

Kevin's Review - 35 NCLEX Practice Questions

1. A client arrives at the ER after slipping on a patch of ice and hitting her head. A CT scan of the head shows a collection of blood between the skull and dura mater. Which type of head injury does this finding suggest?

- A. Subdural hematoma
- B. Subarachnoid hemorrhage
- C. Epidural hematoma
- D. Contusion

Correct Answer: C. Epidural hematoma

An epidural hematoma occurs when blood collects between the skull and the dura mater. An epidural hematoma (EDH) is an extra-axial collection of blood within the potential space between the outer layer of the dura mater and the inner table of the skull. It is confined by the lateral sutures (especially the coronal sutures) where the dura inserts. It is a life-threatening condition, which may require immediate intervention and can be associated with significant morbidity and mortality if left untreated. Rapid diagnosis and evacuation are important for a good outcome.

- **Option A:** In a subdural hematoma, venous blood collects between the dura mater and the arachnoid mater. A subdural hematoma forms because of an accumulation of blood under the dura mater, one of the protective layers to the brain tissue under the calvarium. The understanding of subdural hematoma relies on the knowledge of neuroanatomical sheets covering the brain.
- **Option B:** In a subarachnoid hemorrhage, blood collects between the pia mater and arachnoid membrane. Subarachnoid hemorrhage is defined as blood between the arachnoid membrane and the pia membrane. Several factors compromise this syndrome. Most subarachnoid hemorrhages are traumatic in nature. Aneurysmal subarachnoid hemorrhage compromises a small portion of this patient population, but nevertheless is the most worrisome type of subarachnoid hemorrhage.
- **Option D:** A contusion is a bruise on the brain's surface. Contusions can progress and expand, and in many cases, other hemorrhagic contusions are present. Brain contusions have been attributed to bleeding from the continuous flow of injured microvessels during the initial traumatic episode. Hemorrhagic contusions overlie brain parenchyma with loss of function.

2. Which statement made by the family member caring for the client with a percutaneous gastrostomy tube indicates an understanding of the nurse's teaching?

- A. "I must flush the tube with water after feedings and clamp the tube."
- B. "I must check placement four times per day."
- C. "I will report to the doctor any signs of indigestion."
- D. "If my father is unable to swallow, I will discontinue the feeding and call the clinic."

Correct Answer: A. "I must flush the tube with water after feedings and clamp the tube."

The client's family member should be taught to flush the tube after each feeding and clamp the tube. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus.

- **Option B:** A dressing will be placed on the PEG site following the procedure. This dressing is usually removed after one or two days. After that you should clean the site once a day with diluted soap and water and keep the site dry between cleansings. No special dressing or covering is needed.
- **Option C:** The placement should be checked before feedings, and indigestion can occur with the PEG tube, just as it can occur with any client. Complications can occur with the PEG placement. Possible complications include pain at the PEG site, leakage of stomach contents around the tube site, and dislodgement or malfunction of the tube. Possible complications include infection of the PEG site, aspiration (inhalation of gastric contents into the lungs), bleeding and perforation (an unwanted hole in the bowel wall).
- **Option D:** Medications can be ordered for indigestion, but it is not a reason for alarm. A percutaneous endoscopic gastrostomy tube is used for clients who have experienced difficulty swallowing. The tube is inserted directly into the stomach and does not require swallowing.

3. A patient is scheduled for a magnetic resonance imaging (MRI) scan for suspected lung cancer. Which of the following is a contraindication to the study for this patient?

- A. The patient is allergic to shellfish.
- B. The patient has a pacemaker.
- C. The patient suffers from claustrophobia.
- D. The patient takes antipsychotic medication.

Correct Answer: B. The patient has a pacemaker.

The implanted pacemaker will interfere with the magnetic fields of the MRI scanner and may be deactivated by them. The strong static magnetic field (B0) of MRI scanners can attract and accelerate ferromagnetic objects toward the center of the machine and turn them into dangerous projectiles. This magnetic field can also displace implants or affect the function of devices such as pacemakers and pumps.

- **Option A:** Shellfish/iodine allergy is not a contraindication because the contrast used in MRI scanning is not iodine-based. MRI contrast agents are gadolinium chelates with different stability, viscosity, and osmolality. Gadolinium is a relatively very safe contrast; however, it rarely might cause allergic reactions in patients.
- **Option C:** Open MRI scanners and anti-anxiety medications are available for patients with claustrophobia. Claustrophobic patients might refuse to complete the MRI scan and need sedation. These patients need to be well informed about the MRI scan procedure. The recommendation is that a physician has a discussion with them about the details in advance. Using Larger and opener MRI systems might be helpful in claustrophobic patients.
- **Option D:** Psychiatric medication is not a contraindication to MRI scanning. Patients who are unable to be still or obey breathing instructions in the scanner need special attention. Some patients in pain might move during the procedure, which degrades the quality of the images, restrict the interpretation, and decrease the accuracy of the report. Some MRI sequences need to be obtained while patients hold their breath and lie motionless.

4. Which of the following arteries primarily feeds the anterior wall of the heart?

- A. Circumflex artery
- B. Internal mammary artery
- C. Left anterior descending artery
- D. Right coronary artery

Correct Answer: C. Left anterior descending artery

The left anterior descending artery is the primary source of blood for the anterior wall of the heart. The left anterior descending artery (LAD) supplies the anterior two-thirds of the septum. The LAD is one of two major branches of the LMCA, with the other being the left circumflex (LCx) coronary arteries. Combined, these two supply blood to the left atrium and left ventricle.

- **Option A:** The circumflex artery is responsible for blood supply to the left atrium and the posterior-lateral aspect of the left ventricle while the LAD supplies blood to the anterior portion of the left ventricle. Other small branches of the coronary arteries are the obtuse marginal artery (OMA), diagonals, and septal perforator (SP).
- **Option B:** The circumflex artery supplies the lateral wall, the internal mammary artery supplies the mammary, and the right coronary artery supplies the inferior wall of the heart. The LMCA supplies blood to the left side of the heart. The LAD provides blood to the anterior ventricular septum and the greater portion of the anterior portion of the left ventricle.
- **Option D:** The RCA emerges from the anterior ascending aorta and supplies blood primarily to the right atrium, right ventricle. The sinoatrial nodal artery is a branch of the RCA that supplies the SA node. The RCA also supplies the AV node via a septal perforating branch in 90% of people.

5. What would be the best response to the client's repeated complaints of pain:

- A. "I know the feeling is real tests revealed negative results."
- B. "I think you're exaggerating things a little bit."
- C. "Try to forget this feeling and have activities to take it off your mind."
- D. "So tell me more about the pain."

Correct Answer: A. "I know the feeling is real tests revealed negative results."

Shows empathy and offers information. Provide accommodation for the client and make them more comfortable (ie., pillows, temperature, positioning, etc.) This can help the client feel accepted and develop rapport and trust. This can allow the client to feel more comfortable and express their feelings and emotions more readily to the healthcare team.

- **Option B:** This is a demeaning statement. Encourage behavior modification such as praising the client and offering more attention when symptoms improve. Change the focus from what's wrong to what's right. Helps the client feel accomplished and more positive about improvements in health condition instead of focusing on the symptoms.
- **Option C:** This belittles the client's feelings. Provide education about fears or actual medical conditions. Helps the client understand the condition in a more realistic light and helps alleviate fear and anxiety about a particular health concern.
- **Option D:** Giving undue attention to the physical symptom reinforces the complaint. Discuss symptoms with the client and when they began, what makes them better or worse and how they have been managing these symptoms. This helps make a more definitive diagnosis and helps determine how to best treat the client. Helping the client determine the etiology of symptoms helps

them to recognize and avoid situations that make symptoms worse.

6. The client with a dressing covering the neck is experiencing some respiratory difficulty. What is the nurse's best first action?

- A. Administer oxygen.
- B. Loosen the dressing.
- C. Notify the emergency team.
- D. Document the observation as the only action.

Correct Answer: B. Loosen the dressing.

Respiratory difficulty can arise from external pressure. The first action in this situation would be to loosen the dressing and then reassess the client's respiratory status. Generally, it is recommended that pressure should be maintained between 20 and 30 mm Hg, which is above capillary pressure but less than what would diminish peripheral blood circulation.

- **Option A:** It is unnecessary to administer oxygen. Wearing pressure garments is uncomfortable and challenging; problems with movement, appearance, fit, comfort, swelling of extremities, rashes, and blistering are common; consequently, low compliance with PGT is to be expected.
- **Option C:** The nurse may intervene first. However, monitoring of pressure exerted by pressure garments is currently difficult and time-consuming, and not routinely done and currently, the optimal pressure magnitude for PGT remains unsolved.
- **Option D:** The nurse may loosen the dressing to help the client breathe. Recent evidence suggests that pressure garment therapy is effective for the prevention and/or treatment of abnormal scarring after burn injury but that the clinical benefit is restricted to those patients with moderate or severe scarring.

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

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

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

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

- **Option B:** Acute glomerulonephritis is defined as inflammation and subsequent damage of the glomeruli leading to hematuria, proteinuria, and azotemia; it may be caused by primary renal disease or systemic conditions. The diagnosis of acute glomerulonephritis is usually made on the

basis of urinary findings, especially the presence of red blood cell casts.

- **Option C:** As the glomerular filtration rate (GFR) is decreased, symptoms like edema and hypertension occur, majorly due to the subsequent salt and water retention caused by the activation of the renin-angiotensin-aldosterone system.
- **Option D:** Most intrinsic causes of acute glomerulonephritis fall under the classification of nephritic syndromes. Nephritic syndromes are classified by hematuria, proteinuria, and red blood cell casts with hypertension and decreased urine production.

8. A client arrives at a prenatal clinic for the first prenatal assessment. The client tells a nurse that the first day of her last menstrual period was September 19th, 2013. Using Naegele's rule, the nurse determines the estimated date of confinement as:

- A. July 26, 2013
- B. June 12, 2014
- C. June 26, 2014
- D. July 12, 2014

Correct Answer: C. June 26, 2014.

Accurate use of Naegele's rule requires that the woman has a regular 28-day menstrual cycle. Add 7 days to the first day of the last menstrual period, subtract three months, and then add one year to that date.

- **Option A:** An average pregnancy lasts 280 days from the first day of the last menstrual period (LMP) or 266 days after conception. Historically, an accurate LMP is the best estimator to determine the due date.
- **Option B:** Naegele's rule, derived from a German obstetrician, subtracts 3 months and adds 7 days to calculate the estimated due date (EDD). It is prudent for the obstetrician to get a detailed menstrual history, including duration, flow, previous menstrual periods, and hormonal contraceptives. These factors are used to determine the length of her cycles and ovulation period.
- **Option D:** There are several fallacies with Naegele's rule. First, a woman may not accurately recall the first day of her menstrual cycle. Second, this method assumes a woman's cycle is exactly 28 days, with ovulation occurring at day 14, however, it does not consider menstrual cycles with shorter or longer durations. Third, there are small variations in the duration between fertilization and blastocyst implantation. Last, this method cannot differentiate between menstrual bleeding and early pregnancy bleeding.

9. In the high-acuity setting of a respiratory intensive care unit, a vigilant nurse is closely monitoring a client who has been diagnosed with severe pneumonia leading to ineffective airway clearance. The client, who is receiving mechanical ventilation, is at risk of accumulating secretions that could obstruct the airway and compromise respiratory function. The nurse understands the critical importance of timely and appropriate suctioning to maintain airway patency. Which clinical indicator should the nurse prioritize to most accurately determine the immediate need for suctioning in this client?

- A. Oxygen saturation
- B. Respiratory rate
- C. Breath sounds
- D. Arterial blood gases
- E. Client's level of consciousness
- F. Visible secretions in the artificial airway

Correct Answer: C. Breath sounds

Adventitious breath sounds, such as crackles or wheezes, can indicate secretions in the airways and are a direct sign that the client may benefit from suctioning. Listening to breath sounds provides specific information about airway clearance and is a primary assessment tool for respiratory status.

- **Option A:** While a drop in oxygen saturation is an important indicator of respiratory distress, it is a late sign of airway obstruction. It may not specifically indicate the need for suctioning as various other factors can affect oxygen saturation.
- **Option B:** An increased respiratory rate can indicate respiratory distress, but it is not specific enough to determine the need for suctioning. Like oxygen saturation, many conditions can lead to tachypnea.
- **Option D:** Arterial blood gases (ABGs) provide comprehensive information about oxygenation, ventilation, and acid-base balance but are an invasive test and not a practical tool for making immediate decisions about suctioning.
- **Option E:** A decrease in the client's level of consciousness can indicate hypoxia or other complications but is not a specific indicator of the need for suctioning.
- **Option F:** Visible secretions in the artificial airway are a clear sign that suctioning is needed; however, secretions may be present deeper in the airways and not immediately visible.

10. The nurse is caring for an elderly woman who has had a fractured hip repaired. In the first few days following the surgical repair, which of the following nursing measures will best facilitate the resumption of activities for this client?

- A. Arranging for the wheelchair
- B. Asking her family to visit
- C. Assisting her to sit out of bed in a chair qid
- D. Encouraging the use of an overhead trapeze

Correct Answer: D. Encouraging the use of an overhead trapeze.

Exercise is important to keep the joints and muscles functioning and to prevent secondary complications. Using the overhead trapeze prevents hazards of immobility by permitting movement in bed and strengthening of the upper extremities in preparation for ambulation. Facilitates movement during hygiene or skincare and linen changes; reduces the discomfort of remaining flat in bed. "Post position" involves placing the uninjured foot flat on the bed with the knee bent while grasping the trapeze and lifting the body off the bed.

- **Option A:** Sitting in a wheelchair would require too great hip flexion initially. Place in supine position periodically if possible, when traction is used to stabilize lower limb fractures. Reduces the

risk of flexion contracture of the hip.

- **Option B:** Asking her family to visit would not facilitate the resumption of activities. Provide footboard, wrist splints, trochanter, or hand rolls as appropriate. Useful in maintaining a functional position of extremities, hands, and feet, and preventing complications (contractures, foot drop).
- **Option C:** Sitting in a chair would cause too much hip flexion. The client initially needs to be in a low Fowler's position or taking a few steps (as ordered) with the aid of a walker. Encourage the use of isometric exercises starting with the unaffected limb. Isometrics contract muscles without bending joints or moving limbs and help maintain muscle strength and mass. Note: These exercises are contraindicated while acute bleeding and edema are present.

11. Which of the following can lead to infertility in adult males?

- A. German measles
- B. Orchitis
- C. Chickenpox
- D. Rubella

Correct Answer: B. Orchitis

Orchitis is a complication that may accompany mumps in adult males. This condition is characterized by unilateral inflammation of one of the testes which can lead to atrophy of the affected testis. About 20-30% of males who get mumps after puberty may develop this complication.

- **Option A:** Since rubella infection is extremely dangerous for unborn babies, women of childbearing age are advised to undergo rubella immunity testing before trying to conceive. If immunity cannot be established, they are asked to be vaccinated. Before infertility treatment, doctors will advise to vaccinate for rubella due to the harmful effect it has on the unborn baby. It does not have an effect on the fertility of men.
- **Option C:** Chickenpox can affect male fertility, but typically only for a short time during and after the viral infection. Sperm production and fertility should return to normal after the viral infection subsides and testicular inflammation and/or infection passes.
- **Option D:** German measles, also called rubella, does not affect a man's fertility. However, in a woman, pregnancy should be delayed for a period of 28 days after the mother is vaccinated against rubella. Since rubella causes a range of birth defects in babies, fertility specialists are extremely cautious about rubella immunity testing and vaccinating before they start the fertility treatment.

12. Amphetamines are included in the category of drugs of abuse because of their ability to:

- A. Cause nervousness
- B. Decrease weight
- C. Raise blood pressure
- D. Enhance performance

Correct Answer: D. Enhance performance

Drugs that produce a desired effect, such as feelings of euphoria and improved performance, tend to be overused and abused. Nervousness, decreased weight, and increased blood pressure are all effects of amphetamine. However, they are considered drugs of abuse because of their ability to enhance performance and produce a euphoric effect.

- **Option A:** Amphetamine is FDA-approved for the treatment of attention-deficit/hyperactivity disorder (ADHD) and narcolepsy. It has indications as a first-line agent for ADHD in adults and children six years of age and older. Amphetamine is also a second-line agent for the treatment of narcolepsy.
- **Option B:** Amphetamine is a central nervous (CNS) system stimulant that functions by increasing the amounts of dopamine, norepinephrine, and serotonin (to a lesser extent) in the synaptic cleft through a variety of mechanisms. Amphetamine enters the presynaptic axon terminal through diffusion or uptake by the monoamine transporters DAT, NET, and SERT.
- **Option C:** Once inside the presynaptic terminal, amphetamine increases the amounts of monoamine neurotransmitters in the cytosol through the inhibition of vesicular monoamine transporter 2 (VMAT2) as well as through disruption of the electrochemical gradients necessary for vesicular transporter function. Amphetamine also inhibits the metabolism of monoamine neurotransmitters by inhibiting monoamine oxidase (MAO). At the same time, amphetamine stimulates the intracellular receptor TAAR1, which induces internalization or transporter reversal of DAT.

13. The nurse is teaching a client with polycythemia vera about potential complications from this disease. Which manifestations would the nurse include in the client's teaching plan? Select all that apply.

- A. Hearing loss
- B. Visual disturbance
- C. Headache
- D. Orthopnea
- E. Gout
- F. Weight loss

Correct Answers: B, C, D, E.

Polycythemia vera, a condition in which too many RBCs are produced in the blood serum, can lead to an increase in hematocrit and hypervolemia, hyperviscosity, and hypertension. Subsequently, the client can experience dizziness, tinnitus, visual disturbances, headaches, or a feeling of fullness in the head. The client may also experience cardiovascular symptoms such as heart failure (shortness of breath and orthopnea) and increased clotting time or symptoms of an increased uric acid level such as painful swollen joints (usually the big toe).

- **Option A:** Hearing loss is a symptom of polycythemia vera, not a complication. Polycythemia Vera (PV) is a chronic myeloproliferative neoplasm which is characterized by clonal proliferation causing the accumulation of morphologically normal red and white blood cells, platelets, and their precursors. Bilateral or unilateral sensorineural hearing loss, acute hearing loss, and vertigo may be the first presenting findings of PV.
- **Option B:** Isolated monocular blindness as the presenting feature of polycythemia has been presented only four times indicating the rarity of presentation. Repeated occlusions in the same eye were postulated to be due to hyperviscosity. The most interesting feature was the presence of

ocular pain and congestion before both episodes of monocular blindness indicating the severity of ischemia.

- **Option C:** As polycythemia vera is a myeloproliferative syndrome, it is based on an autonomic increase in the proliferation of all hematopoietic cells—mostly of erythropoiesis. An increase in blood viscosity induces disturbed microcirculation, resulting in headaches with clinical symptoms.
- **Option D:** Blood carries oxygen around the body. When PV slows blood flow, it's hard for oxygen to reach the organs. PV treatments can improve blood flow and oxygen transport to prevent these symptoms.
- **Option E:** The high turnover of red blood cells in people with PV can raise the amount of uric acid in your blood, which can cause gout, a painful joint inflammation. Gout often affects the big toe, but it may strike other joints as well.
- **Option F:** Weight loss is not manifestations associated with polycythemia vera. Many people who have PV will develop an enlarged spleen. Your spleen filters your blood, so when you have polycythemia vera, the excess cells tend to collect in that organ. Symptoms of an enlarged spleen include discomfort, pain or fullness in the upper left side of the abdomen, indigestion, and a loss of appetite.

14. An intoxicated client comes into the emergency unit with uncooperative behavior, mild confusion, and slurred speech. The client is unable to provide a good history but he verbalizes that he has been drinking a lot. Which of the following is a priority action of the nurse?

- A. Administer IV fluid incorporated with Vitamin B1 as ordered
- B. Administer Naloxone (Narcan) 4 mg as ordered
- C. Contact the family to get information about the client
- D. Obtain an order for the determination of blood alcohol level

Correct Answer: A. Administer IV fluid incorporated with Vitamin B1 as ordered.

The client has symptoms of alcohol abuse and there is a risk for Wernicke syndrome, which is caused by a deficiency in Vitamin B. Thiamine deficiency (vitamin B1) is common in patients with alcohol dependence. Cognitive impairments may be an early consequence of thiamine deficiency. Wernicke's encephalopathy is underdiagnosed and undertreated.

- **Option B:** Multiple drug abuse is not uncommon; however, there is currently nothing to suggest an opiate overdose that requires the administration of naloxone. Naloxone is indicated for the treatment of opioid toxicity, specifically to reverse respiratory depression from opioid use. It is useful in accidental or intentional overdose and acute or chronic toxicity.
- **Option C:** Teens and young adults are at higher risk for binge drinking, which can cause alcohol poisoning. Binge drinking is a pattern of drinking that raises the blood alcohol level within a short period of time. Though it varies from person to person, binge drinking is usually defined as four drinks for women and five drinks for men in a two-hour period.
- **Option D:** Additional information or the results of the blood alcohol testing are part of the management but should not delay the immediate treatment. A blood alcohol test may be used to find out if the patient has alcohol poisoning, a life-threatening condition that happens when the blood alcohol level gets very high. Alcohol poisoning can seriously affect basic body functions, including breathing, heart rate, and temperature.

15. Which diet is associated with an increased risk of colorectal cancer?

- A. High protein, simple carbohydrates
- B. High fat, refined carbohydrates
- C. Low carbohydrates, complex proteins
- D. Low protein, complex carbohydrates

Correct Answer: B. High fat, refined carbohydrates

- Option B: A diet that is high in fat and refined carbohydrates increases the risk of colorectal cancer. High-fat content results in an increase in fecal bile acids, which facilitate carcinogenic changes. Refined carbohydrates increase the transit time of food through the gastrointestinal tract and increase the exposure time of the intestinal mucosa to cancer-causing substances.

16. All of the following nursing interventions are correct when using the Z-track method of drug injection except:

- A. Prepare the injection site with alcohol.
- B. Use a needle that's at least 1" long.
- C. Aspirate for blood before injection.
- D. Rub the site vigorously after the injection to promote absorption.

Correct Answer: D. Rub the site vigorously after the injection to promote absorption

The Z-track method is an I.M. injection technique in which the patient's skin is pulled in such a way that the needle track is sealed off after the injection. This procedure seals medication deep into the muscle, thereby minimizing skin staining and irritation. Rubbing the injection site is contraindicated because it may cause the medication to extravasate into the skin.

- **Option A:** Clean the injection site with an alcohol pad to minimize the possibility of infection. Allow the area to air dry for a few minutes. The Z-track method is not often recommended but can be particularly useful with medication that must be absorbed by muscles to work. It also helps to prevent the medication from seeping into the subcutaneous tissue and ensures a full dosage.
- **Option B:** In an adult, the most commonly used needles are one inch or one and a half inches long, and 22 to 25 gauge thick. Smaller needles are typically used when injecting a child. Some medications are dark-colored and can cause staining of the skin. If this is a side effect of the medication you will be taking, the doctor may recommend using this technique to prevent injection site discoloration or lesions.
- **Option C:** Use one hand to pull downward on your skin and fatty tissue. Hold it firmly about an inch away (2.54 cm) from the muscle. On the other hand, hold the needle at a 90-degree angle and insert it quickly and deeply enough to penetrate your muscle. If there is no blood in the syringe, push on the plunger to inject the medication slowly into the muscle.

17. A nurse is monitoring a client who is taking carvedilol (Coreg CR). Which of the following assessment made by the nurse would warrant a possible complication with the use of this medication?

- A. Baseline blood pressure of 160/100 mm hg followed by a blood pressure of 120/70 mm hg after 3 doses.
- B. Baseline heart rate of 97 bpm followed by a heart rate of 62 bpm after 3 doses.
- C. Complaints of nightmares and insomnia.
- D. Complaints of dyspnea.

Correct Answer: D. Complaints of dyspnea.

A complaint of dyspnea is a sign of bronchospasm which is one of the serious complications of beta-blockers.

- **Options A & B:** The following show a decrease in blood pressure and heart rate which are expected in this therapy.
- **Option C:** Complaints of nightmares and insomnia is a side effect of this medication.

18. A patient being seen in the emergency department immediately after being sexually assaulted appears calm and controlled. The nurse analyzes this behavior as indicating which defense mechanism?

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

Correct Answer: A. Denial

Denial is the refusal to admit to a painful reality and maybe a response by a victim of sexual abuse. In this case, the patient is not acknowledging the trauma of the assault either verbally or nonverbally. If a situation is just too much to handle, the person may respond by refusing to perceive it or by denying that it exists.

- **Option B:** Projection is transferring one's internal feelings, thoughts, and unacceptable ideas and traits to someone else. Projection is a psychological defense mechanism proposed by Anna Freud in which an individual attributes unwanted thoughts, feelings, and motives onto another person.
- **Option C:** Rationalization is justifying the unacceptable attributes of oneself. Rationalization is a defense mechanism proposed by Anna Freud involving a cognitive distortion of "the facts" to make an event or an impulse less threatening.
- **Option D:** Intellectualization is the excessive use of abstract thinking or generalizations to decrease painful thinking. In psychology, this behavior pattern is referred to as intellectualization, a defense mechanism, which according to Freud involves engrossing oneself so deeply in the reasoning aspect of a situation that you completely disregard the emotional aspect that is involved.

19. The clinic nurse provides instructions to a client receiving an antineoplastic medication. When implementing the plan, the nurse tells the client to?

- A. To consult with health care providers before receiving immunization.
- B. To avoid hot foods and high fiber-rich foods.

- C. To take acetylsalicylic acid as needed for headache.
- D. To drink beverages containing alcohol in moderate amount during the evening.

Correct Answer: A. To consult with health care providers before receiving immunization.

Because antineoplastic medications lower the resistance of the body, clients must be informed not to received immunizations without a health care provider's approval.

- **Option B:** Diarrhea as one of the common signs of antineoplastic medication needs to avoid spicy and high-fiber foods which can increase peristalsis.
- **Option C:** Clients need to avoid aspirin to minimize the risk of bleeding.
- **Option D:** Clients need to avoid alcohol to minimize the risk of toxicity.

20. What type of milk is present in the breasts 7 to 10 days PP?

- A. Colostrum
- B. Transitional milk
- C. Mature milk
- D. Hind milk

Correct Answer: B. Transitional milk

Transitional milk comes after colostrum and usually lasts until 2 weeks PP. When breastfeeding mothers talk about their milk coming in, they are referring to the onset of production of transitional milk, the creamy milk that immediately follows colostrum. Transitional milk is produced anywhere from about two to five days after birth until ten to fourteen days after birth.

- **Option A:** Alveolar cells of the breast begin to secrete colostrum in the twelfth to sixteenth week of pregnancy. This is called lactogenesis I. Colostrum is a thick, yellowish-white fluid which can be expressed from the breast by the third trimester. Milk secretion is suppressed during pregnancy by estrogen and progesterone. Colostrum has more protein and fewer carbohydrates and fat than mature breast milk. Colostrum is rich in secretory immunoglobulin A (IgA), which helps to protect the infant from infection. Colostrum also helps to establish a normal gut microbiome in the infant. The bowel is considered sterile at birth.
- **Option C:** The breast milk starts becoming mature after around two weeks, but it won't be fully mature milk until the baby's about four weeks old. From now on its composition will be broadly stable – it certainly won't go through dramatic changes like in the first month. Soon after it reaches maturity, the milk starts to contain higher quantities of some components that protect the baby against bacterial and viral infections. It's probably no coincidence that this stage of breast milk production coincides with the time she starts grabbing objects and putting them in her mouth.
- **Option D:** Hindmilk is the high-fat, high-calorie breast milk that the baby gets toward the end of a feeding. It's richer, thicker, and creamier than foremilk, the breast milk that the baby gets when they first start to breastfeed. The color of hindmilk is creamy white. Hindmilk satisfies the baby's hunger and makes the baby feel full and sleepy. It also helps the baby feel fuller longer.

21. A client who has ulcerative colitis has persistent diarrhea. He is thin and has lost 12 pounds since the exacerbation of his ulcerative colitis. The nurse should anticipate that the physician will order which of the following treatment approaches to help the client meet his nutritional needs?

- A. Initiate continuous enteral feedings.
- B. Encourage a high protein, high-calorie diet.
- C. Implement total parenteral nutrition.
- D. Provide six small meals a day.

Correct Answer: C. Implement total parenteral nutrition.

Food will be withheld from the client with severe symptoms of ulcerative colitis to rest the bowel. To maintain the client's nutritional status, the client will be started on TPN. Dietary measures depend on the patient's condition (if disease is mild, the patient may do well on a low-residue, low-fat diet high in protein and calories with lactose restriction). In moderate disease, elemental enteral products may be given to provide nutrition without overstimulating the bowel. Patient with toxic colitis is NPO and placed on parenteral nutrition.

- **Option A:** Enteral feedings do not allow the bowel to rest. Recommend rest before meals. This quiets peristalsis and increases available energy for eating. Encourage bed rest and limited activity during the acute phase of illness. Decreasing metabolic needs aids in preventing caloric depletion and conserves energy.
- **Option B:** A high-calorie, high-protein diet will worsen the client's symptoms. Avoid or limit foods that might cause or exacerbate abdominal cramping, flatulence (milk products, foods high in fiber or fat, alcohol, caffeinated beverages, chocolate, peppermint, tomatoes, orange juice). Individual tolerance varies, depending on the stage of disease and area of bowel affected.
- **Option D:** Dividing the diet into 6 small meals does not allow the bowel to rest. Keep patient NPO as indicated. Resting the bowel decreases peristalsis and diarrhea, limiting malabsorption and loss of nutrients.

22. The parents of a two (2)-year-old boy arrive at a hospital for a visit. The child is in the playroom when the parents arrive. When the parents enter the playroom, the child does not readily approach the parents. The nurse interprets this behavior as indicating that:

- A. The child is withdrawn
- B. The child is self-centered
- C. The child has adjusted to the hospitalized setting
- D. This is a normal pattern

Correct Answer: D. This is a normal pattern.

The phases through which young children progress when separated from their parents include protest, despair, and denial or detachment. In the stage of despair, the child may not approach them readily or may cling to a parent.

- **Option A:** In the stage of protest, when the parents return, the child readily goes to them. The protest phase begins immediately upon separation and lasts up to weeks on end. It is indicated by outward signs of distress such as crying, tantrum behavior, and searching for the return of the parent. Protest decreases during the despair phase, and children become withdrawn and helpless.
- **Option B:** While it may be frustrating to have children who appear to be self-centered, unrelenting, and impulsive, it can be comforting to learn that these traits are typical of the development of all

children. When children are listened to and their feelings are accepted, they are more likely to respond to other people with understanding and compassion.

- **Option C:** In denial or detachment, when the parents return, the child becomes cheerful, interested in the environment and new persons (seemingly unaware of the lost parents), friendly with the staff, and interested in developing superficial relationships.

23. A client with group AB blood whose husband has group O has just given birth. The major sign of ABO blood incompatibility in the neonate is which complication or test result?

- A. Negative Coombs test
- B. Bleeding from the nose and ear
- C. Jaundice after the first 24 hours of life
- D. Jaundice within the first 24 hours of life

Correct Answer: D. Jaundice within the first 24 hours of life.

- **Option D:** The neonate with ABO blood incompatibility with its mother will have jaundice (pathologic) within the first 24 hours of life. The neonate would have a positive Coombs test result.

24. Nurse Amy is aware that the client is at highest risk for suicide?

- A. One who appears depressed frequently thinks of dying and gives away all personal possessions.
- B. One who plans a violent death and has the means readily available.
- C. One who tells others that he or she might do something if life doesn't get better soon.
- D. One who talks about wanting to die.

Correct Answer: B. One who plans a violent death and has the means readily available.

The client at highest risk for suicide is one who plans a violent death (for example, by gunshot, jumping off a bridge, or hanging), has a specific plan (for example, after the spouse leaves for work), and has the means readily available (for example, a rifle hidden in the garage). Several suicide-related demographic factors often occur in the same person. For example, if a male police officer with major depression and a significant problem with alcohol commits suicide using his service revolver (which, unfortunately, happens not infrequently), 5 risk factors are involved: sex, occupation, depression, alcohol, and gun availability.

- **Option A:** A host of thoughts and behaviors are associated with self-destructive acts. Although many assume that people who talk about suicide will not follow through with it, the opposite is true; a threat of suicide can lead to the completed act, and suicidal ideation is highly correlated with suicidal behaviors.
- **Option C:** They are without hope and therefore cannot foresee things ever improving; they also view themselves as helpless in 2 ways: (1) they cannot help themselves, and all their efforts to liberate themselves from the sea of depression in which they are drowning are to no avail; and (2) no one else can help them.
- **Option D:** A client who talks about wanting to die or attempting suicide is considered at a lower risk for suicide because this behavior typically serves to alert others that the client is contemplating suicide and wishes to be helped. Determine whether the person has any thoughts of hurting him or

herself. Suicidal ideation is highly linked to completed suicide. Some inexperienced clinicians have difficulty asking this question. They fear the inquiry may be too intrusive or that they may provide the person with an idea of suicide. In reality, patients appreciate the question as evidence of the clinician's concern. A positive response requires further inquiry.

25. A client with tonic-clonic seizure is receiving phenobarbital (Luminal) and valproic acid (Depakene). The nurse tells the client that:

- A. Valproic acid decreases phenobarbital metabolism.
- B. Valproic acid increases phenobarbital metabolism.
- C. There is no interaction between the two.
- D. Increase the dosage of the two medications.

Correct Answer: A. Valproic acid decreases phenobarbital metabolism.

Valproic acid appears to decrease phenobarbital metabolism, thus there is increased levels of phenobarbital in the body. Therefore, phenobarbital blood levels should be monitored and appropriate dosage adjustments made as indicated.

26. Which of the following conditions is linked to more than 50% of clients with abdominal aortic aneurysms?

- A. DM
- B. HPN
- C. PVD
- D. Syphilis

Correct Answer: B. HPN

Continuous pressure on the vessel walls from hypertension causes the walls to weaken and an aneurysm to occur. The association between hypertension and AAA could potentially be confounded by other risk factors because hypertension is more common among persons with overweight and obesity, less physical activity, who smoke and who have unhealthy diets.

- **Option A:** Diabetes mellitus doesn't have a direct link to an aneurysm. Diabetes mellitus (DM) is a strong cardiovascular risk factor; however, multiple epidemiological studies have confirmed that a negative relationship exists between DM and abdominal aortic aneurysm (AAA) presence, growth, and rupture. Arteries from patients with DM are often harder and more calcified than those from patients without DM; however, increased vessel wall calcification alone does not appear to explain the reduced rate of aortic expansion seen in diabetic patients.
- **Option C:** Atherosclerotic changes can occur with peripheral vascular diseases and are linked to aneurysms, but the link isn't as strong as it is with hypertension.
- **Option D:** Only 1% of clients with syphilis experience an aneurysm. Classically, syphilitic aneurysms occur in 90% of cases on the thoracic aorta, and in 10% in the abdominal aorta [3, 7–9]. Infection of the aortic wall develops during the secondary or bacteremic phase of syphilis, having a latent period from infection until the clinical presentation ranging from 5 to 50 years.

27. The licensed vocational nurse may not assume the primary care for a client:

- A. In the fourth stage of labor
- B. Two days post-appendectomy
- C. With a venous access device
- D. With bipolar disorder

Correct Answer: C. With a venous access device.

- Option C: Only a trained nurse with experience and background in caring for a venous access device can assume the primary care of the client.
- Options A, B, and D: The licensed vocational nurse may care for the client in labor, the client post-operative client, and the client with bipolar disorder.

28. Which of the following is the reason to perform a spinal tap on a client newly diagnosed with leukemia?

- A. To assess for central nervous system infiltration
- B. To aid in classification of the leukemia
- C. To rule out meningitis
- D. To decrease intracranial pressure

Correct Answer: A. To assess for central nervous system infiltration

- **Option A:** A spinal tap is performed to check if leukemia has infiltrated into the central nervous system specifically to the cerebrospinal fluid (CSF).
- **Options B and D:** It wouldn't be done to decrease ICP nor does it aid in the classification of leukemia. Spinal taps can result in brain stem herniation in cases of ICP.
- **Option C:** A spinal tap can be done to rule out meningitis but this isn't the indication for the test on a leukemic client.

29. A client with clotting disorder has an order to continue lovenox (Enoxaparin) injections after discharge. The nurse should teach the client that lovenox injections should:

- A. Be injected into the deltoid muscle
- B. Be injected into the abdomen
- C. Aspirate after the injection
- D. Clear the air from the syringe before injections

Correct Answer: B. Be injected into the abdomen

- **Option A:** Lovenox injections should be given in the abdomen, not in the deltoid muscle.
- **Options C and D:** The client should not aspirate after, but before, the injection or clear the air from the syringe before injection.

30. In which step of the nursing process would the nurse ask a patient if the medication she administered relieved his pain?

- A. Assessment
- B. Analysis
- C. Planning
- D. Evaluation

Correct Answer: D. Evaluation

In the evaluation step of the nursing process, the nurse must decide whether the patient has achieved the expected outcome that was identified in the planning phase. This final step of the nursing process is vital to a positive patient outcome. Whenever a healthcare provider intervenes or implements care, they must reassess or evaluate to ensure the desired outcome has been met. Reassessment may frequently be needed depending upon the overall patient's condition. The plan of care may be adapted based on new assessment data.

- **Option A:** Assessment is the first step and involves critical thinking skills and data collection; subjective and objective. Subjective data involves verbal statements from the patient or caregiver. Objective data is measurable, tangible data such as vital signs, intake and output, and height and weight.
- **Option B:** Analysis can be a part of diagnosing. The formulation of a nursing diagnosis by employing clinical judgment assists in the planning and implementation of patient care. The North American Nursing Diagnosis Association (NANDA) provides nurses with an up to date list of nursing diagnoses. A nursing diagnosis, according to NANDA, is defined as a clinical judgment about responses to actual or potential health problems on the part of the patient, family, or community.
- **Option C:** The planning stage is where goals and outcomes are formulated that directly impact patient care based on EDP guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum.

31. A client is diagnosed with progressive prostate cancer. The nurse expects which drug is given?

- A. Arimidex (anastrozole)
- B. Emcyt (estramustine)
- C. Taxol (paclitaxel)
- D. Camptosar (irinotecan)

Correct Answer: B. Emcyt (estramustine)

- **Option B:** Emcyt (estramustine)– is used as a palliative treatment of metastatic and progressive prostate cancer.

- **Option A:** Arimidex (anastrozole)- is used in the treatment of advanced breast cancer in post-menopausal women following tamoxifen therapy.
- **Option C:** Taxol (paclitaxel) is given as a treatment for ovarian cancer, breast cancer, and AIDS-related to Kaposi's sarcoma.
- **Option D:** Camptosar (irinotecan) is indicated in the treatment of metastatic colon or rectal cancer after treatment with 5-FU.

32. What is the term used to describe an enlargement of the heart muscle?

- A. Cardiomegaly
- B. Cardiomyopathy
- C. Myocarditis
- D. Pericarditis

Correct Answer: A. Cardiomegaly

Cardiomegaly denotes an enlarged heart muscle. The most critical pathophysiological changes leading to cardiomegaly include dilated hypertrophy, fibrosis, and contractile malfunction. Contractile dysfunction and abnormal myocardial remodeling can lead to hypertrophic cardiomyopathy or dilated cardiomyopathy. Mechanical stretching, circulating neurohormones, and oxidative stress are significant stimuli for the signal transduction of inflammatory cytokines and MAP kinase in cardiomyocytes. Signal transduction leads to changes in structural proteins and proteins that regulate excitation-contraction. Dilated cardiomyopathy mutations result in a reduced force of the sarcomere contraction and a reduction in sarcomere content. Hypertrophic cardiomyopathy mutations result in a molecular phenotype of hyperdynamic contractility, poor relaxation, and increased energy consumption.

- **Option B:** Cardiomyopathy is a heart muscle disease of unknown origin. In cardiomyopathy, the heart muscle becomes enlarged, thick, or rigid. In rare cases, the muscle tissue in the heart is replaced with scar tissue.
- **Option C:** Myocarditis refers to inflammation of the heart muscle. It is an inflammatory disease of the myocardium with a wide range of clinical presentations, from subtle to devastating.
- **Option D:** Pericarditis is an inflammation of the pericardium. Pericarditis is usually acute – it develops suddenly and may last up to several months. The condition usually clears up after 3 months, but sometimes attacks can come and go for years. When a client has pericarditis, the membrane around the heart is red and swollen, like the skin around a cut that becomes inflamed. Sometimes there is extra fluid in the space between the pericardial layers, which is called pericardial effusion.

33. The community nurse is following up on Mrs. Jenner who was hospitalized at Nurseslabs Medical Center due to depressive disorder, not otherwise specified, following the death of her spouse. In reviewing the client's chart, the nurse notes that Mrs. Jenner has an Axis II diagnosis of dependent personality disorder. Which behavior would the nurse anticipate in this client?

- A. Difficulty making decisions, lack of self-confidence.
- B. Grandiose thinking, attention-seeking behaviors.

- C. Odd mannerisms, speech, and behaviors.
- D. Unstable moods and impulsive behaviors.

Correct Answer: A. Difficulty making decisions, lack of self-confidence

The client with a dependent personality disorder typically demonstrates anxious and fearful behavior and is reluctant to make decisions. Lack of self-confidence is reflective of chronic low self-esteem. It involves fear of being alone and often causes those who have the disorder to do things to try to get other people to take care of them.

- **Option B:** Grandiose thinking and attention-seeking behaviors are characteristics of someone with a dramatic, emotional, erratic personality disorder, such as narcissistic personality. It is associated with self-centeredness, exaggerated self-image, and lack of empathy for others and is often driven by an underlying fragility in the sense of self.
- **Option C:** Odd mannerisms, speech, and behaviors are characteristics of schizotypal personality disorder, in which odd, eccentric behavior is displayed. Schizotypal personality disorder features odd speech, behavior, and appearance, as well as strange beliefs and difficulty forming relationships.
- **Option D:** Unstable moods and impulsive behaviors describe a borderline personality disorder. It is characterized by instability in interpersonal relationships, emotions, self-image, and impulsive behaviors.

34. A nurse is managing the care of a 32-year-old female client diagnosed with hyperthyroidism. The client reports experiencing palpitations, unintentional weight loss, and intermittent bouts of excessive sweating. The treatment plan includes antithyroid medications. In addition to administering medication, what nursing interventions should be prioritized to manage the client's condition best?

- A. Ensure the client is provided with extra blankets and clothing to maintain a warm environment due to heightened sensitivity to cold.
- B. Closely monitor the client for increased signs of restlessness, sweating, and significant weight loss.
- C. Create a balance between the client's periods of activity and rest to manage fatigue without exacerbating symptoms.
- D. Encourage increased physical activity to counteract the sedative effects of the medication and prevent constipation.
- E. Regularly check the client's temperature as they are prone to developing fevers.
- F. Offer a low-iodine diet and coordinate with a dietitian to manage dietary influences on thyroid function.

Correct Answer: C. Create a balance between the client's periods of activity and rest to manage fatigue without exacerbating symptoms.

Clients with hyperthyroidism may experience symptoms like fatigue and muscle weakness. Balancing activity with rest helps to conserve energy and prevent exacerbation of symptoms.

- **Option A:** Providing extra blankets is more associated with patients with hypothyroidism.
- **Option B:** Monitoring for signs of restlessness and sweating is essential, but this option refers more to the assessment of potential overmedication rather than an intervention.

- **Option D:** Encouraging the client to be active to prevent constipation (D) is less specific to hyperthyroidism, where diarrhea is more common than constipation.
- **Options E and F:** Checking for fever (E) and offering a low-iodine diet (F) are additional supportive measures. However, they do not directly address managing the client's current symptoms and treatment plan as effectively as balancing activity and rest.

35. Which of the following signs will distinguish threatened abortion from imminent abortion?

- A. Severity of bleeding.
- B. Dilation of the cervix.
- C. Nature and location of pain.
- D. Presence of uterine contraction.

Correct Answer: B. Dilation of the cervix

In imminent abortion, the pregnancy will definitely be terminated because the cervix is already open unlike in threatened abortion where the cervix is still closed.

- **Option A:** Nearly 25% of pregnant women have some degree of vaginal bleeding during the first two trimesters and about 50% of these progress to loss of the pregnancy. The bleeding during a threatened abortion is typically mild to moderate.
- **Option C:** A threatened abortion occurs when a pregnant patient at less than 20 weeks gestation presents with vaginal bleeding. The cervical os is closed on a physical exam. The patient may also experience abdominal cramping, pelvic pain, pelvic pressure, and/or back pain.
- **Option D:** A pelvic exam is mandatory to determine the type of abortion. Determining factors include the amount and site of bleeding, whether the cervix is dilated, and whether fetal tissue has passed. In a threatened abortion, the vaginal exam may reveal a closed cervical os with no tissue. There is usually no cervical motion tenderness.