Because a single treatment is usually sufficient, there is usually good compliance. The family should then be tested again in 2 weeks to ensure that no eggs remain. Enterobiasis can cause recurrent reinfection, so treating the entire household, whether symptomatic or not is recommended to prevent a recurrence.

- **Option A:** Enterobiasis usually occurs in children under 10 years of age. The male-to-female infection frequency is 2 to 1. However, a female predominance of infection is seen in those between the ages of 5 and 14 years. It most commonly affects children younger than 18 years of age. It is also commonly seen in adults who take care of children and institutionalized children.
- **Option C:** The medications used for the treatment of pinworm are either mebendazole, pyrantel pamoate, or albendazole. Any of these drugs are given in one dose initially, and then another single dose of the same drug two weeks later.
- **Option D:** Oral antibiotics are the most recommended form of treatment for enterobiasis. Young pinworms tend to be resistant to treatment and hence two doses of medication, two weeks apart are recommended. At the same time, all members of the infected child must be treated. If a large number of children are infected in a class, everyone should be treated twice at 2-week intervals. Follow-up is vital to ensure that a cure has been obtained.

75. What is a characteristic of an intrinsic case study? It yields a better understanding of each case.

- A. It yields a better understanding of each case.
- B. It provides a foundation to challenge a generalization.
- C. It does not include quantitative data.
- D. It can scrutinize only uncomplicated phenomena.

Correct Answer: A. It yields a better understanding of each case.

An intrinsic case study is undertaken to have a better understanding of the case. An intrinsic case study is the study of a case (e.g., person, specific group, occupation, department, organization) where the case itself is of primary interest in the exploration.

- **Option B:** An intrinsic case study is typically undertaken to learn about a unique phenomenon. The researcher should define the uniqueness of the phenomenon, which distinguishes it from all others.
- **Option C:** The case study approach can offer additional insights into what gaps exist in its delivery or why one implementation strategy might be chosen over another. This in turn can help develop or refine theory.
- **Option D:** In an intrinsic case study, the case is selected on its own merits. The case is selected not because it is representative of other cases, but because of its uniqueness, which is of genuine interest to the researchers.

76. Which of the following physical assessment findings would the nurse expect to find in a client with advanced COPD?

- A. Increased anteroposterior chest diameter.
- B. Underdeveloped neck muscles.
- C. Collapsed neck veins.
- D. Increased chest excursions with respiration.

Correct Answer: A. Increased anteroposterior chest diameter.

Increased anteroposterior chest diameter is characteristic of advanced COPD. Air is trapped in the overextended alveoli, and the ribs are fixed in an inspiratory position. The result is the typical barrel-chested appearance. In addition, coarse crackles beginning with inspiration may be heard.

- **Option B:** Overly developed, not underdeveloped, neck muscles are associated with COPD because of their increased use in the work of breathing. Use of accessory respiratory muscles and paradoxical indrawing of lower intercostal spaces is evident (known as the Hoover sign).
- **Option C:** Distended, not collapsed, neck veins are associated with COPD as a symptom of the heart failure that the client may experience secondary to the increased workload on the heart to pump into pulmonary vasculature. In advanced disease, cyanosis, elevated jugular venous pulse (JVP), and peripheral edema can be observed.
- **Option D:** Diminished, not increased, chest excursion is associated with COPD. The sensitivity of a physical examination in detecting mild to moderate COPD is relatively poor; however, physical signs are quite specific and sensitive for severe disease. Patients with severe disease experience tachypnea and respiratory distress with simple activities.

77. A client arrives at the hospital in the second stage of labor. The fetus' head is crowning, the client is bearing down, and the birth appears imminent. The nurse should:

- A. Transfer her immediately by stretcher to the birthing unit.
- B. Tell her to breathe through her mouth and not to bear down.
- C. Instruct the client to pant during contractions and to breathe through her mouth.

D. Support the perineum with the hand to prevent tearing and tell the client to pant.

Correct Answer: D. Support the perineum with the hand to prevent tearing and tell the client to pant.

Gentle pressure is applied to the baby's head as it emerges so it is not born too rapidly. The head is never held back, and it should be supported as it emerges so there will be no vaginal lacerations. It is impossible to push and pant at the same time.

- **Option A:** Imminent delivery is when the baby's head is visible at the vaginal opening during a contraction (crowning). C. A visual inspection of the perineal area should only be done when contractions are less than 5 minutes apart, there is bleeding/fluid discharge, and/or the patient feels the urge to push.
- **Option B:** A visual inspection of the perineal area should only be done when contractions are less than 5 minutes apart, there is bleeding/fluid discharge, and/or the patient feels the urge to push. Do not perform a digital examination to gauge cervical dilation.
- **Option C:** Begin each contraction with two deep breaths. Inhale deeply and exhale slowly through pursed lips. Relax the bottom and push down. Keep the abdominal muscles tight around the baby as she takes another breath. The woman may find herself making throaty sounds. Repeat these steps as long as the contraction lasts.

78. A nurse is giving medicine instructions to a client with hemorrhoids who is receiving a Mineral oil. Which of the following statements made by the client indicates further teaching?

- A. "I can take it at least 2 hours before bedtime".
- B. "It can interfere with the absorption of the vitamin E that I am taking".
- C. "If I miss a dose of mineral oil liquid, I'll take it as soon as I remember".
- D. "I can use mineral oil liquid for an extended period to prevent further damage".

Correct Answer: D. "I can use mineral oil liquid for an extended period to prevent further damage".

Mineral oil liquid is a lubricant laxative that works by slowing the absorption of water from the bowel, which softens the stool. The use of mineral oil liquid for a long time may result in loss of normal bowel function.

- **Options A, B, & C:** These are correct statements regarding mineral oil.

79. Elsa is being treated in a chemical dependency unit. She tells the nurse that she only uses drugs when under stress and therefore does not have a substance problem. Which defense mechanism is the client using?

- A. Compensation
- B. Denial
- C. Suppression
- D. Undoing

Correct Answer: B. Denial

Individuals who have substance problems often use denial. Denial is probably one of the best-known defense mechanisms, used often to describe situations in which people seem unable to face reality or admit an obvious truth (e.g., “He’s in denial”). Addiction is one of the best-known examples of denial. People who are living with a substance use problem will often flat-out deny that their behavior is problematic. In other cases, they might admit that they do use drugs or alcohol but will claim that their substance use is not problematic.

- **Option A:** Compensation is overachieving in one area to compensate for failures in another. This psychological strategy allows people to disguise inadequacies, frustrations, stresses, or urges by directing energy toward excelling or achieving in other areas.
- **Option C:** Sometimes we do this consciously by forcing the unwanted information out of our awareness, which is known as suppression. In most cases, however, this removal of anxiety-provoking memories from our awareness is believed to occur unconsciously.
- **Option D:** Undoing is trying to make up for what one feels are inappropriate thoughts, feelings, or behaviors (e.g., if you hurt someone’s feelings, you might offer to do something nice for them in order to assuage your anxiety or guilt).

80. A patient with no known allergies is to receive penicillin every 6 hours. When administering the medication, the nurse observes a fine rash on the patient’s skin. The most appropriate nursing action would be to:

- A. Withhold the medication and notify the physician.
- B. Administer the medication and notify the physician.
- C. Administer the medication with an antihistamine.
- D. Apply cornstarch soaks to the rash.

Correct Answer: A. Withhold the medication and notify the physician

Initial sensitivity to penicillin is commonly manifested by a skin rash, even in individuals who have not been allergic to it previously. Because of the danger of anaphylactic shock, the nurse should withhold the drug and notify the physician, who may choose to substitute another drug.

- **Option B:** To determine if a patient has an IgE mediated penicillin allergy, the only validated test currently available in the United States is penicillin skin testing. A board-certified allergist should perform the test. It involves a skin-prick with the application of the major and minor determinants as well as a control. The area of skin is examined 15 minutes later. If a wheal of at least 3 mm and concomitant erythema develop, the test is positive. The test should not be performed if the reaction to penicillin was a severe non-IgE mediated reaction.
- **Option C:** Administering an antihistamine is a dependent nursing intervention that requires a written physician’s order. Treatment for acute IgE mediated reaction to penicillin depends on severity. Patients presenting in acute anaphylaxis need to have immediate treatment with IM epinephrine (1 mg/ml) 0.3 mg to 0.5 mg every 5 to 15 minutes until resolution of symptoms. Adjunctive therapies include H1 and H2 antihistamines including diphenhydramine 25 mg to 50 mg intravenously (IV) and ranitidine 50 mg IV, respectively.
- **Option D:** Although applying cornstarch to the rash may relieve discomfort, it is not the nurse’s top priority in such a potentially life-threatening situation. Cutaneous symptoms are often the first and most common finding of an allergic reaction, however, are absent in 10% to 20% of patients experiencing an allergic reaction. Common cutaneous symptoms are generalized urticaria,

flushing, pruritus, and angioedema.

81. Which of the following is not an appropriate nursing intervention for a patient with hypercalcemia?

- A. Administering calcitonin
- B. Administering calcium gluconate
- C. Administering loop diuretics
- D. Encouraging ambulation

Correct Answer: B. Administering calcium gluconate

Calcium gluconate is used for replacement in deficiency states. Calcium gluconate, gluceptate, or chloride (IV) provides rapid treatment in acute calcium deficit, especially in the presence of tetany or convulsions. Calcitonin and loop diuretics are used to lower serum calcium.

- **Option A:** Calcitonin can be administered subcutaneously but in most cases, the effects are mild and limited to a few days. Promotes movement of serum calcium into bones, temporarily reducing serum calcium levels, especially in the presence of the increased parathyroid hormone.
- **Option C:** Loop diuretics should be used with caution as even though they may enhance renal excretion, paradoxical hypercalcemia can occur due to bone resorption. Diuresis promotes renal excretion of calcium and reduces risks of fluid excess from an isotonic saline infusion.
- **Option D:** Hypercalcemia of immobilization can be prevented by encouraging activity as tolerated and adequate hydration. The specific cause of hypercalcemia needs to be identified, and treatment directed accordingly.

82. Kevin is remanded by the courts for psychiatric treatment. His police record, which dates to his early teenage years, includes delinquency, running away, auto theft, and vandalism. He dropped out of school at age 16 and has been living on his own since then. His history suggests maladaptive coping, which is associated with:

- A. Antisocial personality disorder
- B. Borderline personality disorder
- C. Obsessive-compulsive personality disorder
- D. Narcissistic personality disorder

Correct Answer: A. Antisocial personality disorder

The client's history of delinquency, running away from home, vandalism, and dropping out of school are characteristic of antisocial personality disorder. This maladaptive coping pattern is manifested by a disregard for societal norms of behavior and an inability to relate meaningfully to others. Antisocial personality disorder (ASPD) is a deeply ingrained and rigid dysfunctional thought process that focuses on social irresponsibility with exploitive, delinquent, and criminal behavior with no remorse. Disregard for and the violation of others' rights are common manifestations of this personality disorder, which displays symptoms that include failure to conform to the law, inability to sustain consistent employment, deception, manipulation for personal gain, and incapacity to form stable relationships.

- **Option B:** In borderline personality disorder, the client exhibits mood instability, poor self-image, identity disturbance, and labile affect. Borderline personality disorder (BPD) is 1 of 4 Cluster-B disorders that include borderline, antisocial, narcissistic, and histrionic. Borderline personality disorder (BPD) is characterized by hypersensitivity to rejection and resulting instability of interpersonal relationships, self-image, affect, and behavior.
- **Option C:** Obsessive-compulsive personality disorder is characterized by a preoccupation with impulses and thoughts that the client realizes are senseless but can't control. Obsessive-compulsive disorder (OCD) is often a disabling condition consisting of bothersome intrusive thoughts that elicit a feeling of discomfort. To reduce the anxiety and distress associated with these thoughts, the patient may employ compulsions or rituals. These rituals may be personal and private, or they may involve others to participate; the rituals are to compensate for the ego-dystonic feelings of the obsessional thoughts and can cause a significant decline in function.
- **Option D:** Narcissistic personality disorder is marked by a pattern of self-involvement, grandiosity, and demand for constant attention. Narcissistic personality disorder (NPD) is a pattern of grandiosity, need for admiration, and lack of empathy per the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The disorder is classified in the dimensional model of “Personality Disorders.”NPD is highly comorbid with other disorders in mental health.

83. A client with cystic fibrosis is taking pancreatic enzymes. The nurse should administer this medication:

- A. Once per day in the morning
- B. Three times per day with meals
- C. Once per day at bedtime
- D. Four times per day

Correct Answer: B. Three times per day with meals

Pancreatic enzymes should be given with meals for optimal effects. These enzymes assist the body in digesting needed nutrients. Chronic, supportive therapy for patients with CF includes regular pancreatic enzymes, fat-soluble vitamins (A, D, E, K), mucolytics, bronchodilators, antibiotics, and anti-inflammatory agents.

- **Option A:** A new class of medications known as CFTR modulator therapies is designed to correct the dysfunction by improving production, intracellular processing, or function of the CFTR protein caused by the mutated gene. Each medication is targeted at a specific dysfunction caused by a specific gene mutation.
- **Option C:** Individuals with CF are encouraged to consume a high-fat diet with supplemental fat-soluble vitamins to compensate for malabsorption. Additionally, patients living with CF are encouraged to consume a high-calorie diet to maintain a healthy weight and combat chronic inflammation and frequent infections that are commonly encountered.
- **Option D:** According to the Cystic Fibrosis Foundation, women should consume 2500 to 3000 calories a day, while men should consume 3000 to 3700 calories a day. Those living in hot climates or who participate in activities that cause sweating are encouraged to consume additional sodium in their diet.

84. A client with pancreatitis has requested pain medication. Which pain medication is indicated for the client with pancreatitis?

- A. Demerol (meperidine)
- B. Toradol (ketorolac)
- C. Morphine (morphine sulfate)
- D. Codeine (codeine)

Correct Answer: A. Demerol (meperidine)

- Option A: To prevent spasms of the sphincter of Oddi, the client with pancreatitis should receive non-opiate analgesics for pain such as Demerol.
- Option B: The client with pancreatitis might be prone to bleed; therefore, Toradol is not a drug of choice for pain control.
- Options C and D: Morphine and codeine, opiate analgesics, are contraindicated for the client with pancreatitis.

85. The nurse is administering a psychotropic drug to an elderly client who has a history of benign prostatic hypertrophy. It is most important for the nurse to teach this client to:

- A. Add fiber to his diet.
- B. Exercise on a regular basis.
- C. Report incomplete bladder emptying.
- D. Take the prescribed dose at bedtime.

Correct Answer: C. Report incomplete bladder emptying

Urinary retention is a common anticholinergic side effect of psychotic medications, and the client with benign prostatic hypertrophy would have increased risk for this problem. First-generation antipsychotics (FGAs) are associated with significant extrapyramidal side effects. Anticholinergic adverse effects like dry mouth, constipation, urinary retention are common with low potency dopamine receptor antagonists like chlorpromazine, thioridazine.

- **Option A:** Neuroleptic malignant syndrome is a rare but fatal adverse effect that can occur at any time during treatment with FGAs. The onset of symptoms is over 24 to 72 hours with increased temperature, severe muscular rigidity, confusion, agitation, elevation in white blood cell count, elevated creatinine phosphokinase concentrations, elevated liver enzymes, myoglobinuria, and acute renal failure.
- **Option B:** Adding fiber to one's diet and exercising regularly are measures to counteract another anticholinergic effect, constipation. Second-generation antipsychotics (SGAs) have a decreased risk of extrapyramidal side effects as compared to first-generation antipsychotics. SGAs are associated with significant weight gain and the development of metabolic syndrome.
- **Option D:** Depending on the specific medication and how it is prescribed, taking the medication at night may or may not be important. However, it would have nothing to do with urinary retention in this client. The FDA recommends monitoring personal and family history of diabetes mellitus, dyslipidemia, weight, and height, waist circumference, blood pressure, fasting plasma glucose, and fasting lipid profile for all patients.

86. For a patient with advanced chronic obstructive pulmonary disease (COPD), which nursing action best promotes adequate gas exchange?

- A. Encouraging the patient to drink three glasses of fluid daily.
- B. Keeping the patient in semi-Fowler's position.
- C. Using a high-flow venturi mask to deliver oxygen as prescribed.
- D. Administering a sedative, as prescribed.

Correct Answer: C. Using a high-flow venturi mask to deliver oxygen as prescribe

The patient with COPD retains carbon dioxide, which inhibits stimulation of breathing by the medullary center in the brain. As a result, low oxygen levels in the blood stimulate respiration, and administering unspecified, unmonitored amounts of oxygen may depress ventilation. To promote adequate gas exchange, the nurse should use a Venturi mask to deliver a specified, controlled amount of oxygen consistently and accurately.

- **Option A:** Drinking three glasses of fluid daily would not affect gas exchange or be sufficient to liquefy secretions, which are common in COPD. Increase fluid intake to 3000 mL per day within cardiac tolerance. Provide warm or tepid liquids. Recommend the intake of fluids between, instead of during, meals. Hydration helps decrease the viscosity of secretions, facilitating expectoration.
- **Option B:** Patients with COPD and respiratory distress should be placed in high-Fowler's position. Elevation of the head of the bed facilitates respiratory function by use of gravity; however, the patient in severe distress will seek the position that most eases breathing. Supporting arms and legs with table, pillows, and so on helps reduce muscle fatigue and can aid chest expansion.
- **Option D:** They should not receive sedatives or other drugs that may further depress the respiratory center. Assess the patient's respiratory response to activity which includes monitoring of respiratory rate and depth, oxygen saturation, and use of accessory muscles for respiration. Patients with COPD can experience hypoxia during increased activity and may need oxygenation to avoid hypoxemia which puts them at risk for exacerbations of the condition.

87. Which of the following assessment findings in a client with leukemia would indicate that cancer has invaded the brain?

- A. Hypervigilant and anxious behavior
- B. Increased heart rate and decreased blood pressure
- C. Headache and vomiting
- D. Hypervigilant and anxious behavior

Correct Answer: C. Headache and vomiting

- **Option C:** The usual effect of leukemic infiltration of the brain is increased intracranial pressure. The proliferation of cells interferes with the flow of cerebrospinal fluid in the subarachnoid space and at the base of the brain. The increased fluid pressure causes dilation of the ventricles, which creates symptoms of severe headache, vomiting, irritability, lethargy, and eventually, coma.
- **Option B:** Increasing intracranial pressure in brain metastasis would result in symptoms of high blood pressure, decreased pulse rate, and abnormal respirations known as Cushing triad.
- **Options A and D:** Often children with a variety of illnesses are hypervigilant and anxious when hospitalized.

88. Mr. Anderson, a 52-year-old musician, visits the otolaryngologist due to recent issues with his hearing. The otolaryngologist decided to conduct a thorough examination of Mr. Anderson's ear to ascertain the potential problem. As a musician, Mr. Anderson has always been intrigued by the intricacies of sound and is familiar with some basic ear anatomy. During the examination, wanting to understand more about the role certain structures play in hearing, he inquired about the small bones he once read about that are located within the middle ear. During an ear examination, a patient asks about the small bones located within the middle ear that play a vital role in hearing. What are these three auditory ossicles called, and what is their function in the process of sound transmission?

- A. Stapes, incus, and malleus; they amplify sound vibrations.
- B. Cochlea, semicircular canals, and eustachian tube; they help maintain balance and pressure.
- C. Tympanic membrane, oval window, and round window; they protect the inner ear.
- D. Pinna, ear canal, and cerumen; they collect sound waves.

Correct Answer: A. Stapes, incus, and malleus; they amplify sound vibrations.

The three auditory ossicles, the malleus, incus, and stapes, are tiny bones in the middle ear that transmit sound vibrations from the eardrum to the inner ear. These ossicles amplify and transmit mechanical vibrations, allowing the conversion of sound waves into electrical signals that the auditory nerve can carry to the brain for interpretation.

- **Option B:** While the cochlea is involved in hearing and the semicircular canals play a role in balance, the eustachian tube helps equalize pressure between the middle ear and the atmosphere. However, these are not the bones of the middle ear responsible for amplifying sound vibrations.
- **Option C:** The tympanic membrane (or eardrum) receives sound waves and transmits them to the auditory ossicles. The oval and round windows are structures of the inner ear, but their main function is not to protect the inner ear.
- **Option D:** The pinna and ear canal are involved in directing sound waves toward the tympanic membrane. Cerumen, or earwax, does help in protecting the ear by trapping debris. However, none of these are the small bones in the middle ear involved in amplifying sound vibrations.

89. Which of the following is the appropriate route of administration for insulin?

- A. Intramuscular
- B. Intradermal
- C. Subcutaneous
- D. Intravenous

Correct Answer: C. Subcutaneous

The subcutaneous tissue of the abdomen is preferred because the absorption of the insulin is more consistent from this location than subcutaneous tissues in other locations. Insulin may be injected into the subcutaneous tissue of the upper arm and the anterior and lateral aspects of the thigh, buttocks,

and abdomen (with the exception of a circle with a 2-inch radius around the navel).

- **Option A:** Intramuscular injection is not recommended for routine injections. Rotation of the injection site is important to prevent lipohypertrophy or lipoatrophy. Rotating within one area is recommended (e.g., rotating injections systematically within the abdomen) rather than rotating to a different area with each injection. This practice may decrease variability in absorption from day to day.
- **Option B:** Site selection should take into consideration the variable absorption between sites. The abdomen has the fastest rate of absorption, followed by the arms, thighs, and buttocks. Exercise increases the rate of absorption from injection sites, probably by increasing blood flow to the skin and perhaps also by local actions.
- **Option D:** Administration of mixtures of rapid- or short- and intermediate- or long-acting insulins will produce a more normal glycemia in some patients than the use of single insulin. The formulations and particle size distributions of insulin products vary. On mixing, physicochemical changes in the mixture may occur (either immediately or over time). As a result, the physiological response to the insulin mixture may differ from that of the injection of the insulins separately.

90. Which of the following is the primary goal for surgical resection of lung cancer?

- A. To remove all of the tumor and any collapsed alveoli in the same region
- B. To remove as much as the tumor as possible, without removing any alveoli
- C. To remove the tumor and as little surrounding tissue as possible
- D. To remove the tumor and all surrounding tissue

Correct Answer: C. To remove the tumor and as little surrounding tissue as possible

- **Option C:** The goal of surgical resection is to remove the lung tissue that has a tumor in it while saving as much surrounding tissue as possible. There is a possibility of cancer cells remaining in the body after the operation so additional treatment modalities such as chemotherapy and radiation therapy are done.
- **Options A, B, and D:** It may be necessary to remove alveoli and bronchioles, but care is taken to make sure only what's absolutely necessary is removed.

91. The nursing assistant tells nurse Ronald that the client is not in the dining room for lunch. Nurse Ronald would direct the nursing assistant to do which of the following?

- A. Tell the client he'll need to wait until supper to eat if he misses lunch.
- B. Invite the client to lunch and accompany him to the dining room.
- C. Inform the client that he has 10 minutes to get to the dining room for lunch.
- D. Take the client a lunch tray and let the client eat in his room.

Correct Answer: B. Invite the client to lunch and accompany him to the dining room.

The nurse instructs the nursing assistant to invite the client to lunch & accompany him to the dining room to decrease manipulation, secondary gain, dependency and reinforcement of negative behavior

while maintaining the client's worth. Staff working with manipulative patients are best prepared when they establish firm rules that are rigidly interpreted and consistently enforced among all members of the health care team. Frequent discussions regarding the patient's progress can help reduce staff frustration and isolation and minimize the patient's attempts at staff splitting.

- **Option A:** Discussing realistic expectations of time and resources available with the patient is of paramount importance. This establishes boundaries and forms a solid foundation on which to build future rapport. The patient will learn that you can be trusted because you will practice with integrity. By putting forth realistic expectations, you can mitigate many manipulative behaviors exhibited in the healthcare setting.
- **Option C:** One of the best ways to become accountable for exemplary care is to advocate for the patient's autonomy. Giving the patient choices regarding his or her care restores a sense of control that is imperative to feeling secure. Many times the lack of a routine or schedule prompts a patient to allege that the nurse is neglectful. Formulating a schedule and faithfully notifying the manipulative patient of changes will demonstrate that you believe he or she is worthy of your time and efforts.
- **Option D:** There are many specific interventions that may be put into place by an interdisciplinary team caring for a patient who exhibits manipulative behavior. For example, designating one caregiver to be the patient's contact will result in more consistent care. Having two staff members present for all patient interactions will ensure that any claims of misconduct can be evaluated for validity by multiple healthcare professionals.

92. When evaluating a male client for complications of acute pancreatitis, the nurse would observe for:

- A. Increased intracranial pressure
- B. Decreased urine output
- C. Bradycardia
- D. Hypertension

Correct Answer: B. Decreased urine output

Acute pancreatitis can cause decreased urine output, which results from the renal failure that sometimes accompanies this condition. AKI develops late in the course of acute pancreatitis, usually after failure of other organs. Remarkably, the kidney was the first organ to fail in only 8.9% of patients with AKI, and only a minority of patients develop isolated AKI

- **Option A:** Intracranial pressure neither increases nor decreases in a client with pancreatitis. The causes of increased intracranial pressure (ICP) can be divided based on the intracerebral components causing elevated pressures. Generalized swelling of the brain or cerebral edema from a variety of causes such as trauma, ischemia, hyperammonemia, uremic encephalopathy, and hyponatremia.
- **Option C:** Tachycardia, not bradycardia, usually is associated with pulmonary or hypovolemic complications of pancreatitis. Tachycardia and mild hypotension may result from hypovolemia from sequestration of fluid in the pancreatic bed. About 60% of patients develop low-grade pyrexia from peripancreatic inflammation without evident infection.
- **Option D:** Hypotension can be caused by a hypovolemic complication, but hypertension usually isn't related to acute pancreatitis. Release into the systemic circulation of activated enzymes and proteases may cause endothelial damage leading to extravasation of fluids from the vascular space, hypovolemia, hypotension, increased abdominal pressure, intense kidney vasoconstriction,

hypercoagulability, and fibrin deposition in the glomeruli.

93. Nurse Maria is administering a cleansing enema to a client with severe constipation. She will place the client in which position?

- A. Low Fowler's position.
- B. High Fowler's position.
- C. Left Sim's position.
- D. Right Sim's position.

Correct Answer: C. Left Sim's position.

During a cleansing enema, place the client in the left Sim's position to allow the solution to flow by gravity in the natural direction of the colon. Position the patient on the left side, lying with the knees drawn to the abdomen. This eases the passage and flow of fluid into the rectum. Gravity and the anatomical structure of the sigmoid colon also suggest that this will aid enema distribution and retention.

- **Option A:** Position the patient on his left side in Sims' position or left lateral position with the right knee flexed, which will adequately expose the anus. This position allows the solution to flow downward by gravity along the curve of the sigmoid colon and rectum, thus improving the effectiveness of the enema.
- **Option B:** The ideal positions for enema administration are the left-side position and the knee-chest position. It is advised that the patient remains in one of these positions to receive the enema for one-third of the time.
- **Option D:** The left lateral position is the most appropriate position for giving an enema because of the anatomical characteristics of the colon. Although the length of the tube to be inserted is designated as approximately 5-6 cm, do not try to force it but pull it back slightly if any resistance is felt.

94. While conducting an initial health assessment, the nurse is collecting information from an 84-year-old female patient who has recently been admitted to the geriatric ward due to chronic hypertension and mild cognitive impairment. Which of the following pieces of information would be most beneficial for the nurse to gather in order to tailor an individualized care plan?

- A. An overview of the patient's general health and major illnesses over the past decade.
- B. Details of the patient's engagement in current health promotion activities, such as diet and exercise.
- C. A comprehensive family history of chronic diseases like diabetes or cardiovascular conditions.
- D. The patient's marital status and living arrangements to understand social support structures.
- E. The patient's medication adherence and understanding of the diabetes management plan.
- F. Previous experiences with hospitalizations or surgeries that might affect current health status.

Correct Answer: B. Details of the patient's engagement in current health promotion activities, such as diet and exercise.

When taking the health history of an elderly client, it is important to understand their current health promotion activities. This information provides insight into the client's level of engagement in maintaining or improving their health, which is crucial for planning care that is tailored to their needs and capabilities. It helps to identify the client's current health practices and can guide the nurse in formulating a care plan that supports these activities, introduces new ones, or modifies existing ones. This allows the nurse to plan care that supports the patient's active involvement in managing his health conditions, which is particularly important given the recent diagnosis of type 2 diabetes and the presence of other chronic diseases.

95. Which beliefs guide the constructivist paradigm? Select all that apply.

- A. There are multiple realities.
- B. The truth is objective.
- C. Context does not matter as much as truth.
- D. The participant (subject) is an active part of the study.
- E. Knowledge is gained through facts.

Correct Answer: A, D

Constructivism implies that reality is constructed through human interaction. Knowledge is a human product and is socially and culturally constructed. Individuals create meaning through their interactions with each other and with the environment in which they live. Social constructivism emphasizes the importance of culture and context in the process of knowledge construction and accumulation.

- **Option A:** In social constructivism, human interests are important for research purposes and knowledge is constructed through social interaction. Such knowledge is shared rather than an individual experience. According to constructivists, reality is a subjective creation. There is no single reality. Race, for example, is a social construct. Claiming that people are different based on the skin of their color is a (subjective) social construct.
- **Option B:** The aim of constructivist research is to understand particular situations or phenomena. Rich data is gathered from which ideas can be formed. The interaction of a number of people is researched, mostly to solve social problems of the target group.
- **Option C:** Learners add to and reshape their mental models of reality through social collaboration, building new understandings as they actively engage in learning experiences. Scaffolding, i.e. guidance and support, play an important role in the learning process. Research is, of course, largely a learning process and researchers on any level can use it to gain knowledge and to structure their research.
- **Option D:** Social constructivism is based on the principles of constructivism. Like positivism, social constructivism also uses observation to gather information. Different from positivism, the researcher is part of what is being observed in social constructivism.
- **Option E:** Positivism and constructivism are not the same. Both are epistemologies that present a different idea of what constitutes knowledge. However, positivism is a philosophical stance that emphasizes that knowledge should be gained through observable and measurable facts, whereas constructivism states that reality is a social construct.

96. A client with iron-deficiency anemia is taking an oral iron supplement. The nurse should tell the client to take the medication with:

- A. Apple juice
- B. Water only
- C. Milk
- D. Orange juice

Correct Answer: D. Orange juice

- Option D: Iron is better absorbed when taken with ascorbic acid. Orange juice is an excellent source of ascorbic acid.
- Option A: Apple juice does not contain high amounts of ascorbic acid.
- Option B: The medication should be taken with orange juice or tomato juice.
- Option C: Iron should not be taken with milk because it interferes with absorption.

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

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

Correct Answer: D. Acetylcysteine (Mucomyst)

The antidote for acetaminophen toxicity is acetylcysteine. It enhances conversion of toxic metabolites to nontoxic metabolites. Acetaminophen (N-acetyl-para-aminophenol, paracetamol, APAP) toxicity is common primarily because the medication is so readily available, and there is a perception that it is very safe. More than 60 million Americans consume acetaminophen on a weekly basis. All patients with high levels of acetaminophen need admission and treatment with N-acetyl-cysteine (NAC). This agent is fully protective against liver toxicity if given within 8 hours after ingestion.

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

intoxication rather than in patients with multiple drug overdoses.

98. A nurse is giving teachings to a client receiving desloratadine (Clarinet). Which of the following statements made by the client will need further instructions?

- A. "I can eat gum after I drink the medicine".
- B. "I can take the medicine on an empty stomach".
- C. "I should avoid using alcohol".
- D. "I will avoid driving while using this medication".

Correct Answer: B. "I can take the medicine on an empty stomach".

Desloratadine (Clarinet) is an antihistamine that is used to treat symptoms of allergies and urticaria. This medicine should be taken with food or milk to minimize gastrointestinal upset.

- **Option A:** Use gum or hard candy is allowed to minimize dry mouth.
- **Options C & D:** The medication causes drowsiness so avoid taking alcohol or engaging in activities that require mental alertness such as driving a car.

99. A client tends to be insensitive to others, engages in abusive behaviors and does not have a sense of remorse. Which personality disorder is he likely to have?

- A. Narcissistic
- B. Paranoid
- C. Histrionic
- D. Antisocial

Correct Answer: D. Antisocial

These are the characteristics of an individual with an antisocial personality. Antisocial personality disorder includes a pattern of disregarding or violating the rights of others. A person with antisocial personality disorder may not conform to social norms, may repeatedly lie or deceive others, or may act impulsively.

- **Option A:** Narcissistic personality disorder is characterized by grandiosity and a need for constant admiration from others. A pattern of need for admiration and lack of empathy for others. A person with a narcissistic personality disorder may have a grandiose sense of self-importance, a sense of entitlement, take advantage of others, or lack empathy.
- **Option B:** Individuals with paranoid personality demonstrate a pattern of distrust and suspiciousness and interpret others' motives as threatening. A pattern of being suspicious of others and seeing them as mean or spiteful. People with a paranoid personality disorder often assume people will harm or deceive them and don't confide in others or become close to them.
- **Option C:** Individuals with histrionic have excessive emotionality and attention-seeking behaviors. A pattern of excessive emotion and attention-seeking. People with a histrionic personality disorder may be uncomfortable when they are not the center of attention, may use physical appearance to draw attention to themselves, or have rapidly shifting or exaggerated emotions.

100. A diagnosis of Hodgkin's disease was made to a 58- year old man and is admitted for the initial cycle of chemotherapy. During the hospitalization, the nurse should watch out for the following complication, except?

- A. Fertility problems
- B. Benign prostatic hyperplasia
- C. Secondary cancer
- D. Infection

Correct Answer: B. Benign prostatic hyperplasia

- **Option B:** Hodgkin's disease (Hodgkin's lymphoma) is a type of cancer that affects the lymphatic system (bone marrow, spleen, liver, and lymph node tissue. Symptoms include painless swelling of a lymph node, recurrent fever, night sweats, pruritus, and unexplained weight loss. Prostate involvement is rare in Hodgkin's disease.
- **Options A, C, and D:** Complications of the disease would lead to a weakened immune system resulting in various infections, It can also result in fertility problems related to chemotherapy, and a probability of secondary cancers in the future.