

Kevin's Review - 35 NCLEX Practice Questions

1. During surgery, there is an increased potential for arrhythmias when catecholamines are given with:

- A. halothane (Fluothane)
- B. digoxin (Lanoxin)
- C. bupivacaine (Marcaine)
- D. lidocaine (Xylocaine)

Correct Answer: A. halothane (Fluothane)

Arrhythmias are a result of an interaction that can occur with halothane and catecholamines. Halothane is a clear, heavy, and colorless liquid with a sweet and non-irritating odor. Halothane's structure is that of an alkane. It has primarily been used clinically as an inhalational anesthetic. Cardiorespiratory instability (i.e., hypotension, bradycardia), sensitizing the myocardium to catecholamine-induced arrhythmias, and mild liver dysfunction are relatively common side effects of halothane. Arrhythmias are especially common in neonates and children after the administration of halothane, particularly bradyarrhythmias. Other choices do not interact with halothane to cause arrhythmias.

- **Option B:** Digoxin toxicity is clinically relevant as it can lead to fatal cardiac arrhythmias. The estimated frequency is at about 0.8 to 4% of patients on steady digoxin therapy. The rate of toxicity increases as serum digoxin concentration reaches over 2.0 ng/ml. However, toxicity can also occur at lower levels, especially in the setting of other risk factors such as low body weight, advanced age, decreased renal function, and hypokalemia.
- **Option C:** Rarely, patients can exhibit toxicity to bupivacaine in doses much lower than the suggested upper limits of dosing. This toxicity appears to be due to a rare condition related to l-carnitine deficiency. Patients affected may exhibit cardiac toxicity at doses as low as 1.1 mg/kg of bupivacaine injected cutaneously. Case reports exist describing these cases of low dose toxicity in patients later discovered to be deficient in l-carnitine.
- **Option D:** Signs and symptoms of mild toxicity become apparent at plasma levels greater than 5 mcg/mL, beginning with slurred speech, tinnitus, circumoral paresthesia, and feeling faint. Above 10 mcg/mL, the patient may experience seizures or loss of consciousness. The myocardium and central nervous system are further depressed at 15 mcg/mL, progressing to cardiac arrhythmias, respiratory arrest, and cardiac arrest above 20 mcg/mL.

2. The mother of a 2-month-old infant brings the child to the clinic for a well-baby check. She is concerned because she feels only one testis in the scrotal sac. Which of the following statements about the undescended testis is the most accurate?

- A. Normally, the testes are descended by birth.
- B. The infant will likely require surgical intervention.
- C. The infant probably has only one testis.
- D. Normally, the testes descend by one year of age.

Correct Answer: D. Normally, the testes descend by one year of age.

Normally, the testes descend by one year of age. In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated. The exam

should be done in a warm room with warm hands. It is most likely that both testes are present and will descend by a year. If not, a full assessment will determine the appropriate treatment.

- **Option A:** The testes usually descend by one year of age. Most of the time, a boy's testicles descend by the time he is 9 months old. Undescended testicles are common in infants who are born early. The problem occurs less in full-term infants.
- **Option B:** Surgical intervention is unnecessary; the testes descend by one year of age. The testicles will descend normally at puberty and surgery is not needed. Testicles that do not naturally descend into the scrotum are considered abnormal. An undescended testicle is more likely to develop cancer, even if it is brought into the scrotum with surgery. Cancer is also more likely in the other testicle.
- **Option C:** In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated.

3. Crisis intervention carried out to the client has this primary goal:

- A. Assist the client to express her feelings.
- B. Help her identify her resources.
- C. Support her adaptive coping skills.
- D. Help her return to her pre-rape level of function.

Correct Answer: D. Help her return to her pre-rape level of function.

The goal of crisis intervention is to help the client return to her level of function prior to the crisis. Crisis intervention is a short-term management technique designed to reduce potential permanent damage to an individual affected by a crisis. A crisis is defined as an overwhelming event, which can include divorce, violence, the passing of a loved one, or the discovery of a serious illness.

- **Option A:** A successful intervention involves obtaining background information on the patient, establishing a positive relationship, discussing the events, and providing emotional support. SAFER-R is a common intervention model used, which consists of stabilization, acknowledgment, facilitate understanding, encouragement, recovery, and referral. SAFER-R helps patients return to their mental baseline following a crisis.
- **Option B:** Based on prior studies, it is evident that crisis intervention plays a significant role in enhancing outcomes in psychiatric cases. Community Mental Health Centers and local government agencies often have crisis intervention teams that provide support to the local community at times of mental health crisis.
- **Option C:** Another major concern is what coping strategies are most effective. Social support and problem-solving planning are effective coping mechanisms that are frequently used by school staff following a crisis. The use of humor, emotional support, planning, and acceptance also correlate with superior mental health outcomes compared to substance abuse and denial.

4. Mrs. Maria Johnson, a 62-year-old woman with a recent diagnosis of pharyngitis, has been admitted to your medical ward. Due to her diagnosis and potential to spread the infection, the infection control team has advised placing her under droplet precautions until further notice. During the shift, you overhear a conversation between a new graduate nurse and a seasoned nurse discussing the droplet precautions implemented for Mrs. Johnson. As their

charge nurse, you decide to evaluate their understanding of droplet precautions to ensure the safety and well-being of both the patient and the healthcare team. You gather the two nurses and ask them to clarify their understanding of droplet precautions. Which of the following statements, if made by the new graduate nurse, indicates the best understanding of this type of isolation?

- A. The client can be placed in a room with another client with measles (rubeola).
- B. Must maintain a spatial distance of 3 feet.
- C. A special mask (N95) should be worn when working with the client.
- D. Gloves should be only worn when giving direct care.
- E. It's necessary to perform hand hygiene before and after patient contact.
- F. Droplet precautions are primarily aimed at protecting against airborne transmissions.

Correct Answer: B. Must maintain a spatial distance of 3 feet.

This statement reflects the CDC guidelines for droplet precautions, which recommend keeping a distance of at least 3 feet between the healthcare worker and the patient to avoid contact with infectious droplets.

- **Option A:** Patients on droplet precautions should ideally be placed in single-patient rooms. If this is not possible, they may share a room with others with the same infectious disease, but not with those who have diseases spread through different routes, like measles which requires airborne precautions.
- **Option C:** N95 respirators are not usually required for droplet precautions, but are for airborne precautions. A surgical mask is generally adequate for droplet precautions unless aerosol-generating procedures are being performed.
- **Option D:** While it's true gloves should be worn during direct patient care, this statement does not reflect a complete understanding of droplet precautions which also includes use of gowns, masks, and eye protection when indicated, alongside maintaining a spatial distance.
- **Option E:** While correct and crucial, this statement is a standard practice for all patient interactions, not specific to droplet precautions.
- **Option F:** Droplet precautions are aimed at preventing the spread of infections via large respiratory droplets, not airborne transmissions which involve smaller particles and require different precautions (airborne precautions).

5. A client with diabetes mellitus visits a health care clinic. The client's diabetes previously had been well controlled with glyburide (Diabeta), 5 mg PO daily, but recently, the fasting blood glucose has been running 180-200 mg/dl. Which medication, if added to the clients regimen, may have contributed to the hyperglycemia?

- A. prednisone (Deltasone)
- B. atenolol (Tenormin)
- C. phenelzine (Nardil)
- D. allopurinol (Zyloprim)

Correct Answer: A. prednisone (Deltasone)

Prednisone may decrease the effect of oral hypoglycemics, insulin, diuretics, and potassium supplements. Prednisone may interfere with blood glucose control and reduce the effectiveness of metFORMIN and other diabetic medications. Monitor blood sugar levels closely. The client may need a dose adjustment of the diabetic medications during and after treatment with prednisone.

- **Option B:** Research results indicated that atenolol can inhibit urinary excretion of metformin via decreasing renal rMate1 expression, and long-term atenolol and metformin co-administration may induce potential lactic acidosis.
- **Option C:** Phenelzine may lower blood sugar levels. However, it does not have any effects when taken with oral hypoglycemic agents. Some products that may interact with this drug include: other antidepressants (including maprotiline, mirtazapine, nefazodone, TCAs such as amitriptyline/nortriptyline), appetite suppressants (such as diethylpropion), drugs for attention deficit disorder (such as atomoxetine, methylphenidate), apraclonidine, bupropion, etc.
- **Option D:** No interactions were found between allopurinol and metformin. Allopurinol may also increase the risk of developing a rash if taken with antibiotics ampicillin or amoxicillin. Allopurinol may also increase the effect of warfarin and other drugs that thin the blood. These are known as anticoagulants.

6. Late deceleration patterns are noted when assessing the monitor tracing of a woman whose labor is being induced with an infusion of Pitocin. The woman is in a side-lying position, and her vital signs are stable and fall within a normal range. Contractions are intense, last 90 seconds, and occur every 1 1/2 to 2 minutes. The nurse's immediate action would be to:

- A. Change the woman's position
- B. Stop the Pitocin
- C. Elevate the woman's legs
- D. Administer oxygen via a tight mask at 8 to 10 liters/minute

Correct Answer: B. Stop the Pitocin

Late deceleration patterns noted are most likely related to alteration in uteroplacental perfusion associated with the strong contractions described. The immediate action would be to stop the Pitocin infusion since Pitocin is an oxytocin which stimulates the uterus to contract.

- **Option A:** The woman is already in an appropriate position for uteroplacental perfusion. A late deceleration is a symmetric fall in the fetal heart rate, beginning at or after the peak of the uterine contraction and returning to baseline only after the contraction has ended
- **Option C:** Elevation of her legs would be appropriate if hypotension were present. Regardless of the depth of the deceleration, all late decelerations are considered potentially ominous. A pattern of persistent late decelerations is nonreassuring, and further evaluation of the fetal pH is indicated.
- **Option D:** Oxygen is appropriate but not the immediate action. The occurrence of a late or worsening variable deceleration pattern in the presence of normal variability generally means that the fetal stress is either of a mild degree or of recent origin; however, this pattern is considered nonreassuring.

7. Joy has entered the chemical dependency unit for treatment of alcohol dependency. Which of the following client's possessions will the nurse most likely place in a locked area?

- A. Toothpaste
- B. Shampoo
- C. Antiseptic wash
- D. Moisturizer

Correct Answer: C. Antiseptic wash

Antiseptic mouthwash often contains alcohol & should be kept in a locked area, unless labeling clearly indicates that the product does not contain alcohol. Alcohol misuse has been linked to numerous social, economic, and health problems. Estimates vary but have suggested that up to 40% of patients have experienced complications of alcohol misuse. In the United States, 138.3 million people aged 12 and older, surveyed, report that they actively use alcohol, according to the 2015 National Survey on Drug Use and Health. Of those, 48.2% report that they had binge drinking episode(s) within 30 days before taking the survey. Of those who reported binge drinking, 26% reported heavy alcohol use, defined as binge drinking five or more days in the previous 30 days, which accounts for 12.5% of total alcohol users.

- **Option A:** History gathering will often reveal reported episodes of binge drinking of four or five or more drinks at a time. Use of the CAGE questionnaire will reveal a score of 2 or greater (CAGE means (1) have you ever felt you should Cut down on your drinking, (2) have you ever been Annoyed by people criticizing your drinking, (3) have you ever felt Guilty about your alcohol use, or (4) have you ever needed an Eye-opener to steady your nerves or get rid of a hangover).
- **Option B:** The patient may also report frequent falls, blackout spells, unsteadiness, or visual disturbances. They may report seizures if they went a few days without drinking, or tremors, confusion, emotional disturbances, and frequent job changes. They may also report social issues, such as job termination, separation/divorce, estrangement from family, or loss of their home. They may also report sleep disturbances.
- **Option D:** On exams, they may exhibit signs of cerebellar dysfunction, such as ataxia or difficulty with fine motor skills. They may exhibit slurred speech, tachycardia, memory impairment, nystagmus, disinhibited behavior, or hypotension. They may present with tremors, confusion/mental status changes, asterixis, ruddy palms, jaundice, ascites, or other signs of advanced liver disease. There may also be spider angiomas, hepatomegaly/splenomegaly (early; liver becomes cirrhotic and shrunken in advanced disease).

8. A nurse is preparing to deliver a food tray to a Jewish client. The nurse checks the food on the tray and notes that the client has received a hamburger and whole milk as a beverage. Which is the appropriate action for the nurse?

- A. Ask the dietary department to replace the hamburger with crabs.
- B. Replace the whole milk with fat-free milk.
- C. Call the dietary department and ask for a new meal tray.
- D. Deliver the designated food tray to the client.

Correct Answer: C. Call the dietary department and ask for a new meal tray.

“You may not cook a young animal in the milk of its mother” -Torah says (Ex.23:19). From this, it is derived that milk and meat products may not be combined together. Not only may they not be cooked together, but they may not be served together on the same table and surely not eaten at the same time. This rule is followed observantly by the Jewish people so the appropriate nursing action is to call the dietary department to change the meal tray of the patient.

- **Option A:** Jewish dietary laws are known as kashrut and food that adheres to these standards is called kosher. Many mandates of the kosher diet are similar to those found in Islam. The only type of fish that may be eaten are those that have fins and scales. Therefore, shellfish, such as lobster, shrimp, oysters and crab, are prohibited.
- **Option B:** Certain parts of permitted animals may not be eaten. In the case of forbidden animals, their eggs and milk also cannot be consumed. Eating any pork or pork products, including animal shortening, is prohibited.
- **Option D:** Dairy products and meat products cannot be eaten together, because this is considered unhealthy. Cooking equipment and eating utensils that have come into contact with dairy products cannot be used with meat, and vice versa.

9. Which of the following parameters would the nurse monitor to evaluate the effectiveness of thickened feedings for an infant with gastroesophageal reflux disease (GERD)?

- A. Vomiting
- B. Stools
- C. Uterine
- D. Weight

Correct Answer: A. Vomiting

Thickened feedings are used with GER to stop the vomiting. Therefore, the nurse would monitor the child's vomiting to evaluate the effectiveness of using the thickened feedings.

- **Option B:** Feed thickeners are commonly used for managing infants with GOR despite the lack of strong supporting evidence. It is postulated that feed thickener reduces GOR by increasing the viscosity or 'stickiness' of the liquid content, enabling the feed to be retained in the stomach.
- **Option C:** However, feed thickeners can increase the energy density and osmolality of the feed which may increase the frequency of relaxation of the lower esophageal sphincter and delay gastric emptying, worsening GOR.
- **Option D:** If feedings are ineffective, this should be noted before there is any change in the child's weight

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

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

Correct Answer: B. ethionamide (Trecator)

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

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

11. Nurse Taylor is aware that the victims of domestic violence should be assessed for what important information?

- A. Reasons they stay in the abusive relationship (for example, lack of financial autonomy and isolation).
- B. Readiness to leave the perpetrator and knowledge of resources.
- C. Use of drugs or alcohol.
- D. History of previous victimization.

Correct Answer: B. Readiness to leave the perpetrator and knowledge of resources.

Victims of domestic violence must be assessed for their readiness to leave the perpetrator and their knowledge of the resources available to them. Nurses can then provide the victims with information and options to enable them to leave when they are ready. Training and support programs for clinicians and administrative staff have been shown to improve identification of women experiencing domestic violence and referral to advocacy services. Use of a domestic violence advocate in the ED resulted in a higher incidence of detection of incidents of acute violence than the data reported in the literature.

- **Option A:** The reasons they stay in the relationship are complex and can be explored at a later time. Reportedly, at least 40% of domestic violence victims never contact the police. Of female victims of domestic violence homicide, 44% had visited an ED within 2 years of their murder.
- **Option C:** The use of drugs or alcohol is irrelevant. Since substance abuse may develop or worsen as a result of domestic violence, it is appropriate to consider domestic violence when evaluating a patient for alcohol intoxication, drug toxicity, or drug overdose. A family history of alcohol and drug abuse or similar history in the patient's partner is also an important risk factor.
- **Option D:** There is no evidence to suggest that previous victimization results in a person's seeking or causing abusive relationships. The frequency and severity of previous attacks indicate the degree of present danger. Threats are as important as any actual injury. The presence of weapons in the home is a risk factor. In addition to threats and physical abuse, relationships with high risk for injury or death commonly feature exaggerated forms of coercion and manipulation to maintain the partner's dependence. This may result in the Stockholm syndrome.

12. When the bag of water ruptures, the nurse should check the characteristic of the amniotic fluid. The normal color of amniotic fluid is:

- A. Clear as water
- B. Bluish
- C. Greenish
- D. Yellowish

Correct Answer: A. Clear as water

The normal color of the amniotic fluid is clear like water. If it is yellowish, there is probably Rh incompatibility. If the color is greenish, it is probably meconium stained.

- **Option B:** A color change from yellow to blue (nitrazine indicator) indicates the possible presence of amniotic fluid.
- **Option C:** Fluid that looks green or brown usually means that the baby has passed his first bowel movement (meconium) while in the womb.
- **Option D:** Amniotic fluid is usually clear to pale yellow in color.

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

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

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

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

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

14. During patient teaching, the nurse explains the difference between a sedative and hypnotic by stating:

- A. "Sedatives are much stronger than hypnotic drugs and should only be used for short periods of time."
- B. "Sedative drugs induce sleep, whereas hypnotic drugs induce a state of hypnosis."
- C. "Most drugs produce sedation at low doses and sleep (the hypnotic effect) at higher doses."
- D. "There really is no difference; the terms are used interchangeably."

Correct Answer: C. “Most drugs produce sedation at low doses and sleep (the hypnotic effect) at higher doses.”

Many drugs have both sedative and hypnotic properties, with the sedative properties evident at low doses and the hypnotic properties demonstrated at larger doses. A sedative drug decreases activity, moderates excitement, and calms the recipient, whereas a hypnotic drug produces drowsiness and facilitates the onset and maintenance of a state of sleep that resembles natural sleep in its electroencephalographic characteristics and from which the recipient can be aroused easily.

- **Option A:** Sedation is a side effect of many drugs that are not general CNS depressants (e.g., antihistamines and antipsychotic agents). Although such agents can intensify the effects of CNS depressants, they usually produce more specific therapeutic effects at concentrations far lower than those causing substantial CNS depression.
- **Option B:** Sedatives cannot induce surgical anesthesia in the absence of other agents. The benzodiazepine sedative-hypnotics resemble such agents; although coma may occur at very high doses, neither surgical anesthesia nor fatal intoxication is produced by benzodiazepines in the absence of other drugs with CNS-depressant actions.
- **Option D:** A sedative is a drug that produces a relaxing, calming effect. Sedatives are usually given during daytime hours, and although they may make the patient drowsy, they usually do not produce sleep. A hypnotic is a drug that induces sleep, that is, it allows the patient to fall asleep and stay asleep. Hypnotics also may be called soporifics. Hypnotics are given at night or hour of sleep (HS).

15. Mrs. Cruz, 80 years old is diagnosed with pneumonia. Which of the following symptoms may appear first?

- A. Altered mental status and dehydration
- B. Fever and chills
- C. Hemoptysis and Dyspnea
- D. Pleuritic chest pain and cough

Correct Answer: A. Altered mental status and dehydration

Elderly clients may first appear with only an altered mental status and dehydration due to a blunted immune response.

- **Option B:** Fever and chills are classic signs of pneumonia that may appear later in the elderly. The inflammatory response results in a proliferation of neutrophils. This can damage lung tissue, leading to fibrosis and pulmonary edema, which also impairs lung expansion.
- **Option C:** Hemoptysis is a late sign of pneumonia. Bleeding in the lungs may originate from bronchial arteries, pulmonary arteries, bronchial capillaries, and alveolar capillaries. Dyspnea may occur early, especially among the elderly. Swelling and mucus can make it harder to move air through the airways, making it harder to breathe. This leads to shortness of breath, difficulty of breathing, and feeling more tired than normal.
- **Option D:** Cough and pleuritic chest pain are the common symptoms of pneumonia. The air sacs may fill with fluid or pus, causing cough with phlegm or pus, fever, chills, and difficulty breathing.

16. When attempting to interact with a neonate experiencing drug withdrawal, which behavior would indicate that the neonate is willing to interact?

- A. Gaze aversion
- B. Hiccups
- C. Quiet alert state
- D. Yawning

Correct Answer: C. Quiet alert state.

- **Option C:** When caring for a neonate experiencing drug withdrawal, the nurse needs to be alert for distress signals from the neonate. Stimuli should be introduced one at a time when the neonate is in a quiet and alert state. Gaze aversion, yawning, sneezing, hiccups, and body arching are distress signals that the neonate cannot handle stimuli at that time.

17. A licensed practical nurse is planning the client assignments for the day. Which of the following is the most appropriate assignment for the nursing assistant? Select all that apply.

- A. A client who requires wound irrigation
- B. A client who requires frequent ambulation
- C. A client who is receiving continuous tube feedings
- D. A client who requires frequent vital signs after a cardiac catheterization
- E. A client who needs to be turned or repositioned in bed

Correct Answer: B & E.

The nurse must determine the most appropriate assignment on the basis of the skills of the staff member and the needs of the client.

- **Option A:** Wound irrigations and tube feedings are not performed by unlicensed personnel. The staff members' levels of education, knowledge, past experiences, skills, abilities, and competencies are also evaluated and matched with the needs of all of the patients in the group of patients that will be cared for.
- **Option B:** In general, simple, routine tasks such as making unoccupied beds, supervising patient ambulation, assisting with hygiene, and feeding meals can be delegated. But if the patient is morbidly obese, recovering from surgery, or frail, work closely with the UAP or perform the care yourself.
- **Option C:** Care of the client receiving continuous tube feedings should be delegated to another registered nurse because it requires monitoring. Scopes of practice are also considered prior to the assignment of care. All states have scopes of practice for advanced nurse practitioners, registered nurses, licensed practical nurses and unlicensed assistive personnel like nursing assistants and patient care technicians.
- **Option D:** The client who had a cardiac catheterization will require specific monitoring in addition to that of the vital signs. Based on the basic entry educational preparation differences among these members of the nursing team, care should be assigned according to the level of education of the particular team member.
- **Option E:** In this case, the most appropriate assignment for a nursing assistant would be to care for the client who requires client repositioning. The nursing assistant is skilled in these tasks.

18. A 55-year old client with benign prostatic hyperplasia doesn't respond to medical treatment and is admitted to the facility for prostate gland removal. Before providing preoperative and postoperative instructions to the client, Nurse Gerry asks the surgeon which prostatectomy procedure will be done. What is the most widely used procedure for prostate gland removal?

- A. Transurethral resection of the prostate (TURP)
- B. Suprapubic prostatectomy
- C. Retropubic prostatectomy
- D. Transurethral laser incision of the prostate

Correct Answer: A. Transurethral resection of the prostate (TURP)

TURP is the most widely used procedure for prostate gland removal. Because it requires no incision, TURP is especially suitable for men with relatively minor prostatic enlargements and for those who are poor surgical risks. Transurethral resection of the prostate is a procedure used in the management of bladder outlet obstruction caused by prostatic hypertrophy and prostatic abscess management. This procedure should be performed if the patient desires to be of medical management for bladder outlet obstruction or who fails medical management.

- **Option B:** Suprapubic means that the surgery is done through an incision in the lower abdomen, above the pubic bone. An incision is made in the bladder, and the center of the prostate gland is removed. This part of the prostate gland is known as the transition zone. Suprapubic prostatectomy is an inpatient procedure.
- **Option C:** Surgery to remove the entire prostate and some of the tissue around it, including the seminal vesicles (a gland that helps make semen). Nearby lymph nodes may also be removed. During a radical retropubic prostatectomy, an incision (cut) is made in the wall of the lower abdomen, behind the pubic bone. An attempt is made to protect the nerves that control penile erection and the bladder from damage.
- **Option D:** Transurethral incision of the prostate (TUIP) may be done to treat benign prostatic hyperplasia (BPH). The surgeon uses an instrument inserted into the urethra that generates an electric current or laser beam to make incisions in the prostate where the prostate meets the bladder.

19. A female client whose physical findings suggest a hyperpituitary condition undergoes an extensive diagnostic workup. Test results reveal a pituitary tumor, which necessitates a transsphenoidal hypophysectomy. The evening before the surgery, nurse Jacob reviews preoperative and postoperative instructions given to the client earlier. Which postoperative instruction should the nurse emphasize?

- A. "You must lie flat for 24 hours after surgery."
- B. "You must avoid coughing, sneezing, and blowing your nose."
- C. "You must restrict your fluid intake."
- D. "You must report ringing in your ears immediately."

Correct Answer: B. "You must avoid coughing, sneezing, and blowing your nose."

After a transsphenoidal hypophysectomy, the client must refrain from coughing, sneezing, and blowing the nose for several days to avoid disturbing the surgical graft used to close the wound. The need for nasal packs is dependent on the type of reconstructive technique and the surgeon's choice (used only in a minority of cases). The nasal pack is removed on postoperative day 1. Septal splints are warranted in traditional sublabial-transseptal-transsphenoidal approaches and removed on a postoperative day 5 to 7.

- **Option A:** The head of the bed must be elevated, not kept flat, to prevent tension or pressure on the suture line. The first follow-up visit is 1 week after the procedure, where postoperative day 7 serum sodium levels are reviewed to rule out occult hyponatremia. Serial nasal endoscopies are done for debridement and to assess healing. The frequency of follow-up visits is determined by nasal crusting and maintenance of nasal hygiene with irrigation.
- **Option C:** Within 24 hours after hypophysectomy, transient diabetes insipidus commonly occurs; this calls for increased, not restricted, fluid intake. DI is the most common endocrine complication after sellar surgery, with the postoperative incidence of DI ranging between 5% and 35%. Postoperative DI is often characterized by a triphasic response: polyuria and polydipsia occurring in the first 48 hours and last a few days. Following this, a period of antidiuresis and hyponatremia develops, commonly after 1 week of surgery. This is followed by the polyuric phase, ending in permanent DI.
- **Option D:** Visual, not auditory, changes are a potential complication of hypophysectomy. Worsening of vision as a result of bleeding or manipulation and arterial hemorrhage are other immediate complications. A detailed study of preoperative imaging is essential to avoid catastrophes like optic nerve and carotid artery injury. The presence of anatomical variations such as sphenothmoidal cell or Onodi cell places the optic nerve at risk. Suspected injury to the optic nerve would entail a full gamut of measures, from observation, intravenous high dose steroids to optic nerve decompression, depending on the degree of suspicion, time since the injury, and loss/ progressive deterioration of vision.

20. Osmotic pressure is created through the process of:

- A. Osmosis
- B. Diffusion
- C. Filtration
- D. Capillary dynamics

Correct Answer: B. Diffusion

In diffusion, the solute moves from an area of higher concentration to one of lower concentration, creating osmotic pressure. There is a form of passive transport called facilitated diffusion. It occurs when molecules such as glucose or amino acids move from high concentration to low concentration facilitated by carrier proteins or pores in the membrane.

- **Option A:** Osmotic pressure is related to the process of osmosis. Osmosis is a form of passive transport when water molecules move from low solute concentration (high water concentration) to high solute or low water concentration across a membrane that is not permeable to the solute.
- **Option C:** Filtration is created by hydrostatic pressure. Filtration is a process used to separate solids from liquids or gases using a filter medium that allows the fluid to pass through but not the solid. The term "filtration" applies whether the filter is mechanical, biological, or physical. The fluid that passes through the filter is called the filtrate.

- **Option D:** Capillary dynamics are related to fluid exchange at the intravascular and interstitial levels. Capillary dynamics are controlled by the four Starling forces. Oncotic pressure is a form of osmotic pressure exerted by proteins either in the blood plasma or interstitial fluid. ... The net filtration pressure is the balance of the four Starling forces and determines the net flow of fluid across the capillary membrane.

21. For which of the following medical conditions would the nurse anticipate that an antianxiety agent would not be indicated?

- A. Seizure disorders
- B. Alcohol detoxification
- C. Parkinson's disease
- D. Panic disorder

Correct Answer: C. Parkinson's disease

Benzodiazepines may exacerbate the symptoms of Parkinson's disease. Benzodiazepines are a class of drugs that act upon benzodiazepine receptors (BZ-R) in the central nervous system (CNS). The receptor is a protein composed of five transmembrane subunits that form a chloride channel in the center, i.e., GABA-A receptor. The five subunits consist of two alpha, two beta, and one gamma subunit. The extracellular portions of the alpha and beta subunit proteins form a receptor site for gamma-aminobutyric acid (GABA), an inhibitory neurotransmitter.

- **Option A:** Benzodiazepines are especially important in the cessation of seizure activity, as 1% to 2% of emergency department visits annually in the United States are for seizures. Indications for benzodiazepine administration include, but are not limited to, anxiety disorders, insomnia, acute status epilepticus, induction of amnesia, spastic disorders, seizure disorders, and agitation.
- **Option B:** Benzodiazepines have the largest and the best evidence base in the treatment of alcohol withdrawal, and are considered the gold standard. Others, such as anticonvulsants, barbiturates, adrenergic drugs, and GABA agonists have been tried and have evidence.
- **Option D:** Benzodiazepines approved by the FDA for the treatment of panic disorder include alprazolam (Xanax) and clonazepam (Klonopin). Benzodiazepines are generally used only on a short-term basis because they can be habit-forming, causing mental or physical dependence.

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

- A. Formula or breastmilk
- B. Dilute nonfat dry milk
- C. Warmed fruit juice
- D. Fluoridated tap water

Correct Answer: A. Formula or breastmilk

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

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

23. When teaching an elderly client how to prevent constipation, which of the following instructions should the nurse include?

- A. "Drink 6 glasses of fluid each day."
- B. "Avoid grain products and nuts."
- C. "Add at least 4 grams of bran to your cereal each morning."
- D. "Be sure to get regular exercise."

Correct Answer: D. "Be sure to get regular exercise."

Exercise helps prevent constipation. Urge the patient for some physical activity and exercise. Consider isometric abdominal and gluteal exercises. Movement promotes peristalsis. Abdominal exercises strengthen abdominal muscles that facilitate defecation.

- **Option A:** Fluids and dietary fiber promote normal bowel function. The client should drink eight to ten glasses of fluid each day. Encourage the patient to take in fluid 2000 to 3000 mL/day, if not contraindicated medically. Sufficient fluid is needed to keep the fecal mass soft. But take note of some patients or older patients having cardiovascular limitations requiring less fluid intake.
- **Option B:** Grain products should be a part of the client's diet. A balanced diet that comprises adequate fiber, fresh fruits, vegetables, and grains is important. Twenty grams of fiber per day is suggested.
- **Option C:** Although adding bran to cereal helps prevent constipation by increasing dietary fiber, the client should start with a small amount and gradually increase the amount as tolerated to a maximum of 2 grams a day. Assist the patient to take at least 20 g of dietary fiber (e.g., raw fruits, fresh vegetables, whole grains) per day.

24. An 18-year-old client is admitted with a closed head injury sustained in a MVA. His intracranial pressure (ICP) shows an upward trend. Which intervention should the nurse perform first?

- A. Reposition the client to avoid neck flexion.
- B. Administer 1 g Mannitol IV as ordered.
- C. Increase the ventilator's respiratory rate to 20 breaths/minute.

D. Administer 100 mg of pentobarbital IV as ordered.

Correct Answer: A. Reposition the client to avoid neck flexion.

The nurse should first attempt nursing interventions, such as repositioning the client to avoid neck flexion, which increases venous return and lowers ICP. Elevate the head of the bed to greater than 30 degrees. Keep the neck midline to facilitate venous drainage from the head. Nursing care must pay close attention to changes in neurologic status, any change in vitals such as an increasingly erratic heart rate, development of bradycardia, accurate and equal intake and output when having diuresis, and maintenance of proper blood pressure.

- **Option B:** Osmotic agents can be used to create an osmotic gradient across blood thereby drawing fluid intravascularly and decreasing cerebral edema. Mannitol was the primary agent used at doses of 0.25 to 1 g/kg body weight and is thought to exert its greatest benefit by decreasing blood viscosity and to a lesser extent by decreasing blood volume. Side effects of mannitol use are eventual osmotic diuresis and dehydration as well as renal injury if serum osmolality exceeds 320 mOsm.
- **Option C:** Hypercarbia lowers serum pH and can increase cerebral blood flow contributing to rising ICP, hence hyperventilation to lower pCO₂ to around 30 mm Hg can be transiently used.
- **Option D:** If nursing measures prove ineffective notify the physician, who may prescribe pentobarbital. Pentobarbital is a drug within the barbiturate class that works primarily on the central nervous system. Common off-label uses are for control of intracranial pressure in patients with severe brain injuries, cerebral ischemia, and those receiving treatment for Reye syndrome.

25. 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.

26. The most reliable index to determine the respiratory status of a client is to:

- A. Observe the chest rising and falling.
- B. Observe the skin and mucous membrane color.
- C. Listen and feel the air movement.
- D. Determine the presence of a femoral pulse.

Correct Answer: C. Listen and feel the air movement.

To check for breathing, the nurse places her ear and cheek next to the client's mouth and nose to listen and feel for air movement. During the inspection, the examiner should pay attention to the pattern of breathing: thoracic breathing, thoracoabdominal breathing, coastal markings, and use of accessory breathing muscles. The use of accessory breathing muscles (i.e., scalenes, sternocleidomastoid muscle, intercostal muscles) could point to excessive breathing effort caused by pathologies.

- **Option A:** The chest rising and falling is not conclusive of a patent airway. The position of the patient should also be noted, patients with extreme pulmonary dysfunction will often sit up-right, and in distress, they assume the tripod position (leaning forward, resting their hands on their knees).
- **Option B:** Observing skin color is not an accurate assessment of respiratory status. The body habitus of the patient could provide information regarding chest compliance, especially in the case of severely obese patients where chest mobility and compliance are reduced due to added weight from adipose tissue.
- **Option D:** Checking the femoral pulse is not an assessment of respiratory status. Palpation should focus on detecting abnormalities like masses or bony crepitus. During palpation the examiner can evaluate tactile fremitus: the examiner will place both of his hands on the patient's back, medial to the shoulder blades, and ask the patient to say "ninety-nine."

27. A 75-year-old male patient with a history of right-sided hemiplegia due to a recent stroke is learning how to use a cane under the guidance of the nurse. The patient expresses a desire to be as independent as possible in mobility. During the teaching session, the nurse observes the patient's ability to use the cane correctly. Which of the following behaviors, if demonstrated by the patient, indicates that the teaching was effective?

- A. The client holds the cane with his right hand, moves the cane forward followed by the right leg, and then moves the left leg.
- B. The client holds the cane with his right hand, moves the cane forward followed by his left leg, and then moves the right leg.
- C. The client holds the cane with his left hand, moves the cane forward followed by the right leg, and then moves the left leg.
- D. The client holds the cane with his left hand, moves the cane forward followed by his left leg, and then moves the right leg.

Correct Answer: C. The client holds the cane with his left hand, moves the cane forward followed by the right leg, and then moves the left leg.

The cane acts as a support and aids in weight-bearing for the weaker right leg.

- **Option A:** The client should hold the cane with his left hand because this side provides more stable support than the injured side.
- **Option B:** The right side should act as the weight-bearing side because the left side is weaker.
- **Option D:** Always move the affected leg first; in this case, the right leg.

28. Dr. Kennedy prescribes glipizide (Glucotrol), an oral antidiabetic agent, for a male client with type 2 diabetes mellitus who has been having trouble controlling the blood glucose level through diet and exercise. Which medication instruction should the nurse provide?

- A. "Be sure to take glipizide 30 minutes before meals."
- B. "Glipizide may cause a low serum sodium level, so make sure you have your sodium level checked monthly."
- C. "You won't need to check your blood glucose level after you start taking glipizide."
- D. "Take glipizide after a meal to prevent heartburn."

Correct Answer: A. "Be sure to take glipizide 30 minutes before meals."

The client should take glipizide twice a day, 30 minutes before a meal, because food decreases its absorption. The immediate release dosage form should be administered 30 minutes before meals to achieve the most significant reduction in postprandial hyperglycemia. Administration of the extended-release dosage form should be with breakfast or the first meal of the day. Practitioners should instruct patients to swallow the tablets whole and not to chew, split, or crush the tablets.

- **Option B:** The drug doesn't cause hyponatremia and therefore doesn't necessitate monthly serum sodium measurement. The primary adverse effects of glipizide include hypoglycemia and weight gain. The most common adverse reactions are gastrointestinal and include nausea and diarrhea. In rare cases, cholestatic jaundice may result from glipizide therapy, and this requires immediate discontinuation of the medication.
- **Option C:** The client must continue to monitor the blood glucose level during glipizide therapy. Monitor fasting plasma glucose and A1c at three months in patients taking glipizide. Some experts recommend monitoring liver enzymes and renal function in patients who are prescribed glipizide for more than two months.
- **Option D:** Glipizide is a second-generation sulfonylurea that is FDA-approved for the treatment of adults with diabetes mellitus type 2. Its use is as an adjunct to diet and exercise. It is usable in combination with metformin, a biguanide, to reach goal HbA1c in patients with not adequate metabolic control in 3 months, despite compliance with diet, exercise, and medication.

29. Which of the following is appropriate when there is a benzodiazepine overdose? Select all that apply.

- A. Administration of syrup of ipecac
- B. Gastric lavage

- C. Activated charcoal and a saline cathartic
- D. Hemodialysis
- E. Administration of Flumazenil

Correct Answer: B, C, & E.

Benzodiazepines are currently used to treat anxiety, seizures, withdrawal states, insomnia, agitation, and are commonly used for procedural sedation. Due to their many uses and addictive properties, benzodiazepines have been widely prescribed and abused since their development several decades ago.

- **Option A:** The administration of syrup of ipecac is contraindicated because of aspiration risks related to sedation. Ipecac, or syrup of ipecac (SOI), is a medication once used to induce vomiting. Its medical use has virtually vanished, and it is no longer recommended for routine use in toxic ingestion. The abuse of SOI as a purgative in eating disorders, however, is increasing.
- **Option B:** If ingestion is recent, the decontamination of the GI system is indicated. Gastric lavage is generally the best and most effective means of gastric decontamination. Occasionally, gastric lavage and administration of activated charcoal is indicated, but only if the patient is awake and potentially sensitive to benzodiazepines and if a large dose has been ingested within the last 1 to 2 hours.
- **Option C:** Activated charcoal and a saline cathartic may be administered to remove any remaining drug. Early administration of activated charcoal in patients able to protect their airway is only needed if there are coingestants.
- **Option D:** Hemodialysis is not useful in the treatment of benzodiazepine overdose. Forced diuresis and dialysis techniques are not indicated since they will not significantly accelerate the elimination of these agents.
- **Option E:** Flumazenil is a nonspecific competitive antagonist at the benzodiazepine receptor that can reverse benzodiazepine-induced sedation. Flumazenil can be used to acutely reverse the sedative effects of benzodiazepines, though this is normally done only in cases of extreme overdose or sedation.

30. Patellar reflex is being monitored for patients receiving magnesium sulfate therapy. When assessing the deep tendon reflex, which of the following grades pertains to diminished response?

- A. Grade 0
- B. Grade 1
- C. Grade 2
- D. Grade 4

Correct Answer: B. Grade 1

Grade 1 pertains to the sluggish or diminished response.

- **Option A:** Refers to no response.
- **Option C:** Refers to active or expected response.
- **Option D:** Refers to brisk, hyperactive, with intermittent or transient clonus.

31. Nurse Harry is providing cardiopulmonary resuscitation (CPR) to a child, age 4. the nurse should:

- A. Perform only two-person CPR
- B. Deliver 12 breaths/minute
- C. Place two fingers on the sternum, press down about 1.5 inches deep
- D. Use the heel of one hand for sternal compressions at least 2 inches deep

Correct Answer: D. Use the heel of one hand for sternal compressions

The nurse should use the heel of one hand at the center of the chest, then place the heel of the other hand on top of the first hand and lace fingers together and give 30 compressions that are about 2 inches deep. For a child, compress the chest at least one-third the depth of the chest. This may be less than two inches for small children but will be approximately two inches for larger children (4-5 cm).

- **Option A:** For a small child, a two-person rescue may be inappropriate. If the child does not respond and is not breathing (or if only gasping), have the second rescuer call 911/EMS and get an AED.
- **Option B:** For children, the compression to breath ratio is 15:2 for all age groups. If you cannot feel a pulse (or if you are unsure), begin CPR by doing 15 compressions followed by two breaths. If you can feel a pulse but the pulse rate is less than 60 beats per minute, you should begin CPR. This rate is too slow for a child.
- **Option C:** The nurse uses 2 fingers to give 30 quick compressions that are each about 1.5 inches deep appropriate for infants. Place 2 fingers just below that line on the breastbone and push down hard on the breastbone 1½ inches toward the backbone. Let the chest come back to its normal position after each compression. Compressions are done fast at a rate of 100 per minute.

32. The client who experienced an inhalation injury 6 hours ago has been wheezing. When the client is assessed, wheezes are no longer heard. What is the nurse's best action?

- A. Raise the head of the bed.
- B. Notify the emergency team.
- C. Loosen the dressings on the chest.
- D. Document the findings as the only action.

Correct Answer: B. Notify the emergency team.

Clients with severe inhalation injuries may sustain such progressive obstruction that they may lose the effective movement of air. When this occurs, wheezing is no longer heard and neither are breath sounds. The client requires the establishment of an emergency airway and the swelling usually precludes intubation.

- **Option A:** Raising the head of the bed would be not much help because of the obstructed airway. Airway protection should include considering early and preemptive intubation for patients with inhalation injury.
- **Option C:** Dressings may be loosened, but emergency intubation would still be needed. Airway edema may occur suddenly as edema worsens, and often, the upper airways develop injury and obstruction earliest, prior to the parenchymal injury.

- **Option D:** This is not a normal finding. There may be accessory muscle usage, tachypnea, cyanosis, stridor, and rhonchi/rales/wheezing. Findings of stridor or upper airway turbulence/noise are often a sign of impending airway compromise, and prompt intubation should be strongly considered.

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

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

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

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

- **Option A:** Prepregnant weight is usually achieved by 2 to 3 months after birth, not within the 6-week postpartum period. Through diet and regular exercise, it might be reasonable to lose up to 1 pound (0.5 kilogram) a week. It might take six months to one year to return to pre-pregnancy weight, whether breast-feeding or not.
- **Option B:** Weight loss from diuresis, diaphoresis, and bleeding is about 9 pounds. Most women lose about 13 pounds (5.9 kilograms) during childbirth, including the weight of the baby, placenta and amniotic fluid. During the first week after delivery, the woman will lose additional weight as she shed retained fluids — but the fat stored during pregnancy won't disappear on its own.
- **Option D:** Weight loss continues during breastfeeding since fat stores developed during pregnancy and extra calories consumed are used as part of the lactation process. If breastfeeding, wait until the baby is at least 2 months old and the milk supply has normalized before drastically cutting calories. Women who are exclusively breastfeeding need about 500 more calories per day than they did before pregnancy. Get these calories from healthy choices such as fruits, vegetables, whole grains, and lean protein. Breastfeeding makes the body burn calories which helps lose weight. If the woman is patient, she may be surprised at how much weight she may lose naturally while breastfeeding.

34. Which of the following symptoms should the nurse teach the client with unstable angina to report immediately to her physician?

- A. A change in the pattern of her pain.
- B. Pain during sex.
- C. Pain during an argument with her husband.

D. Pain during or after an activity such as lawn mowing.

Correct Answer: A. A change in the pattern of her pain

The client should report a change in the pattern of chest pain. It may indicate an increasing severity of CAD. This is important to note as these differences may indicate impending myocardial infarction, and ST-elevation myocardial infarction (STEMI) and should be evaluated expeditiously as the risk of morbidity and mortality are higher in this scenario versus stable angina.

- **Option B:** Patients will often present with chest pain, shortness of breath. The chest pain will often be described as pressure-like, although it is not necessarily limited to this description. Tightness, burning, sharp types of pain can be described. Often patients will report discomfort as opposed to actual pain.
- **Option C:** One distinguishing factor of unstable angina is that the pain may not completely resolve with these reported relieving factors. Also, many patients will already have coronary artery disease. This may be either established coronary artery disease or symptoms they have been experiencing for some time. These patients may have familiarity with the symptoms and may report an increase in episodes of chest pain that takes longer to resolve and an increase in the severity of symptoms.
- **Option D:** The pain will often radiate to the jaw or arms, both left and right sides can be affected. Constitutional symptoms such as nausea, vomiting, diaphoresis, dizziness, and palpitations may also be present. Exertion may worsen pain and rest can ease the pain. Nitroglycerin and aspirin administration may also improve the pain.

35. Linda is pacing the floor and appears extremely anxious. The duty nurse approaches in an attempt to alleviate Linda's anxiety. The most therapeutic question by the nurse would be?

- A. Would you like to watch TV?
- B. Would you like me to talk with you?
- C. Are you feeling upset now?
- D. Ignore the client.

Correct Answer: B. Would you like me to talk with you?

The nurse's presence may provide the client with support & a feeling of control. Maintain a calm, non-threatening manner while working with the client. Anxiety is contagious and may be transferred from health care provider to client or vice versa. The client develops a feeling of security in presence of a calm staff person. Remain with the client at all times when levels of anxiety are high (severe or panic); reassure the client of his or her safety and security. The client's safety is an utmost priority. A highly anxious client should not be left alone as his anxiety will escalate.

- **Option A:** Move the client to a quiet area with minimal stimuli such as a small room or seclusion area (dim lighting, few people, and so on.) Anxious behavior escalates by external stimuli. A smaller or secluded area enhances a sense of security as compared to a large area which can make the client feel lost and panicked.
- **Option C:** Establish and maintain a trusting relationship by listening to the client; displaying warmth, answering questions directly, offering unconditional acceptance; being available, and respecting the client's use of personal space. Therapeutic skills need to be directed toward putting the client at ease, because the nurse who is a stranger may pose a threat to the highly anxious client.

- **Option D:** Stay with the patient during panic attacks. Use short, simple directions. During a panic attack, the patient needs reassurance that he is not dying and the symptoms will resolve spontaneously. In anxiety, the client's ability to deal with abstractions or complexity is impaired.