

Kevin's Review - 35 NCLEX Practice Questions

1. A client is in her third month of her first pregnancy. During the interview, she tells the nurse that she has several sex partners and is unsure of the identity of the baby's father. Which of the following nursing interventions is a priority? A. Counsel the woman to consent to HIV screening.

- A. Counsel the woman to consent to HIV screening.
- B. Perform tests for sexually transmitted diseases.
- C. Discuss her high risk for cervical cancer.
- D. Refer the client to a family planning clinic.

Correct Answer: A. Counsel the woman to consent to HIV screening

The client's behavior places her at high risk for HIV. Testing is the first step. If the woman is HIV positive, the earlier treatment begins, the better the outcome.

- **Option B:** Before performing the tests, the client should be informed first and she must give her consent. Separate written consent for HIV testing is not recommended. General informed consent for medical care that notifies the patient that an HIV test will be performed unless the patient declines (opt-out screening) should be considered sufficient to encompass informed consent for HIV testing.
- **Option C:** Discussion about the risks can come after determining if the client is HIV positive or not. Increased HIV vulnerability is often associated with legal and social factors, which increases exposure to risk situations and creates barriers to accessing effective, quality and affordable HIV prevention, testing and treatment services.
- **Option D:** Family planning could come after the HIV screening has results. For women with HIV who want to become pregnant, use of antiretroviral prophylaxis during pregnancy can reduce mother-to-child transmission of HIV. Afterwards, family planning services that promote healthy timing and spacing of pregnancies are important to reduce the risk of adverse pregnancy outcomes such as low birth weight, preterm birth, and infant mortality.

2. The nurse is planning care for an 18 month-old child. Which of the following should be included in the child's care?

- A. Hold and cuddle the child often
- B. Encourage the child to feed himself finger food
- C. Allow the child to walk independently on the nursing unit
- D. Engage the child in games with other children

Correct Answer: B. Encourage the child to feed himself finger food.

According to Erikson, the toddler is in the stage of autonomy versus shame and doubt. The nurse should encourage increasingly independent activities of daily living. Gaining a sense of personal control over the world is important at this stage of development. Children at this age are becoming increasingly independent and want to gain more control over what they do and how they do it.

- **Option A:** This refers to the Erickson stage of trust vs mistrust where the child develops a sense of trust after receiving consistent and reliable care. Children who learn to trust caregivers in infancy will be more likely to form trusting relationships with others throughout the course of their lives.

- **Option C:** This refers to the Erickson stage of identity vs role confusion where the child is becoming more independent. Those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and a feeling of independence and control.
- **Option D:** This refers to the Erickson stage of initiative vs guilt where the child begins to develop interpersonal skills by spending their time playing with other children. During the initiative versus guilt stage, children begin to assert their power and control over the world through directing play and other social interaction.

3. Which question will critique the sampling of a research project?

- A. Is the strategy used for analysis compatible with the purpose of the study?
- B. What is the projected significance of the work to nursing?
- C. Are the informants who were chosen appropriate to inform the research?
- D. What are the philosophical underpinnings of the research method?

Correct Answer: C. Are the informants who were chosen appropriate to inform the research?

A research critique is an analysis of a research undertaking that focuses on its strengths and limitations. Critiquing is a systematic process for evaluating research studies and the results reported.

- **Option A:** “The purpose of a research critique is to determine whether the findings are usable for you” (Brink & Wood, 2001, p. 57). Understand the purpose and problem, while determining if the design and methodology are consistent with the purpose.
- **Option B:** Determine if the methodology is properly applied. Assess if outcomes and conclusions are believable and supported by findings. Reflect on overall quality, strengths, and limitations.
- **Option D:** Regardless of the type of critique, certain elements comprise a critique. Some general questions can be associated with the elements of a critique.

4. While cooking, your client couldn't feel the temperature of a hot oven. Which lobe could be dysfunctional?

- A. Frontal
- B. Occipital
- C. Parietal
- D. Temporal

Correct Answer: C. Parietal

The parietal lobe regulates sensory function, which would include the ability to sense hot or cold objects. The anterior parietal lobe contains the primary sensory cortex (SI), located in the postcentral gyrus (Brodmann area BA 3, 1, 2). SI receives the majority of the sensory inputs that are coming from the thalamus, and it's responsible for interpreting the simple somatosensory signals like (touch, position, vibration, pressure, pain, temperature).

- **Option A:** The frontal lobe regulates thinking, planning, and judgment. Prospective memory is a type of memory that involves remembering the plans that you made, from a simple daily plan to future lifelong plans.

- **Option B:** The occipital lobe is primarily responsible for vision function. The occipital lobe is the smallest lobe in the cerebral cortex, and it is located in the most posterior region of the brain, posterior to the parietal lobe and temporal lobe. The role of this lobe is visual processing and interpretation.
- **Option D:** The temporal lobe regulates memory. Semantic memory is a type of memory involved in remembering the thoughts or objectives that are common knowledge (for example, where the bathroom is located).

5. During a school health fair, a nurse is stationed at the vital signs booth. As students from various age groups approach, the nurse takes their vital signs. Later, while reviewing the recorded data, the nurse identifies one set of vital signs that seems abnormal for the age group. Which of the following vital signs taken during the health fair appears to be outside the typical range for the respective age group?

- A. 11-year-old male athlete who just finished a sprint: 90 BPM, 22 RPM, 100/70 mmHg
- B. 13-year-old female who mentioned she was feeling a bit anxious about an upcoming exam: 105 BPM, 22 RPM, 105/50 mmHg
- C. 5-year-old male who was excitedly running around with friends before coming to the booth: 102 BPM, 24 RPM, 90/65 mmHg
- D. 6-year-old female who was calmly coloring a picture before her turn: 100 BPM, 26 RPM, 90/70 mmHg
- E. 14-year-old male who was resting and reading a book: 85 BPM, 20 RPM, 110/70 mmHg
- F. 12-year-old female who was practicing deep breathing exercises: 88 BPM, 18 RPM, 95/60 mmHg

Correct Answer: B. 13-year-old female who mentioned she was feeling a bit anxious about an upcoming exam: 105 BPM, 22 RPM, 105/50 mmHg

The normal range of vital signs for 11 to 14-year-olds: Heart rate: 60-105 BPM; Respiratory rate: 12-20 CPM; Blood pressure: Systolic-85-120, diastolic- 55-80 mmHg; Body temperature: 98.0 degrees Fahrenheit (36.6 degrees Celsius) to 98.6 degrees Fahrenheit (37 degrees Celsius). The client's diastolic pressure is lower than the normal range. Both her respiratory rate and heart rate are slightly increased.

6. A client is being tapered off opioids and the nurse is watchful for signs of withdrawal. What is one of the first signs of withdrawal?

- A. Fever
- B. Nausea
- C. Diaphoresis
- D. Abdominal cramps

Correct Answer: C. Diaphoresis

Diaphoresis is one of the early signs that occur between 6 and 12 hours. Fever, nausea, and abdominal cramps are late signs that occur between 48 and 72 hours. According to Diagnostic and Statistical

Manual of Mental Disorders (DSM–5) criteria, signs, and symptoms of opioid withdrawal include lacrimation or rhinorrhea, piloerection “goose flesh,” myalgia, diarrhea, nausea/vomiting, pupillary dilation and photophobia, insomnia, autonomic hyperactivity (tachypnea, hyperreflexia, tachycardia, sweating, hypertension, hyperthermia), and yawning.

- **Option A:** A fever can be a withdrawal symptom among people who have been addicted to various substances, or even after a period of intense substance use. Fever symptoms may range from mild to severe. Although mild fevers can accompany a variety of substance withdrawal syndromes and are usually self-limiting, fever can also be a component of a particularly dangerous type of alcohol withdrawal.
- **Option B:** Prolonged use of these drugs changes the way nerve receptors work in the brain, and these receptors become dependent upon the drug to function. If the client becomes physically sick after he stops taking an opioid medication, it may be an indication that he's physically dependent on the substance.
- **Option D:** The symptoms the client is experiencing will depend on the level of withdrawal he is experiencing. Also, multiple factors dictate how long a person will experience the symptoms of withdrawal. Because of this, everyone experiences opioid withdrawal differently. However, there's typically a timeline for the progression of symptoms.

7. A client who has recently traveled to China comes to the emergency department (ED) with increasing shortness of breath and is strongly suspected of having a severe acute respiratory syndrome (SARS). Which of these prescribed actions will you take first?

- A. Obtain blood, urine, and sputum for cultures
- B. Infuse normal saline at 100ml/hr
- C. Administer methylprednisolone (Solu-Medrol) 1 gram/IV
- D. Place the client on contact and airborne precautions

Correct Answer: D. Place the client on contact and airborne precautions.

Since SARS is a severe disease with a high mortality rate, the initial action should be to protect other clients and health care workers by placing the client in isolation. If an airborne-agent isolation (negative pressure) room is not available in the ED, droplet precautions should be initiated until the client can be moved to a negative-pressure room.

- **Option A:** SARS-CoV testing for diagnosis should be done via PCR from samples obtained from at least two sites and as early in the illness as possible and then repeated five to seven days later if symptoms continue.
- **Option B:** There are potential agents for use against SARS. Lopinavir-ritonavir has shown some activity in vitro only thus far. Additionally, the experimental agent for Ebola, Remdesivir, has shown activity against both SARS and MERS coronaviruses.
- **Option C:** There is no specific treatment for severe acute respiratory syndrome (SARS), and supportive care is emphasized. To date, no antiviral agents have been found to be beneficial, nor were glucocorticoids shown to have a beneficial effect.

8. A 25 year old man with chronic bronchitis is receiving theophylline intravenously. After several dosages, the client started to become restless and

complains of palpitations. The nurse determines that the client is experiencing theophylline toxicity in which of the following?

- A. Theophylline level of 8 mcg/ml
- B. Theophylline level of 10 mcg/ml
- C. Theophylline level of 15 mcg/ml
- D. Theophylline level of 25 mcg/ml

Correct Answer: D. Theophylline level of 25 mcg/ml

Theophylline toxicity is most likely to occur when the serum level is higher than 20 mcg/ml. Early signs of toxicity include restlessness, nervousness, tachycardia, tremors, and palpitations.

- **Options A, B, and C:** These theophylline values are within the safe range.

9. Mrs. Jones will have to change the dressing on her injured right leg twice a day. The dressing will be a sterile dressing, using 4 X 4s, normal saline irrigant, and abdominal pads. Which statement best indicates that Mrs. Jones understands the importance of maintaining asepsis?

- A. "If I drop the 4 X 4s on the floor, I can use them as long as they are not soiled."
- B. "If I drop the 4 X 4s on the floor, I can use them if I rinse them with sterile normal saline."
- C. "If I question the sterility of any dressing material, I should not use it."
- D. "I should put on my sterile gloves, then open the bottle of saline to soak the 4 X 4s."

Correct Answer: C. "If I question the sterility of any dressing material, I should not use it."

If there is ever any doubt about the sterility of an instrument or dressing, it should not be used. Sterile technique is essential to help prevent surgical site infections (SSI), an unintended and oftentimes preventable complication arising from surgery. SSI is defined as an "infection that occurs after surgery in the area of surgery" (CDC, 2010, p. 2).

- **Option A:** Anything dropped on the floor is no longer sterile and should not be used. The statement indicates lack of understanding. Preventing and reducing SSI are the most important reasons for using sterile technique during invasive procedures and surgeries.
- **Option B:** The 4 X 4s should be soaked prior to donning the sterile gloves. Normal saline would not keep the gauze sterile after being dropped on the floor. The client would need to replace the unsterile gauze with a new, sterile pack.
- **Option D:** Once the sterile gloves touch the bottle of normal saline they are no longer sterile. This statement indicates a need for further instruction. Sterile objects must only be touched by sterile equipment or sterile gloves.

10. Which of the following is the primary predisposing factor related to mastitis?

- A. Epidemic infection from nosocomial sources localizing in the lactiferous glands and ducts.
- B. Endemic infection occurring randomly and localizing in the peri glandular connective tissue.

- C. Temporary urinary retention due to decreased perception of the urge to void.
- D. Breast injury caused by overdistention, stasis, and cracking of the nipples.

Correct Answer: D. Breast injury caused by overdistention, stasis, and cracking of the nipples

With mastitis, injury to the breast, such as overdistention, stasis, and cracking of the nipples, is the primary predisposing factor.

- **Option A:** If a breast doesn't completely empty at feedings, one of the milk ducts can become clogged. The blockage causes milk to back up, leading to breast infection.
- **Option B:** Bacteria from your skin's surface and baby's mouth can enter the milk ducts through a crack in the skin of your nipple or through a milk duct opening. Stagnant milk in a breast that isn't emptied provides a breeding ground for the bacteria.
- **Option C:** Temporary urinary retention due to decreased perception of the urge to void is a contributory factor to the development of urinary tract infection, not mastitis.

11. The nurse is taking the history of a client who has had benign prostatic hyperplasia in the past. To determine whether the client currently is experiencing difficulty, the nurse asks the client about the presence of which of the following early symptoms?

- A. Urge incontinence
- B. Nocturia
- C. Decreased force in the stream of urine
- D. Urinary retention

Correct Answer: C. Decreased force in the stream of urine

Decreased force in the stream of urine is an early sign of BPH. The stream later becomes weak and dribbling. The client then may develop hematuria, frequency, urgency, urge incontinence, and nocturia. If untreated, complete obstruction and urinary retention can occur. Men with BPH are likely to report predominant symptoms of nocturia, poor stream, hesitancy, or prolonged micturition.

- **Option A:** Lower urinary tract symptoms can be divided into storage (frequency, nocturia, urgency) and voiding symptoms (stream, straining, hesitancy, prolonged micturition) and can help establish other causes of urinary symptoms such as urinary tract infections/overactive bladder, in addition to determining the site affected (bladder vs. prostate).
- **Option B:** Red flags help point to more sinister causes of urinary symptoms such as bladder/prostate cancer, neurology such as cauda equina, or chronic high-pressure retention (which can lead to silent renal failure). The presence of these can be established by asking about visible haematuria/bone pain/weight loss, neurology, and nocturnal enuresis/incontinence, respectively.
- **Option D:** The development of benign prostatic hyperplasia is characterized by stromal and epithelial cell proliferation in the prostate transition zone (surrounding the urethra), this leads to compression of the urethra and the development of bladder outflow obstruction (BOO) which can result in clinical manifestations of lower urinary tract symptoms (LUTS), urinary retention or infections due to incomplete bladder emptying.

12. Which of the following characteristics is typical of the pain associated with DVT?

- A. Dull ache
- B. No pain
- C. Sudden onset
- D. Tingling

Correct Answer: C. Sudden onset

DVT is associated with deep leg pain of sudden onset, which occurs secondary to the occlusion. A deep-vein thrombosis (DVT) is a blood clot that forms within the deep veins, usually of the leg, but can occur in the veins of the arms and the mesenteric and cerebral veins. Deep-vein thrombosis is a common and important disease.

- **Option A:** A dull ache is more commonly associated with varicose veins. Deep-vein thrombosis and pulmonary emboli are common and often “silent” and thus go undiagnosed or are only picked up at autopsy. Therefore, the incidence and prevalence are often underestimated.
- **Option C:** If the thrombus is large enough, it will cause pain. DVT is part of the venous thromboembolism disorders which represent the third most common cause of death from cardiovascular disease after heart attacks and stroke. Even in patients who do not get pulmonary emboli, recurrent thrombosis and “post-thrombotic syndrome” are major cause of morbidity.
- **Option D:** A tingling sensation is associated with an alteration in arterial blood flow. The triggers of venous thrombosis are frequently multifactorial, with the different parts of the triad of Virchow contributing in varying degrees in each patient, but all result in early thrombus interaction with the endothelium. This then stimulates local cytokine production and causes leukocyte adhesion to the endothelium, both of which promote venous thrombosis.

13. Nurse Henry admits a child with suspected type 1 DM; Which of the following questions should the nurse ask the parents?

- A. "Does the child complain of headache?"
- B. "How much exercise does the child get?"
- C. "Has the child's number and type of bowel movements changed?"
- D. "Has the child experienced nocturia or bedwetting?"
- E. "How much candy and sweets does your child take daily?"

Correct Answer: D. “Has the child experienced nocturia or bedwetting?”

Bedwetting in children who have previously stayed dry at night is often an early sign of diabetes. Type 1 diabetes is a disease when the pancreas that produces insulin and helps get sugars (glucose) into the cells does not produce insulin. As most children with type 1 diabetes are otherwise healthy, history and physical health is usually limited to the assessment of pertinent diabetes care.

- **Option A:** At presentation, children usually have a history of polyuria, polydipsia, and weight loss for days to months. If the diagnosis is delayed, there may be vomiting, lethargy, altered mental status, dehydration, and acidosis.

- **Option B:** At regular visits, the provider will assess changes in diabetes status and life circumstances affecting diabetes management, for example, school experience, changes in patterns of exercise and diet, the developmental stage of the child, their participation in diabetes care tasks, family and home life changes, and adherence to therapy.
- **Option C:** History and physical assessment also focus on addressing issues related to glucose monitoring, insulin delivery (e.g., lipodystrophy, skin tolerance to medical adhesives on diabetes technology), and screening for symptoms of associated medical issues such as thyroid dysfunction or celiac disease.

14. Following a tonsillectomy procedure, a 25-year-old female client, Amelia, is transitioned back to the medical-surgical unit from the post-anesthesia care unit (PACU). Amelia has a history of chronic tonsillitis, which prompted the tonsillectomy. On arrival to the unit, Amelia appears lethargic due to the residual effects of anesthesia and reports a sore throat, a common complaint post-tonsillectomy. The surgical protocol for post-tonsillectomy care underlines the importance of maintaining a patent airway and monitoring for hemorrhage, which could emanate from the surgical site. The medical-surgical nurse, in alignment with these priorities and the assessment of Amelia's level of consciousness and discomfort, needs to determine the most therapeutic position for Amelia to ensure airway patency, comfort, and minimize the risk of postoperative complications such as aspiration or hemorrhage. Which of the following positions should the nurse place Amelia in?

- A. Semi-Fowler's
- B. Supine
- C. High-Fowler's
- D. Side-lying
- E. Prone
- F. Sims'
- G. Trendelenburg

Correct Answer: D. Side-lying

Side-lying position is the most therapeutic position for Amelia as it promotes airway patency and allows for drainage from the surgical site, minimizing the risk of aspiration especially given her lethargic state.

- **Option A:** Semi-Fowler's position, with the head of the bed elevated to about 30 to 45 degrees, can assist in maintaining airway patency but may not provide optimal drainage from the surgical site, especially in a lethargic client, which could increase the risk of aspiration.
- **Option B:** Supine position is not ideal for Amelia post-tonsillectomy as it could predispose her to airway obstruction and does not promote drainage from the surgical site, increasing the risk of aspiration.
- **Option C:** High-Fowler's position, with the head of the bed elevated to about 90 degrees, could also assist in maintaining airway patency but may be uncomfortable for Amelia who is lethargic, and it may not provide the necessary drainage to prevent aspiration.

- **Option E:** Prone position could potentially obstruct Amelia's airway and is not traditionally used following a tonsillectomy due to the risk of increasing pressure on the surgical site, which could lead to hemorrhage.
- **Option F:** Sims' position might promote drainage but may not be as effective in keeping the airway open as the side-lying position.
- **Option G:** Trendelenburg position is used to increase venous return to the heart and is not suitable for post-tonsillectomy positioning as it does not promote airway patency or drainage and could potentially exacerbate Amelia's sore throat.

15. Which of the following would be the priority nursing diagnosis for the adult client with acute leukemia?

- A. Oral mucous membrane, altered related to chemotherapy
- B. Risk for injury related to thrombocytopenia
- C. Fatigue related to the disease process
- D. Interrupted family processes related to life-threatening illness of a family member

Correct Answer: B. Risk for injury related to thrombocytopenia

The client with acute leukemia has bleeding tendencies due to decreased platelet counts, and any injury would exacerbate the problem.

- **Option A:** Alterations in the oral mucous membrane may occur with chemotherapy but it is not a priority.
- **Option C:** Fatigue is common among patients receiving chemotherapy but not a priority.
- **Option D:** Interrupted family processes can also be a diagnosis but not a priority.

16. A female client has clear fluid leaking from the nose following a basilar skull fracture. The nurse assesses that this is cerebrospinal fluid if the fluid:

- A. Is clear and tests negative for glucose.
- B. Is grossly bloody in appearance and has a pH of 6.
- C. Clumps together on the dressing and has a pH of 7.
- D. Separates into concentric rings and tests positive for glucose.

Correct Answer: D. Separates into concentric rings and tests positive for glucose.

Leakage of cerebrospinal fluid (CSF) from the ears or nose may accompany basilar skull fracture. CSF can be distinguished from other body fluids because the drainage will separate into bloody and yellow concentric rings on dressing material, called a halo sign. The fluid also tests positive for glucose.

- **Option A:** Cerebrospinal fluid (CSF) is a clear liquid that is around and within the organs of the central nervous system. When compared to plasma, CSF has a higher concentration of sodium, chloride, and magnesium but a lower concentration of potassium and calcium. Unlike plasma, CSF has only trace amounts of cells, protein, and immunoglobulins.
- **Option B:** Several analyses are possible on the contents of CSF obtained from a lumbar puncture. Since CSF should be transparent, the color is worth noting. A cloudy appearance can suggest an

infectious cause, and red color can suggest the presence of blood.

- **Option C:** The CSF helps reduce the potential damage in such an event by acting as a cushion and a shock absorber. Since there are continuous production and production of CSF, it also appears to help clear waste products from around the brain and regulate intracranial pressures.

17. A client tells the nurse that she plans to use the rhythm method of birth control. The nurse is aware that the success of the rhythm method depends on the:

- A. Age of the client
- B. Frequency of intercourse
- C. Regularity of the menses
- D. Range of the client's temperature

Correct Answer: C. Regularity of the menses

The success of the rhythm method of birth control is dependent on the client's menses being regular. Women are only fertile (an egg is present) for a few days each month. Women using the rhythm method monitor their body and analyze their past menstrual cycles to try to determine when their fertile days are. They can then either choose to not have sex during those days, or can use a "barrier" form of birth control, such as condoms or spermicide.

- **Option A:** The rhythm method is not dependent on the age of the client. The rhythm method works best for women whose cycles are consistent because it is easier to predict when she ovulates (releases an egg from her ovaries).
- **Option B:** Rhythm method is not successful when based entirely on the frequency of intercourse. Most women will have a period 14 to 16 days after ovulation, regardless of the length of their overall cycle. Counting backward from the day their period begins can be a good way to know when they ovulated.
- **Option D:** Basal temperature method relies on the client's temperature during ovulation period. The basal body temperature method is a method of natural family planning that requires only the purchase of a very accurate thermometer. The method, which calls for tracking the woman's body temperature on a daily basis, helps to determine which days of the month she is fertile.

18. A client is in diabetic ketoacidosis (DKA) secondary to infection. As the condition progresses, which of the following symptoms might the nurse see?

- A. Kussmaul's respirations and a fruity odor on the breath
- B. Shallow respirations and severe abdominal pain
- C. Decreased respiration and increased urine output
- D. Cheyne-stokes respirations and foul-smelling urine

Correct Answer: A. Kussmaul's respirations and a fruity odor on the breath

Coma and severe acidosis are ushered in with Kussmaul's respirations (very deep but not labored respirations) and a fruity odor on the breath. Kussmaul's breathing, which is labored, deep, and tachypneic, may occur. Some providers may appreciate a fruity scent to the patient's breath, indicative

of the presence of acetone.

- **Option B:** The patient with diabetic ketoacidosis may present with a myriad of symptoms and physical exam findings. Patients may have symptoms of hyperglycemia like polyphagia, polyuria, or polydipsia. If there is a superimposed infection that triggered the episode of DKA, the patient may have other infectious symptoms like fever, cough, or other urinary symptoms.
- **Option C:** As patients become more volume-depleted, they may experience decreased urine output, dry mouth, or decreased sweating indicative of dehydration. They may complain of many other symptoms, including anorexia, nausea, vomiting, abdominal pain, and weight loss.
- **Option D:** On examination, vital signs typically reveal tachycardia and tachypnea. Due to the possibility of an infectious trigger for DKA, the patient may be febrile or hypothermic. Blood pressure may also vary, though hypotension is possible and indicative of a more severe disease process.

19. Ben feels hatred each time he sees her father showing affection to her mother. According to Freud, this behavior is known as?

- A. Misomater
- B. Oedipus Complex
- C. Superiority Complex
- D. Electra Complex

Correct Answer: B. Oedipus complex

Oedipus complex is a Freudian concept that describes a child's sexual desire for the parent of the opposite sex and a sense of rivalry with the parent of the same sex. This desire is kept out of conscious awareness through repression, but Freud believed that it still had an influence over a child's behavior and played a role in development.

- **Option A:** Misomater is a term that describes a person's animosity toward his or her mother. Parent-offspring conflict describes the evolutionary conflict arising from differences in optimal fitness of parents and their offspring.
- **Option C:** Superiority complex is a psychological behavior that exists when a person overcompensates his or her feelings of inferiority. A superiority complex is a belief that one's abilities or accomplishments are somehow dramatically better than other people's. People with a superiority complex may be condescending, smug, or mean to other people who don't agree with them.
- **Option D:** Electra complex is used to describe a girl's attraction to their father and resentment or rivalry towards their mothers. The term Electra complex was introduced by Carl Jung to describe how this complex manifests in girls.

20. 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.

21. Mario has a burn injury. After 48 hours, the physician orders for Mario 2 liters of IV fluid to be administered q12 h. The drop factor of the tubing is 10 gtt/ml. The nurse should set the flow to provide:

- A. 18 gtt/min
- B. 28 gtt/min
- C. 32 gtt/min
- D. 36 gtt/min

Correct Answer: B. 28 gtt/min

This is the correct flow rate; multiply the amount to be infused (2000 ml) by the drop factor (10) and divide the result by the amount of time in minutes (12 hours x 60 minutes)

- **Option A:** This amount is inadequate according to the formula used.
- **Option C:** 32 gtt/min is more than the prescribed gtt/min given.
- **Option D:** This amount is incorrect according to the formula used to get the correct flow rate.

22. What are the three most important prognostic factors in determining long-term survival for children with acute leukemia?

- A. Histologic type of disease, initial WBC count, and client's age at diagnosis
- B. Progression of illness, WBC at the time of diagnosis, and client's age at the time of diagnosis
- C. Histologic type of disease, initial platelet count, and type of treatment
- D. Type of treatment and client's sex

Correct Answer: A. Histologic type of disease, initial WBC count, and client's age at diagnosis

- **Option A:** The factor whose prognostic value is considered to be of greatest significance in determining the long-range outcome is the histologic type of leukemia. Children with a normal or low WBC count appear to have a much better prognosis than those with a high WBC count. Children diagnosed between ages 2 and 10 have consistently demonstrated a better prognosis because of age 2 or after 10.

23. Stephanie is often seen interacting with the medical intern during coffee breaks and after duty hours. What type of organizational structure is this?

- A. Formal
- B. Informal
- C. Staff
- D. Line

Correct Answer: B. Informal

This is usually not published and oftentimes concealed. The informal organization is the interlocking social structure that governs how people work together in practice. It is the aggregate of behaviors, interactions, norms, and personal/professional connections through which work gets done and relationships are built among people. It consists of a dynamic set of personal relationships, social networks, communities of common interest, and emotional sources of motivation.

- **Option A:** The formal structure of a group or organization includes a fixed set of rules of procedures and structures, usually set out in writing, with a language of rules that ostensibly leave little discretion for interpretation. In some societies and organizations, such rules may be strictly followed; in others, they may be little more than an empty formalism.
- **Option C:** In the staff organization structure, the employees follow the directives of the managers. The line group as a whole is seen as a function that is essential to the business. Staff positions are those that indirectly support line functions in the organizations. Like line positions, staff positions also consist of managers and employees.
- **Option D:** Line organization structure is the oldest and simplest form of organization. In these organizations, a supervisor exercises direct supervision over a subordinate. Also, authority flows from the top-most person in the organization to the person in the lowest rung.

24. A nurse on the newborn nursery floor is caring for a neonate. On assessment the infant is exhibiting signs of cyanosis, tachypnea, nasal flaring, and grunting. Respiratory distress syndrome is diagnosed, and the physician prescribes surfactant replacement therapy. The nurse would prepare to administer this therapy by:

- A. Subcutaneous injection
- B. Intravenous injection
- C. Instillation of the preparation into the lungs through an endotracheal tube
- D. Intramuscular injection

Correct Answer: C. Instillation of the preparation into the lungs through an endotracheal tube.

Option C: The aim of therapy in RDS is to support the disease until the disease runs its course with the subsequent development of surfactant. The infant may benefit from surfactant replacement therapy. In surfactant replacement, an exogenous surfactant preparation is instilled into the lungs through an endotracheal tube.

25. Before feeding a client via NGT, the nurse checks for residual and obtains a residual amount of 90ml. What is the appropriate action for the nurse to take?

- A. Discard the residual amount.
- B. Hold the due feeding.
- C. Skip the feeding and administer the next feeding due in 4 hours.
- D. Reinstill the amount and continue with administering the feeding.

Correct Answer: D. Reinstill the amount and continue with administering the feeding.

If the residual feeding is less than 100ml, feeding is administered. Fasting volume of the normal stomach ranged from 0 to 98 mL in the study group. The researchers defined high as 100 mL for nasogastric (NG) tubes and 200 mL for gastrostomy (G) tubes and concluded that EN feedings should not be stopped for a single high GRV if there are no other physical examination or radiography findings to show actual gastrointestinal dysfunction.

- **Option A:** When interpreting Gastric Residual Volume (GRV), clinicians must keep in mind that the stomach has reservoir function and that the stomach fluid is a mixture of both the infused EN formula and normal gastric secretions. Chang and colleagues explained this concept in the article “Monitoring Bolus Nasogastric Tube Feeding by the Brix Value Determination and Residual Volume Measurement of Gastric Contents” published in the Journal of Parenteral and Enteral Nutrition (JPEN) in 2004.
- **Option B:** In a review article, “Measurement of Gastric Residual Volume: State of the Science,” published in 2000 in MEDSURG Nursing, Edwards and Metheny reported that the literature contained a variety of recommendations for what is considered a high GRV, ranging from 100 to 500 mL. Some sources have even (incorrectly) suggested holding tube feedings for a GRV of greater than 30 mL, or 1.5 times the flow rate, or even one-half of the hourly flow rate.
- **Option C:** Normal gastric emptying occurs within three hours and after a lag time of approximately one hour for a meal of solid foods. The process is slower for high-fat meals. Liquids empty more quickly (within one hour for a glucose solution and two hours for a protein solution).³ During fasting, the stomach secretes approximately 500 to 1,500 mL²; in the fed state, it secretes approximately 2,500 mL per day.

26. Which of the following characteristics will distinguish a postmature neonate at birth?

- A. Plenty of lanugo and vernix caseosa.
- B. Lanugo mainly on the shoulders and vernix in the skin folds.
- C. Pinkish skin with good turgor.
- D. Almost leather-like, dry, cracked skin, negligible vernix caseosa.

Correct Answer: D. Almost leather-like, dry, cracked skin, negligible vernix caseosa

A post mature fetus has the appearance of an old person with dry wrinkled skin and the vernix caseosa has already diminished.

- **Option A:** Lanugo plays an important role in binding the vernix caseosa to the skin of fetuses. Vernix caseosa is the viscous white covering on newborns that protects their skin, prevents water loss, plays an important role in thermoregulation, and contributes to innate immunity.

- **Option B:** Lanugo is the first type of hair to develop in humans. The interaction of lanugo with the vernix is also important in controlling the tempo of the fetal developmental rate during various times in the gestation cycle. Lanugo arises at about three months into development. Hair growth starts on the scalp around the eyebrow, nose, and forehead area and proceeds in a cephalocaudal direction from head to toe. It is shed at about 33 to 36 weeks gestation, when it becomes subsequently incorporated into the amniotic fluid, eventually contributing to the composition of the meconium.
- **Option C:** The skin of a healthy newborn at birth has: Deep red or purple skin and bluish hands and feet. The skin darkens before the infant takes their first breath (when they make that first vigorous cry). A thick, waxy substance called vernix covering the skin.

27. The nurse is providing care for a client who has had a stroke. Since the onset of symptoms, the client has been experiencing left-sided hemianopsia. Which nursing interventions would be appropriate? Select all that apply.

- A. Place the client's belongings on the right side of the bed.
- B. Approach the client from the left side.
- 3. Refuse to acknowledge the condition to promote the client's independence.
- C. Refuse to acknowledge the condition to promote the client's independence.
- D. Stand on the right side of the bed when providing care.
- E. Provide the client with an eye patch for the right eye.
- F. Dim the lights in the room to prevent eye strain.

Correct Answer: A & D.

Hemianopsia is a condition in which the client has lost half of the visual field. It is most often associated with stroke. Homonymous hemianopsia may result from stroke, head trauma, mass occupying lesions, invasive surgical procedures, or neurologic conditions such as multiple sclerosis, Alzheimer's disease, and epilepsy.

- **Option A:** In this case, the stroke has affected the client's left side; therefore, placing belongings on the right side of the bed will enable the client to best see them. In order to improve patients' ability to compensate for their visual loss, several researchers have developed training schemes designed to teach patients more efficient strategies for visual scanning.
- **Option B:** Approaching the client from the left side is counterproductive because the client would not be able to adequately see the nurse. The compensatory training approaches typically use target-localization tasks to train patients to make large eye movements and use visual search tasks to teach patients to use systematic scanning strategies when searching their visual world.
- **Option C:** Due to the enjoyment which can be gained from reading and other leisure activities requiring visual search skills, any impairment in these has obvious consequences for the emotional well-being of the patient.
- **Option D:** Standing on the right side of the bed when providing care will ensure the client is able to see the nurse. Optical aids such as prism glasses can be used to reduce the apparent visual field loss by shifting visual stimuli from the blind field into the patient's seeing field. These prisms are fitted to spectacles but need to be restricted to just one-half of each of the lenses (typically on the side of the blind field).
- **Option E:** Using an eye patch will not help with treating or managing the condition. Patient recovery may benefit from a multifaceted approach that includes visual training, visual assist

devices (prism correction), occupational therapy, and psychological rehabilitation.

- **Option F:** Dimming the lights would further decrease seeing the visual field. Some patients can respond quite accurately to visual stimuli presented to their blind field (for example by pointing to it) even though they insist that they cannot see it. This phenomenon has been called blindsight.

28. For clients to participate in goal setting, they should be:

- A. Alert and have some degree of independence.
- B. Ambulatory and mobile.
- C. Able to speak and write.
- D. Able to read and write.

Correct Answer: A. Alert and have some degree of independence.

Goal setting in nursing provides direction for planning nursing interventions and evaluating patient progress. The purpose of goal setting in nursing is to enable the patient and nurse to determine when the problem has been resolved and help motivate the patient and the nurse by providing a sense of achievement.

- **Option B:** In light of the potential benefits of patient participation in goal setting, a study by Baker, Rice, Zimmerman, Marshak, et. al. believes the following are needed: (1) patient and therapist education regarding the potential advantages of participation, (2) the enhancement of patient readiness to assume greater responsibility in their care, and (3) the development of models for use in achieving patient participation.
- **Option C:** Patient and therapist education is needed regarding methods for patient participation during initial goal-setting activities. In a study by Baker, Rice, Zimmerman, Marshak, et. al., the therapists stated that they believed that it is important to include patients in goal-setting activities and that outcomes will be improved if patients participate. Patients also indicated that participation is important to them.
- **Option D:** Patient participation in goal setting is emphasized in order to enhance patient management and the effectiveness of treatment. Participation should improve outcomes and could be used to identify benefits that may result from the treatment. These benefits include greater goal attainment, increased patient satisfaction, gains in function, better adherence to treatment regimens, decreased depression in patients, and reduced burnout rates among physical therapists.

29. The most common psychogenic disorder among elderly person is:

- A. Depression
- B. Sleep disturbances (such as bizarre dreams)
- C. Inability to concentrate
- D. Decreased appetite

Correct Answer: A. Depression

Depression typically begins before the onset of old age and usually is caused by psychosocial, genetic, or biochemical factors. Depression is a common problem among older adults, but it is NOT a normal part of aging. In fact, studies show that most older adults feel satisfied with their lives, despite having more illnesses or physical problems. However, important life changes that happen as we get older may

cause feelings of uneasiness, stress, and sadness. Sometimes older people who are depressed appear to feel tired, have trouble sleeping, or seem grumpy and irritable. Confusion or attention problems caused by depression can sometimes look like Alzheimer's disease or other brain disorders.

- **Option B:** Primary sleep disorders are more common in the elderly than in younger persons. Restless legs syndrome and periodic limb movement disorder can disrupt sleep and may respond to low doses of antiparkinsonian agents as well as other drugs. Sleep apnea can lead to excessive daytime sleepiness.
- **Option C:** A study finds that seniors' attention shortfall is associated with the locus coeruleus, a tiny region of the brainstem that connects to many other parts of the brain. The locus coeruleus helps focus brain activity during periods of stress or excitement. Increased distractibility is a sign of cognitive aging.
- **Option D:** Sleep disturbances, inability to concentrate, and decreased appetite are symptoms of depression, the most common psychogenic disorder among elderly persons. Other symptoms include diminished memory, apathy, disinterest in appearance, withdrawal, and irritability.

30. In the extracellular fluid, chloride is a major:

- A. Compound
- B. Ion
- C. Anion
- D. Cation

Correct Answer: C. Anion

Chloride is a major anion found in the extracellular fluid. Chloride is an inorganic anionic halogen with an atomic weight of 35.5. It is distributed exclusively within the extracellular fluid compartment (ECF), which comprises the blood/plasma (or serum) compartment and the interstitial fluid compartment. Chloride is the major anion associated with sodium in the ECF.

- **Option A:** A compound occurs when two ions are bound together. When two distinct elements are chemically combined—i.e., chemical bonds form between their atoms—the result is called a chemical compound. Most elements on Earth bond with other elements to form chemical compounds, such as sodium (Na) and Chloride (Cl), which combine to form table salt (NaCl).
- **Option B:** Chloride is an ion, but this choice is too general. Ions are formed when the number of protons in an atom does not equal the number of electrons. If more protons are present, the ion is positive and is known as a cation; if more electrons are present, the ion is negative and referred to as an anion.
- **Option D:** HCO_3^- is a cation. Cations are positively charged ions. They are formed when a metal loses its electrons. They lose one or more than one electron and do not lose any protons. Therefore, they possess a net positive charge.

31. The following are signs and symptoms of fetal distress EXCEPT:

- A. Fetal heart rate (FHR) decreases during a contraction and persists even after the uterine contraction ends.
- B. The FHR is less than 120 bpm or over 160 bpm.

C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm, and FHR after uterine contraction is 126 bpm.

D. FHR is 160 bpm, weak and irregular.

Correct Answer: C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm, and FHR after uterine contraction is 126 bpm.

The normal range of FHR is 120-160 bpm, strong and regular. During a contraction, the FHR usually goes down but must return to its pre-contraction rate after the contraction ends.

- **Option A:** Usually, doctors identify fetal distress based on an abnormal heart rate pattern in the fetus. Throughout labor, the fetus's heart rate is monitored. It is usually monitored continuously with electronic fetal heart monitoring. Or a handheld Doppler ultrasound device may be used to check the heart rate every 15 minutes during early labor and after each contraction during late labor.
- **Option B:** Contractions that are too strong and/or too close together may cause fetal distress. If oxytocin was used to stimulate contractions, it is stopped immediately. The woman may be repositioned and given analgesics. If no drug was used to stimulate contractions, the woman may be given a drug that can slow labor (such as terbutaline, given by injection) to stop or slow the contractions.
- **Option D:** Fetal rhythm abnormalities, which include fetal heart rates that are irregular, too fast or too slow, occur in up to 2% of pregnancies and account for 10–20% of the referrals to fetal cardiologists.

32. Nurse Martinez is tending to Mr. Rodriguez, a 67-year-old patient with atrial fibrillation. He has been on digoxin (Lanoxin) 0.25 mg daily to control his heart rate. His cardiologist, aware of his medication regimen, has added metoprolol (Lopressor) 25 mg B.I.D to further manage his condition. Before Nurse Martinez administers the two medications, she carefully assesses Mr. Rodriguez's vital signs. Which of her findings would be of greatest concern and necessitate immediate communication with the cardiologist?

A. Blood pressure 94/60 mm Hg

B. Heart rate 76 bpm

C. Urine output 50 ml/hour

D. Respiratory rate 16 bpm

Correct Answer: A. Blood pressure 94/60 mm Hg

Both medications decrease the heart rate. Metoprolol affects blood pressure. Therefore, the heart rate and blood pressure must be within the normal range (HR 60-100; systolic BP over 100) in order to safely administer both medications. The combination of both medications might further decrease his blood pressure. This is a significant concern and should be reported.

- **Option B:** A heart rate of 76 is within the normal range.
- **Option C:** Increased urine output is the desired effect of diuretics, given with digoxin.
- **Option D:** A respiratory rate of 16 is within the normal range.

33. A nurse performs an admission assessment on a female client with a diagnosis of tuberculosis. The nurse reviews the result of which diagnosis test that will confirm this diagnosis?

- A. Bronchoscopy
- B. Sputum culture
- C. Chest x-ray
- D. Tuberculin skin test

Correct Answer: B. Sputum culture

Tuberculosis is definitively diagnosed through culture and isolation of *Mycobacterium tuberculosis*. Mycobacterial culture is the gold standard for diagnosis. Mycobacterial culture should be performed on both the solid and liquid medium. Liquid media culture can detect very low bacterial load and is considered a gold standard. Culture essential for drug susceptibility testing. A presumptive diagnosis is made based on a tuberculin skin test, a sputum smear that is positive for acid-fast bacteria, a chest x-ray, and histological evidence of granulomatous disease on biopsy. Active tuberculosis is diagnosed by isolating *Mycobacterium tuberculosis* complex bacilli from bodily secretions.

- **Option A:** If all measures fail to obtain a sputum sample, a fiberoptic bronchoscopy with bronchoalveolar lavage can be performed with or without a transbronchial biopsy. Bronchoscopy can also be performed in high clinical suspicion with negative sputum studies and to rule out an alternative diagnosis.
- **Option C:** Primary tuberculosis often causes middle and lower lung field opacities associated with mediastinal adenopathy. Whereas secondary tuberculosis commonly involves upper lobes, causing opacities, cavities, or fibrotic scar tissue.
- **Option D:** The Mantoux test is a two-part test consisting of an intradermal injection of .1ml purified protein derivative and observing for induration 48-72 hours. The patient's risk of exposure is taken into consideration when interpreting the result. Patients are then classified into three groups based on the size of the induration and the risk of exposure.

34. A client with gastric cancer can expect to have surgery for resection. Which of the following should be the nursing management priority for the preoperative client with gastric cancer?

- A. Discharge planning
- B. Correction of nutritional deficits
- C. Prevention of DVT
- D. Instruction regarding radiation treatment

Correct Answer: B. Correction of nutritional deficits

Client's with gastric cancer commonly have nutritional deficits and may be cachectic. For patients undergoing surgery, the preoperative nutritional condition directly affects postoperative prognosis, overall survival, and disease-specific survival. The goal of nutritional therapy is to improve the nutritional status, metabolism, adherence to antitumor therapies, quality of life, and course of the disease.

- **Option A:** Discharge planning before surgery is important, but correcting the nutrition deficit is a higher priority. Provide accurate, consistent information regarding diagnosis and prognosis. Avoid arguing about the patient's perceptions of the situation.
- **Option C:** Prevention of DVT also isn't a high priority to surgery, though it assumes greater importance after surgery. The link between thromboembolism and cancer has been recognized for over 100 years. Venous thromboembolism (VTE) is associated with considerable morbidity in patients with cancer, with emerging research also indicating a detrimental effect on survival.
- **Option D:** At present, radiation therapy hasn't been proven effective for gastric cancer, and teaching about it preoperatively wouldn't be appropriate. People with stomach cancer usually receive external-beam radiation therapy, which is radiation given from a machine outside the body. Radiation therapy may be used before surgery to shrink the size of the tumor or after surgery to destroy any remaining cancer cells.

35. The home health nurse is caring for a patient who has been receiving interferon therapy for treatment of cancer. Which statement by the patient may indicate a need for a change in treatment?

- A. "I rarely have the energy to get out of bed."
- B. "I experience chills after I inject the interferon."
- C. "I take acetaminophen (Tylenol) every 4 hours."
- D. "I have frequent muscle aches and pains."

Correct Answer: A. "I rarely have the energy to get out of bed."

- **Option A:** Fatigue can be dose-limiting toxicity for use of biologic therapies.
- **Options B and D:** Flu-Like symptoms, such as muscle aches and chills, are common side effects of interferon use.
- **Option D:** Patients are advised to use Tylenol every 4 hours.