

Kevin's Review - 35 NCLEX Practice Questions

1. Which of the following amounts of blood loss following birth marks the criterion for describing postpartum hemorrhage?

- A. More than 200 ml
- B. More than 300 ml
- C. More than 400 ml
- D. More than 500 ml

Correct Answer: D. More than 500 ml

Postpartum hemorrhage is defined as blood loss of more than 500 ml following birth. Any amount less than this is not considered postpartum hemorrhage.

- **Option A:** The amount of 200 ml is less than the amount considered as postpartum hemorrhage. Postpartum hemorrhage (PPH) is the leading cause of maternal mortality. All women who carry a pregnancy beyond 20 weeks' gestation are at risk for PPH and its sequelae. Although maternal mortality rates have declined greatly in the developed world, PPH remains a leading cause of maternal mortality elsewhere.
- **Option B:** 300 ml is less than the amount considered as postpartum hemorrhage. PPH is defined as blood loss of more than 500 mL following vaginal delivery or more than 1000 mL following cesarean delivery. A loss of these amounts within 24 hours of delivery is termed early or primary PPH, whereas such losses are termed late or secondary PPH if they occur 24 hours after delivery.
- **Option C:** At term, the estimated blood flow to the uterus is 500-800 mL/min, which constitutes 10-15% of cardiac output. Most of this flow traverses the low-resistance placental bed. The uterine blood vessels that supply the placental site traverse a weave of myometrial fibers. As these fibers contract following delivery, myometrial retraction occurs. Retraction is the unique characteristic of the uterine muscle to maintain its shortened length following each successive contraction. The blood vessels are compressed and kinked by this crisscross latticework, and, normally, blood flow is quickly occluded. This arrangement of muscle bundles has been referred to as the "living ligatures" or "physiologic sutures" of the uterus.

2. The following are natural childbirth procedures, except?

- A. Lamaze method
- B. Dick-Read method
- C. Ritgen's maneuver
- D. Psychoprophylactic method

Correct Answer: C. Ritgen's maneuver

Ritgen's method is used to prevent perineal tear/laceration during the delivery of the fetal head. Lamaze method is also known as psychoprophylactic method and Dick-Read method are commonly known natural childbirth procedures which advocate the use of nonpharmacologic measures to relieve labor pain.

- **Option A:** Lamaze breathing historically is considered the hallmark of Lamaze preparation for childbirth. Controlled breathing enhances relaxation and decreases the perception of pain. It is one of many comfort strategies taught in Lamaze classes. In restricted birthing environments, breathing may be the only non-pharmacological comfort strategy available to women. Conscious breathing

and relaxation, especially in combination with a wide variety of comfort strategies, can help women avoid unnecessary medical intervention and have a safe, healthy birth.

- **Option B:** The term 'natural childbirth' derives from the title of a short 1933 treatise by Grantly Dick-Read. In this and several other books and articles published over the next quarter-century, the British-born physician outlined an alternative to the anesthetized, medically controlled way of birth common among Western women of privilege, based on the premise that fear lay at the root of pain in labor. For Dick-Read, whether or not a mother experienced pain in labor depended not on some property inherent to the physiology of parturition but on cultural attitudes to childbirth. Through education and relaxation, women could overcome what he termed the 'Fear–Tension–Pain' cycle and labor in comfort without resorting to medical intervention. Preparation for labor meant providing pregnant women with detailed instruction, from their physician, midwife, or qualified childbirth educator, on the physiology of pregnancy and birth, nutrition, exercise, hygiene, and infant care.
- **Option D:** In the late 1940s, Soviet scientists invented a new non-pharmacological method called the 'psychoprophylactic method of painless childbirth' (PPM), which later became well known as the Lamaze method in the West.¹ This gift of Soviet science to the women of the world was based on the assumption that it was possible to eliminate the sensation of bodily pain during labor by training the mind of a pregnant woman before she gives birth.

3. A full-term male has hypospadias. Which statement describes hypospadias?

- A. The urethral opening is absent.
- B. The urethra opens on the dorsal side of the penis.
- C. The penis is shorter than usual.
- D. The urethral meatus opens on the underside of the penis.

Correct Answer: D. The urethral meatus opens on the underside of the penis.

Hypospadias is a congenital abnormality in which the urethral meatus is on the underside of the penis. Hypospadias is an anatomical congenital malformation of the male external genitalia. It is characterized by abnormal development of the urethral fold and the ventral foreskin of the penis that causes abnormal positioning of the urethral opening.

- **Option A:** Urethral agenesis is the absence of the urethral opening. Urethral atresia is a rare urethral malformation, which is not compatible with life unless the urachus open in the umbilicus, an alternative communication between the bladder and rectum exists in a form of congenital fistula, or a prenatal placement of a vesico-amniotic shunt established. Terminal renal failure and multiple reconstructive operations have to be expected in the course of the disease.
- **Option B:** The urethral opening is located ventrally, not dorsally, in hypospadias. In hypospadias, the external urethral meatus may present various degrees of malpositioning and may be found with associated penile curvature. Depending on the location of the defect, patients may have an additional genitourinary malformation.
- **Option C:** Penis shorter than usual is not a characteristic of a patient with hypospadias. Key features include a glandular groove and a dorsal hood of the foreskin but in almost all cases the prepuce is incomplete ventrally. In addition, the urethral meatus is usually in an abnormal location. If the infant has a complete foreskin, the hypospadias may become obvious after circumcision.

4. Jose is in danger of respiratory arrest following the administration of a narcotic analgesic. An arterial blood gas value is obtained. Nurse Oliver would expect the paco₂ to be which of the following values?

- A. 15 mm Hg
- B. 30 mm Hg
- C. 40 mm Hg
- D. 80 mm Hg

Correct Answer: D. 80 mm Hg

A client about to go into respiratory arrest will have inefficient ventilation and will be retaining carbon dioxide. The value expected would be around 80 mm Hg. All other values are lower than expected.

- **Option A:** 15 mmHg is a low value for a client about to go into respiratory arrest.
- **Option B:** 30 mmHg is lower than the expected value because of inefficient ventilation.
- **Option C:** 40 mmHg is still less than the expected value for a client who is about to go into respiratory arrest.

5. Smoking is contraindicated in pregnancy because:

- A. Nicotine causes vasodilation of the mother's blood vessels.
- B. Carbon monoxide binds with the hemoglobin of the mother reducing available hemoglobin for the fetus.
- C. The smoke will make the fetus, and the mother feels dizzy.
- D. Nicotine will cause vasoconstriction of the fetal blood vessels.

Correct Answer: B. Carbon monoxide binds with the hemoglobin of the mother reducing available hemoglobin for the fetus.

Carbon monoxide is one of the substances found in cigarette smoke. This substance diminishes the ability of the hemoglobin to bind with oxygen thus reducing the amount of oxygenated blood reaching the fetus.

- **Option A:** There is blood flow restriction to the placenta due to the vasoconstrictive effects of catecholamines released from the adrenals and nerve cells after nicotine activation.
- **Option C:** Nicotine is rapidly absorbed when the tobacco smoke reaches the small airways and alveoli of the lung. This causes a quick rise in blood nicotine concentrations, but due to the eventual burnout of the cigarette, these levels also peak early and thereafter drop to lower levels.
- **Option D:** Direct effects on nicotinic acetylcholine receptors (nAChRs), which are present and functional very early in the fetal brain [5] are also likely to contribute.

6. A nurse is reviewing the complete blood count (CBC) of a child who has been diagnosed with idiopathic thrombocytopenic purpura. Which of the following laboratory results should the nurse report immediately to the physician?

- A. Platelet count of 30,000/mm³.

- B. Hemoglobin level of 7.5 g/dL.
- C. Reticulocyte count of 6.5%.
- D. Eosinophil count of 700 cells/mm³.

Correct Answer: B. Hemoglobin level of 7.5 g/dL.

The low hemoglobin level indicates that the client has active bleeding, and immediate actions such as additional diagnostic exams and blood transfusions can be suggested. An initial impression of the severity of ITP is formed by examining the skin and mucous membranes. Widespread petechiae and ecchymoses, oozing from a venipuncture site, gingival bleeding, and hemorrhagic bullae indicate that the patient is at risk for a serious bleeding complication.

- **Option A:** Decreased platelet count is expected in a child with idiopathic thrombocytopenic purpura. Immune thrombocytopenia (ITP) is a syndrome in which platelets become coated with autoantibodies to platelet membrane antigens, resulting in splenic sequestration and phagocytosis by mononuclear macrophages. The resulting shortened life span of platelets in the circulation, together with incomplete compensation by increased platelet production by bone marrow megakaryocytes, results in a decreased number of circulating platelets.
- **Option C:** Increased reticulocyte is expected in a child with idiopathic thrombocytopenic purpura. The measurement of the content of hemoglobin of reticulocytes (CHr or Ret-He) reflects the synthesis of hemoglobin in marrow precursors and allows the detection of early stages of iron deficiency.
- **Option D:** An increased eosinophil count is expected in a child with idiopathic thrombocytopenic purpura. Many authors have reported associations between the increased numbers of eosinophils with platelet dysfunctions, such as increased bleeding time, reduction in platelet aggregation induced by various agonists, among other disorders.

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

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

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

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

8. A nurse is assigned to the pediatric rheumatology clinic and is assessing a child who has just been diagnosed with juvenile idiopathic arthritis. Which of the following statements about the disease is most accurate?

- A. The child has a poor chance of recovery without joint deformity.
- B. Most children progress to adult rheumatoid arthritis.
- C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.
- D. Physical activity should be minimized.

Correct Answer: C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.

Nonsteroidal anti-inflammatory drugs are important first-line treatment for juvenile idiopathic arthritis (formerly known as juvenile rheumatoid arthritis). NSAIDs require 3-4 weeks for the therapeutic anti-inflammatory effects to be realized. Nonsteroidal anti-inflammatory drugs (NSAIDs) are the mainstay of initial symptomatic treatment for all subtypes. The NSAID use in JIA has decreased over time with modern aggressive treatment, including methotrexate and biologics.

- **Option A:** Half of the children with the disorder recover without joint deformity. The prognosis of JIA has changed dramatically in recent years thanks to the availability of novel drugs, which can inhibit the biological mechanisms responsible for persistent inflammation selectively. Prompt and accurate diagnosis and treatment are essential to prevent permanent joint damage and preserve joint functionality.
- **Option B:** About a third will continue with symptoms into adulthood. A recent study on 168 patients showed the remission of medication in 48.8% of cases, the remission on medication (or minimal disease activity) in 49.9% of cases, and only 1.3% of subjects were no-responders. No association was found between the state and duration of remission and age of patients, clinical features, disease course, or laboratory findings.
- **Option D:** Physical activity is an integral part of therapy. Assist parents and child to develop plans and goals for daily ADL and include interventions formed by a physical and occupational therapist. Promotes independence and compliance in self-care.

9. In the diagnosis of a possible pervasive developmental autistic disorder. The nurse would find it most unusual for a 3-year-old child to demonstrate:

- A. An interest in music.
- B. An attachment to odd objects.
- C. Ritualistic behavior.
- D. Responsiveness to the parents.

Correct Answer: D. Responsiveness to the parents

One of the symptoms of autistic child displays a lack of responsiveness to others. There is little or no extension to the external environment. The diagnostic category of pervasive developmental disorders (PDD) refers to a group of disorders characterized by delays in the development of socialization and communication skills. Parents may note symptoms as early as infancy, although the typical age of onset is before 3 years of age.

- **Option A:** Autism (a developmental brain disorder characterized by impaired social interaction and communication skills, and a limited range of activities and interests) is the most characteristic and best studied PDD. Other types of PDD include Asperger's Syndrome, Childhood Disintegrative Disorder, and Rett's Syndrome. Children with PDD vary widely in abilities, intelligence, and behaviors. Some children do not speak at all, others speak in limited phrases or conversations, and some have relatively normal language development.

- **Option B:** Symptoms may include problems with using and understanding language; difficulty relating to people, objects, and events; unusual play with toys and other objects; difficulty with changes in routine or familiar surroundings, and repetitive body movements or behavior patterns.
- **Option C:** Repetitive play skills and limited social skills are generally evident. Unusual responses to sensory information, such as loud noises and lights, are also common. There is no known cure for PDD. Medications are used to address specific behavioral problems; therapy for children with PDD should be specialized according to need. Some children with PDD benefit from specialized classrooms in which the class size is small and instruction is given on a one-to-one basis. Others function well in standard special education classes or regular classes with additional support.

10. To assist an adult client to sleep better the nurse recommends which of the following?

- A. Drinking a glass of wine just before retiring to bed.
- B. Eating a large meal 1 hour before bedtime.
- C. Consuming a small glass of warm milk at bedtime.
- D. Performing mild exercises 30 minutes before going to bed.

Correct Answer: C. Consuming a small glass of warm milk at bedtime.

A small glass of milk relaxes the body and promotes sleep. Encourage the client to take milk. L-tryptophan is a component of milk that promotes sleep. Instruct the patient to follow a consistent daily schedule for rest and sleep. Consistent schedules facilitate regulation of the circadian rhythm and decrease the energy needed for adaptation to changes.

- **Option A:** Educate the patient on the proper food and fluid intake such as avoiding alcohol, caffeine, or smoking before bedtime. Alcohol produces drowsiness and may facilitate the onset of sleep but interferes with REM sleep.
- **Option B:** Educate the patient on the proper food intake such as avoiding heavy meals before bedtime. Having full meals just before bedtime may produce gastrointestinal upset and hinder sleep onset.
- **Option D:** Encourage daytime physical activities but instruct the patient to avoid strenuous activities before bedtime. In insomnia, stress may be reduced by therapeutic activities and may promote sleep. However, strenuous activities may lead to fatigue and may cause insomnia.

11. A patient who has been told by the health care provider that the cells in a bowel tumor are poorly differentiated asks the nurse what is meant by “poorly differentiated.” Which response should the nurse make?

- A. "Your tumor cells look more like immature fetal cells than normal bowel cells."
- B. "The cells in your tumor have mutated from the normal bowel cells."
- C. "The cells in your tumor do not look very different from normal bowel cells."
- D. "The tumor cells have DNA that is different from your normal bowel cells."

Correct Answer: A. “Your tumor cells look more like immature fetal cells than normal bowel cells.”

- **Option A:** An undifferentiated cell has an appearance more like a stem cell or fetal cell and less like the normal cells of the organ or tissue.
- **Option B:** All tumor cells are mutations from the normal cells of the tissue.
- **Options C and D:** The DNA in cancer cells is always different from normal cells, whether the cancer cells are well differentiated or not.

12. Ms. Clark has hyperthyroidism and is scheduled for a thyroidectomy. The physician has ordered Lugol's solution for the client. The nurse understands that the primary reason for giving Lugol's solution preoperatively is to:

- A. Decrease the risk of agranulocytosis postoperatively.
- B. Prevent tetany while the client is under general anesthesia.
- C. Reduce the size and vascularity of the thyroid and prevent hemorrhage.
- D. Potentiate the effect of the other preoperative medication so less medicine can be given while the client is under anesthesia.

Correct Answer: C. Reduce the size and vascularity of the thyroid and prevent hemorrhage.

The client may receive an iodine solution (Lugol's solution) for 10 to 14 days before surgery to decrease vascularity of the thyroid and thus prevent excess bleeding. Plummer observed a 75% decrease in mortality associated with thyroidectomy when Lugol's solution was introduced. At that time metabolic rate decreased as well as symptoms.

- **Option A:** Doses of over 30 mg/day may increase the risk of agranulocytosis. In a recent randomized control trial in patients receiving Lugol's solution median blood losses (50 vs. 140 mL), and operative times (138 vs. 150 min), were also significantly less compared to controls. The reduced blood loss is associated with both a 60% reduction in systemic angiogenic factor (VEGF) and with 50% of interleukin-16. If other angiogenic mediators also are involved is unknown.
- **Option B:** Lugol's solution does not act to prevent tetany. Calcium is used to treat tetany. Lugol's solution is used both in combination with antithyroid drugs preoperatively in planned thyroidectomies in certain centers routinely, and alone as rescue therapy if severe side effects to antithyroid drugs have occurred.
- **Option D:** Lugol's solution does not potentiate any other preoperative medication. Lugol's solution and other iodide preparations seem to have a low frequency of adverse effects. In doses of 1000 times the normal nutritional need, side effects may include acne, loss of appetite, or upset stomach. More severe side effects are fever, weakness, unusual tiredness, swelling in the neck or throat, mouth sores, skin rash, nausea, vomiting, stomach pains, irregular heartbeat, numbness or tingling of the hands or feet, or a metallic taste in the mouth.

13. The nurse is about to give a Type 2 diabetic her insulin before breakfast on her first day postpartum. Which of the following answers best describes insulin requirements immediately postpartum?

- A. Lower than during her pregnancy
- B. Higher than during her pregnancy
- C. Lower than before she became pregnant

D. Higher than before she became pregnant

Correct Answer: C. Lower than before she became pregnant

PP insulin requirements are usually significantly lower than pre-pregnancy requirements. Occasionally, clients may require little to no insulin during the first 24 to 48 hours postpartum. Immediately after delivery, postpartum insulin requirements decrease dramatically as a result of the rapid decrease in diabetogenic placental hormone levels and resulting dissipation of pregnancy-induced insulin resistance.

- **Option A:** The policy specifies that women with type 1 or type 2 diabetes who require ongoing insulin administration should decrease insulin doses and undergo monitoring of preprandial blood glucose values while on the postpartum unit. Glycemic targets approximating nonpregnant targets are utilized. Among women with type 1 diabetes, insulin requirements typically return to prepregnancy levels or lower following delivery.
- **Option B:** Women are typically advised to decrease basal and prandial insulin doses to 50 to 80% of their preconception doses, but recommendations are individualized. If preconception insulin doses are not known, one-third to one-half of the term pregnancy dose or weight-based dosing may be used as a starting point.
- **Option D:** Among women with type 2 diabetes, postpartum medication requirements vary depending on the severity of hyperglycemia postpartum and the prepregnancy diabetes therapeutic regimen, ranging from no medical therapy to resumption of insulin therapy at reduced doses (as above) or noninsulin therapies following delivery.

14. Nurse Kim is teaching a group of parents about otitis media. When discussing why children are predisposed to this disorder, the nurse should mention the significance of which anatomical feature?

- A. Eustachian tubes
- B. Nasopharynx
- C. Tympanic membrane
- D. External ear canal

Correct Answer: A. Eustachian tubes

In a child, Eustachian tubes are short and lie in a horizontal plane, promoting entry of nasopharyngeal secretions into the tubes and thus setting the stage for otitis media. Due to the constricted anatomical space of the middle ear, the edema caused by the inflammatory process obstructs the narrowest part of the Eustachian tube leading to a decrease in ventilation.

- **Option B:** Otitis media begins as an inflammatory process following a viral upper respiratory tract infection involving the mucosa of the nose, nasopharynx, middle ear mucosa, and Eustachian tubes.
- **Option C:** The growth of microbes in the middle ear then leads to suppuration and eventually frank purulence in the middle ear space. This is demonstrated clinically by a bulging or erythematous tympanic membrane and purulent middle ear fluid.
- **Option D:** The external ear canal has no unusual features that would predispose a child to otitis media. Acute otitis media is defined as an infection of the middle ear space. In AOM, the TM may be erythematous or normal, and there may be fluid in the middle ear space.

15. A male client is found sitting on the floor of the bathroom in the day treatment clinic with moderate lacerations on both wrists. Surrounded by broken glass, he sits staring blankly at his bleeding wrists while staff members call for an ambulance. How should Nurse Anuktakanuk approach her initially?

- A. Enter the room quietly and move beside him to assess his injuries.
- B. Call for staff back-up before entering the room and restraining him.
- C. Move as much glass away from him as possible and sit next to him quietly.
- D. Approach him slowly while speaking in a calm voice, calling his name, and telling him that the nurse is here to help him.

Correct Answer: D. Approach her slowly while speaking in a calm voice, calling her name, and telling her that the nurse is here to help her

Ensuring the safety of the client and the nurse is the priority at this time. Therefore, the nurse should approach the client cautiously while calling her name and talking to her in a calm, confident manner. Nursing's hands-on approach to patient care and our ability to create therapeutic connections with patients enables us to pick up on key cues. Identifying these cues starts with understanding that suicidal behaviors are neither considered an illness nor a condition, but rather a complex set of behaviors that actually exists on a continuum that ranges from ideas/thoughts to eventual actions.

- **Option A:** The nurse should keep in mind that the client shouldn't be startled or overwhelmed. After explaining that the nurse is there to help, the nurse should observe the client's response carefully. The promotion of a care environment that is safe and conducive to their full recovery is essential in carrying out comprehensive care in mental health. The first step is qualified listening, but it cannot be immersed in a bigoted discourse, full of judgment. One must consider that not always the person is willing to express or externalize what they really feel, and so a new challenge to the health professional emerges, which is the careful observation of the reality of the patient and the listening of silence when the person is not willing to talk.
- **Option B:** If the client shows signs of agitation or confusion or poses a threat, the nurse should retreat and request assistance. For the care to surpass the technical focus, the psychological care and the continuous observation of patients and family members are also necessary, aiming to prioritize the communication in accordance with the qualified listening, as these patients are often insecure. It is important to highlight that all people who attempted suicide should receive professional care due to the emotional fragility in which they find themselves. The competence of the emergency team is saving lives, considering not only the physical aspects but also the psychological aspects involved in the process of caring
- **Option C:** The nurse shouldn't attempt to sit next to the client or examine injuries without first announcing the nurse's presence and assessing the dangers of the situation. There are some essential behaviors that nursing can use to meet a person who attempted suicide or has suicidal ideation, namely: listen carefully, be empathetic, convey non-verbal messages of acceptance, express respect for the opinion of another, talk honestly, show concern, and focus on the feelings of the person. The mere interaction with the patient has a great potential to calm down, prevent, or minimize the severity and intensity of the symptoms. Still, the team should try to establish a bond of trust from the start, whereas, on the other hand, the idea that the patient attempted suicide to manipulate others should be abandoned.

16. The nurse collecting family assessment data asks. "Who is in your family and where do they live?" Which of the following is the nurse attempting to

identify?

- A. Boundaries
- B. Ethnicity
- C. Relationships
- D. Triangles

Correct Answer: A. Boundaries

Family boundaries are parameters that define who is inside and outside the system. The best method of obtaining this information is asking the family directly who they consider to be members. Every system has ways of including and excluding elements so that the line between those within the system and those outside of the system is clear to all. If a family is permeable and has vague boundaries it is considered "open." Open boundary systems allow elements and situations outside the family to influence it. It may even welcome external influences. Closed boundary systems isolate its members from the environment and seem isolated and self-contained. No family system is completely closed or completely open.

- **Option B:** Ethnicity is a broader term than race. The term is used to categorize groups of people according to their cultural expression and identification. Commonalities such as racial, national, tribal, religious, linguistic, or cultural origin may be used to describe someone's ethnicity.
- **Option C:** The relationship between two people or groups is the way in which they feel and behave towards each other. A relationship is a close connection between two people, especially one involving romantic or sexual feelings.
- **Option D:** Triangulation or triangling is defined in the AAMFT Family Therapy Glossary as the "process that occurs when a third person is introduced into a dyadic relationship to balance either excessive intimacy, conflict, or distance and provide stability in the system" (Evert et al. 1984 p. 32). This concept is associated with Murray Bowen (1978) who saw triangulation as a way to reduce anxiety in a dyadic relationship.

17. A nurse in the emergency department is observing a 4-year-old child for signs of increased intracranial pressure after a fall from a bicycle, resulting in head trauma. Which of the following signs or symptoms would be cause for concern?

- A. Bulging anterior fontanel.
- B. Repeated vomiting.
- C. Signs of sleepiness at 10 PM.
- D. Inability to read short words from a distance of 18 inches.

Correct Answer: B. Repeated vomiting.

Increased pressure caused by bleeding or swelling within the skull can damage delicate brain tissue and may become life threatening. Repeated vomiting can be an early sign of pressure as the vomit center within the medulla is stimulated. Clinical suspicion for intracranial hypertension should be raised if a patient presents with the following signs and symptoms: headaches, vomiting, and altered mental status varying from drowsiness to coma.

- **Option A:** The anterior fontanel is closed in a 4-year-old child. The average closure time of the anterior fontanelle ranges from 13 to 24 months. Infants of African descent statically have larger fontanelles that range from 1.4 to 4.7 cm, and in terms of sex, the fontanelles of male infants will closer sooner compared to female infants.
- **Option C:** Evidence of sleepiness at 10 PM is normal for a four year old. Newborns spend most of their day sleeping, and they only wake up to be fed, on the other hand, 1-year-old infants sleep for 10 to 12 hours at night without waking. The coordination between biological rhythm and sleep-wake cycle develops over the first six months of life.
- **Option D:** The average 4-year-old child cannot read yet, so this too is normal. Most children learn to read by 6 or 7 years of age. Some children learn at 4 or 5 years of age. Even if a child has a head start, she may not stay ahead once school starts. The other students most likely will catch up during the second or third grade.

18. Which of the following actions is the appropriate initial response to a client coughing up pink, frothy sputum?

- A. Call for help.
- B. Call the physician.
- C. Start an I.V. line.
- D. Suction the client.

Correct Answer: A. Call for help

Production of pink, frothy sputum is a classic sign of acute pulmonary edema. Because the client is at high risk for decompensation, the nurse should call for help but not leave the room. Fluid shifts may cause cerebral edema and changes in mentation, especially in the geriatric population. The other three interventions would immediately follow.

- **Option B:** Note presence of neck and peripheral vein distention, along with pitting edema, and dyspnea; signs of cardiac decompensation and heart failure. Monitor laboratory studies, such as sodium, potassium, BUN, and arterial blood gasses (ABGs), as indicated.
- **Option C:** Monitor infusion rate of parenteral fluids closely; May use infusion pump, as necessary. Rapid fluid bolus or prolonged excessive administration potentiates volume overload and risk of cardiac decompensation.
- **Option D:** Encourage deep breathing and coughing exercises. Pulmonary fluid shifts potentiate respiratory complications. Turn or reposition, and provide skin care at regular intervals. Decreases pressure and friction on edematous tissue, which is more prone to breakdown than normal tissue.

19. The school nurse assesses for anorexia nervosa in an adolescent girl. Which of the following findings are characteristic of this disorder? Select all that apply.

- A. Bradycardia
- B. Hypotension
- C. Chronic pain in one or more sites
- D. Fear of having a serious illness

E. Irregular or absent menses

F. Refusal to maintain a minimally normal weight

Correct Answer: A, B, E, F

These are all characteristics of anorexia nervosa. Anorexia nervosa is an eating disorder defined by restriction of energy intake relative to requirements, leading to a significantly low body weight. Patients will have an intense fear of gaining weight and distorted body image with the inability to recognize the seriousness of their significantly low body weight.

- **Option A:** Cardiac complications are arguably one of the most severe medical issues stemming from anorexia. Bradycardia (heart rate less than 60 beats per minute) and hypotension (blood pressure less than 90/50) are among the most common physical findings in anorexia, with bradycardia seen in up to 95 percent of patients.
- **Option B:** Bradycardia (pulse <60) and hypotension are among the most common physical findings in patients with anorexia nervosa, with bradycardia seen in up to 95% of patients. Anorexia nervosa should be considered in the differential for unexplained bradycardia in the outpatient setting. Low blood pressure and heart rate universally increase to normal levels after refeeding and restoration of normal weight.
- **Option C:** Chronic pain in one or more sites is common for somatoform pain disorder. The Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5) category of Somatic Symptom Disorders and Other Related Disorders represents a group of disorders characterized by thoughts, feelings, or behaviors related to somatic symptoms. This category represents psychiatric conditions because the somatic symptoms are excessive for any medical disorder that may be present.
- **Option D:** Fear of having a serious illness is common in hypochondriasis. Illness anxiety disorder (IAD) is a recent term for what used to be diagnosed as hypochondriasis, or hypochondria. People diagnosed with IAD strongly believe they have a serious or life-threatening illness despite having no, or only mild, symptoms. Yet IAD patients' concerns are to them very real. Even if they go to doctors and no illnesses are found, they are generally not reassured and their obsessive worry continues.
- **Option E:** Of patients with anorexia nervosa, 20–25 percent may experience amenorrhea before the onset of significant weight loss, and 50–75 percent will experience amenorrhea during the course of dieting and its weight loss. In some patients with anorexia nervosa, amenorrhea occurs only after more marked weight loss. Overall, the development of amenorrhea is most strongly correlated to loss of body weight.
- **Option F:** Many exercise compulsively for extended periods of time. Patients with anorexia nervosa develop multiple complications related to prolonged starvation and purging behaviors.

20. When planning care for a client with ulcerative colitis who is experiencing symptoms, which client care activities can the nurse appropriately delegate to an unlicensed assistant? Select all that apply.

- A. Assessing the client's bowel sounds.
- B. Providing skincare following bowel movements.
- C. Evaluating the client's response to antidiarrheal medications.
- D. Maintaining intake and output records.

E. Obtaining the client's weight.

Correct Answer: B, D, and E.

The nurse can delegate the following basic care activities to the unlicensed assistant: providing skincare following bowel movements, maintaining intake and output records, and obtaining the client's weight. Assessing the client's bowel sounds and evaluating the client's response to medication are registered nurse activities that cannot be delegated.

- **Option A:** Assessing a patient's abdomen can provide critical information about his internal organs. Always follow this sequence: inspection, auscultation, percussion, and palpation. Changing the order of these assessment techniques could alter the frequency of bowel sounds and make your findings less accurate.
- **Option C:** The evaluation of the effectiveness of pharmacotherapy includes measurable improvement in clinical signs and symptoms and/or laboratory values. The evaluation of the safety of pharmacotherapy includes evidence of adverse drug reactions and/or toxicity.

21. A long-term goal for a paranoid male client who has unjustifiably accused his wife of having many extramarital affairs would be to help the client develop:

- A. Insight into his behavior
- B. Better self-control
- C. Feeling of self-worth
- D. Faith in his wife

Correct Answer: C. Feeling of self-worth

Helping the client to develop a feeling of self-worth would reduce the client's need to use pathologic defenses. Paranoid personality disorder (PPD) is one of a group of conditions called Cluster A or eccentric personality disorders. People with these disorders often appear odd or peculiar. The essential characteristic of people with PPD is paranoia, a relentless mistrust and suspicion of others without adequate reason to be suspicious. This disorder often begins in childhood or early adolescence and appears to be more common in men than in women. Studies estimate that PPD affects between 2.3% and 4.4% of the general population.

- **Option A:** People with PPD are always on guard, believing that others are constantly trying to demean, harm, or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, interfere with their ability to form close or even workable relationships.
- **Option B:** Patients with paranoid personality disorder distrust others and assume that others intend to harm or deceive them, even when they have no or insufficient justification for these feelings. From 2.3 to 4.4% of the general US population are estimated to have paranoid personality disorder. It is thought to be more common among men. Patients with paranoid personality disorder suspect that others are planning to exploit, deceive, or harm them. They feel that they may be attacked at any time and without reason. Even though there is little or no evidence, they persist in maintaining their suspicions and thoughts.
- **Option D:** Often, these patients think that others have greatly and irreversibly injured them. They are hypervigilant for potential insults, slights, threats, and disloyalty and look for hidden meanings in remarks and actions. They closely scrutinize others for evidence to support their suspicions. For example, they may misinterpret an offer of help as implication that they are unable to do the task on their own. If they think that they have been insulted or injured in any way, they do not forgive the person who injured them. They tend to counterattack or to become angry in response to these

perceived injuries. Because they distrust others, they feel a need to be autonomous and in control.

22. Collaborative interventions are therapies that require:

- A. Physician and nurse interventions.
- B. Nurse and client interventions.
- C. Client and Physician intervention.
- D. Multiple health care professionals.

Correct Answer: D. Multiple health care professionals.

Collaborative interventions are actions that the nurse carries out in collaboration with other health team members, such as physicians, social workers, dietitians, and therapists. These actions are developed in consultation with other health care professionals to gain their professional viewpoint.

- **Option A:** Dependent nursing interventions are activities carried out under the physician's orders or supervision. Includes orders to direct the nurse to provide medications, intravenous therapy, diagnostic tests, treatments, diet, and activity or rest.
- **Option B:** Independent nursing interventions are activities that nurses are licensed to initiate based on their sound judgment and skills. Includes ongoing assessment, emotional support, providing comfort, teaching, physical care, and making referrals to other health care professionals.
- **Option C:** Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis. In this step, nursing interventions are identified and written during the planning step of the nursing process; however, they are actually performed during the implementation step.

23. After taking glipizide (Glucotrol) for 9 months, a male client experiences secondary failure. Which of the following would the nurse expect the physician to do?

- A. Initiate insulin therapy.
- B. Switch the client to a different oral antidiabetic agent.
- C. Prescribe an additional oral antidiabetic agent.
- D. Restrict carbohydrate intake to less than 30% of the total caloric intake.

Correct Answer: B. Switch the client to a different oral antidiabetic agent.

Many clients (25% to 60%) with secondary failure respond to a different oral antidiabetic agent. Therefore, it wouldn't be appropriate to initiate insulin therapy at this time. However, if a new oral antidiabetic agent is unsuccessful in keeping glucose levels at an acceptable level, insulin may be used in addition to the antidiabetic agent.

- **Option A:** Glipizide can be used concomitantly with insulin, but the dose of glipizide will typically need to be at the lower end of the dose range to prevent hypoglycemia. If discontinuation of insulin becomes necessary, then the patient's urine and blood sugars should be monitored at least three times a day.
- **Option C:** Second-generation sulfonylureas are considered to be more potent by weight when compared to the first-generation agents. Sulfonylureas were discovered in 1942 and have enjoyed

extensive use in type 2 diabetes mellitus treatment since the 1960s.

- **Option D:** Other drug classes used in the treatment of diabetes mellitus type 2 include alpha-glucosidase inhibitors, biguanides, dipeptidyl peptidase-4 (DPP-4) inhibitors, glucagon-like peptide-1 (GLP-1) receptor agonists, glinides, and thiazolidinediones.

24. Martin, a 65-year-old retired orchestra conductor, has been managing his gout for several years. Due to the persistence of his symptoms and elevated uric acid levels, his doctor has recently prescribed probenecid. During a follow-up visit at the clinic, Nurse Gabrielle inquired about Martin's understanding of the new medication. Which statement by Martin would suggest that further patient teaching is necessary?

- A. "I will increase my fluid intake while taking this medication."
- B. "I will take this medication with food to prevent stomach upset."
- C. "I will avoid alcohol while on this medication."
- D. "I will monitor my uric acid levels regularly."

Correct Answer: B. "I will take this medication with food to prevent stomach upset."

Probenecid is best taken on an empty stomach to maximize absorption. Taking it with food may reduce its effectiveness.

- **Option A:** Increasing fluid intake is essential when taking probenecid to help prevent the formation of uric acid kidney stones.
- **Option C:** Avoiding alcohol is advised while on probenecid as it can increase uric acid levels and reduce the effectiveness of the drug.
- **Option D:** Monitoring uric acid levels regularly is essential for those with gout, it is the healthcare provider's responsibility to order these tests at appropriate intervals.

25. In the client with terminal lung cancer, the focus of nursing care is on which of the following nursing interventions?

- A. Prepare the client's will
- B. Provide pain control
- C. Provide nutritional support
- D. Provide emotional support

Correct Answer: B. Provide pain control

- **Option B:** The client with terminal lung cancer may have extreme pleuritic pain and should be treated to reduce his discomfort therefore improving the quality of life of the patient. Examples of pain medication used with advanced cancer are opioids such as morphine, oxycodone, fentanyl, or methadone.
- **Option A:** Nursing care doesn't focus on helping the client prepare the will.
- **Option D:** Preparing the client and his family for the impending death and providing emotional support is also important but shouldn't be the primary focus until the pain is under control.

- **Option C:** Nutritional support may be provided, but as the terminal phase advances, the client's nutritional needs greatly decrease.

26. In planning activities for the depressed client, especially during the early stages of hospitalization, which of the following plans is best?

- A. Provide an activity that is quiet and solitary to avoid increased fatigue, such as working on a puzzle or reading a book.
- B. Plan nothing until the client asks to participate in milieu.
- C. Offer the client a menu of daily activities and insist the client participate in all of them
- D. Provide a structured daily program of activities and encourage the client to participate.

Correct Answer: D. Provide a structured daily program of activities and encourage the client to participate.

A depressed person experiences a depressed mood and is often withdrawn. The person also experiences difficulty concentrating, loss of interest or pleasure, low energy, fatigue, and feelings of worthlessness, and poor self-esteem. The plan of care needs to provide successful experiences in a stimulating yet structured environment. Involve the client in gross motor activities that call for very little concentration (e.g., walking). Such activities will aid in relieving tensions and might help in elevating the mood.

- **Option A:** Initially, provide activities that require minimal concentration (e.g., drawing, playing simple board games). Depressed people lack concentration and memory. Activities that have no "right or wrong" or "winner or loser" minimizes opportunities for the client to put himself/herself down. When the client is in the most depressed state, involve the client in a one-to-one activity. Maximizes the potential for interactions while minimizing anxiety levels.
- **Option B:** Eventually involve the client in group activities (e.g., group discussions, art therapy, dance therapy). Socialization minimizes feelings of isolation. Genuine regard for others can increase feelings of self-worth. Eventually maximize the client's contacts with others (first one other, then two others, etc.). Contact with others distracts the client from self-preoccupation.
- **Option C:** This is a forceful and absolute approach. Allow the patient to engage in simple recreational activities, advancing to more complex activities in a group environment. The patient may feel overwhelmed at the start when participating in a group setting. Encourage the client to participate in group therapy where the members share the same situations/feelings that they have.

27. 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.

28. The nurse is aware that the following is the most common cause of hyperaldosteronism?

- A. Excessive sodium intake
- B. A pituitary adenoma
- C. Deficient potassium intake
- D. An adrenal adenoma

Correct Answer: D. An adrenal adenoma

An autonomous aldosterone-producing adenoma is the most common cause of hyperaldosteronism. Hyperplasia is the second most frequent cause. Excess production of aldosterone is referred to as hyperaldosteronism. Hyperaldosteronism can initially present as mild or severe to refractory hypertension but can often go undiagnosed. Aldosterone secretion is independent of sodium and potassium intake as well as of pituitary stimulation.

- **Option A:** Aldosterone is the primary mineralocorticoid in the body. Aldosterone acts on the epithelial sodium channels (ENaC) in the collecting tubules and causes sodium reabsorption. The increased reabsorption of sodium leads to hypertension and volume expansion. Sodium reabsorption, volume expansion, and increased peripheral vascular resistance are the causative factors for hypertension in aldosteronism.
- **Option B:** Primary hyperaldosteronism is due to the excess production of the adrenal gland, more specifically the zona glomerulosa. It can present more commonly as a primary tumor in the gland known as Conn syndrome or bilateral adrenal hyperplasia.
- **Option C:** Sodium reabsorption creates a negative potential in the tubular lumen and, in turn, causes movement of cations (primarily potassium and hydrogen ions) into the tubular lumen to maintain electrical neutrality, resulting in hypokalemia and metabolic alkalosis. Symptoms are usually due to moderate to severe high blood pressure or secondary to hypokalemia. High blood pressure can cause headaches, dizziness, vision problems, chest pain, and dyspnea.

29. Which choice describes the action of nucleoside analogs?

- A. Exert anti-HIV activity at the reverse transcriptase level and cause premature termination of viral DNA chain synthesis.
- B. Completely stop the replication of HIV virus.
- C. Allow for a patient to become non-contagious after taking for at least 3 days.
- D. Are all equally effective and free of side effects.

Correct Answer: A. Exert anti-HIV activity at the reverse transcriptase level and cause premature termination of viral DNA chain synthesis

This choice correctly describes the action of nucleoside analogs. The nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs) were the first class of antiretroviral drugs to be approved by the FDA. NRTIs are taken as prodrugs and must be taken into the host cell and phosphorylated before they become active. Once inside the host cell, cellular kinases will activate the drug. The drug exerts its effect through its structure.

- **Option B:** NRTIs lack a 3'-hydroxyl group at the 2'-deoxyribosyl moiety and will have either a nucleoside or nucleotide as a base. Due to the missing 3'hydroxyl group, the NRTI prevents the formation of a 3'-5'-phosphodiester bond in growing DNA chains and can thus prevent replication of the virus.
- **Option C:** An interesting feature of these drugs is that their incorporation during RNA-dependent DNA or DNA-dependent DNA synthesis, which inhibits the production of either positive or negative strands of the DNA.
- **Option D:** Currently, research and trials are underway to assess the efficacy in the use of reverse transcriptase inhibitors for pre-exposure prophylaxis. Studies show that there is anywhere from a 67% to 75% reduction in the risk of becoming infected through the use of pre-exposure prophylaxis.

30. A client diagnosed with post-traumatic stress disorder is admitted to an inpatient psychiatric unit for evaluation and medication stabilization. Which therapeutic communication technique used by the nurse is an example of a broad opening?

- A. "What occurred prior to the rape, and when did you go to the emergency department?"
- B. "What would you like to talk about?"
- C. "I notice you seem uncomfortable discussing this."
- D. "How can we help you feel safe during your stay here?"

Correct Answer: B. "What would you like to talk about?"

The nurse's statement, "What would you like to talk about?" is an example of the therapeutic communication technique of giving broad openings. Using a broad opening allows the client to take the initiative in introducing the topic and emphasizes the importance of the client's role in the interaction.

- **Option A:** Placing events in time or sequences refers to clarifying the relationship of events in time. Putting events in proper sequence helps both the nurse and the client to see them in perspective. The client may gain insight into cause-and-effect behavior and consequences.
- **Option C:** Making observations refers to verbalizing what the nurse perceives. For example, the nurse says, "You appear tense." or "I notice you are biting your lip." Sometimes clients cannot verbalize or make themselves understood. Or the client may not be ready to talk.

- **Option D:** Theme identification allows the nurse to identify underlying issues and problems experienced by the client that emerge repeatedly during a nurse-client relationship. It allows the nurse to best promote the client's exploration and understanding of important problems.

31. Anthony suffers burns on the legs, which nursing intervention helps prevent contractures?

- A. Applying knee splints.
- B. Elevating the foot of the bed.
- C. Hyperextending the client's palms.
- D. Performing shoulder range-of-motion exercises.

Correct Answer: A. Applying knee splints.

Applying knee splints prevents leg contractures by holding the joints in a position of function.

- **Option B:** Elevating the foot of the bed can't prevent contractures because this action doesn't hold the joints in a position of function.
- **Option C:** Hyperextending a body part for an extended time is inappropriate because it can cause contractures.
- **Option D:** Performing shoulder range-of-motion exercises can prevent contractures in the shoulders, but not in the legs.

32. She tries to design an organizational structure that allows communication to flow in all directions and involves workers in decision-making. Which form of organizational structure is this?

- A. Centralized
- B. Decentralized
- C. Matrix
- D. Informal

Correct Answer: B. Decentralized

Decentralized structures allow the staff to make decisions on matters pertaining to their practice and communicate in downward, upward, lateral and diagonal flow. Decentralization is a type of organizational structure in which daily operations and decision-making responsibilities are delegated by top management to middle and lower-level managers.

- **Option A:** Centralized management is the organizational structure where a small handful of individuals make most of the decisions in a company. More centralized management is usually seen in highly competitive industries, where companies specialize in similar products to their competition.
- **Option C:** A matrix organizational structure is a workplace format in which employees report to two or more managers rather than one manager overseeing every aspect of a project. For example, an employee may have a primary manager they report to as well as one or more project managers they work under.

- **Option D:** The informal organization is the interlocking social structure that governs how people work together in practice. It is the aggregate of behaviors, interactions, norms, and personal/professional connections through which work gets done and relationships are built among people.

33. A group of people arrived at the emergency unit by a private car with complaints of periorbital swelling, cough, and tightness in the throat. There is a strong odor emanating from their clothes. They report exposure to a “gas bomb” that was set off in the house. What is the priority action?

- A. Instruct personnel to don personal protective equipment
- B. Direct the clients to the cold or clean zone for immediate treatment
- C. Immediately remove other clients and visitors from the area
- D. Measure vital signs and auscultate lung sounds
- E. Direct the clients to the decontamination area

Correct Answer: E. Direct the clients to the decontamination area.

Decontamination in a specified area is the priority. The decontamination and support areas are established within the Warm Zone, also referred to as the Contamination Reduction Zone. Decontamination involves thorough washing to remove contaminants.

- **Option A:** Personnel should don personal protective equipment before assisting with decontamination or assessing the clients. Take precautionary measures to preserve the health and safety of emergency responders working within the Contamination Reduction (Warm) Zone and the Exclusion (Hot) Zone. This includes ensuring responders wear appropriate personal protective equipment (PPE).
- **Option B:** The clients must undergo decontamination before entering cold or clean areas. In mass casualty incidents, decontamination corridors can be set up that consist of high volume, low-pressure water deluges. Assign personnel to decontamination stations to control and instruct victims when they enter the decontamination area.
- **Option C:** Decontamination triage is especially important in mass casualty incidents and should not be confused with medical triage. Decontamination triage is the process of determining which victims require decontamination and which do not. Rapidly identifying victims who may not require decontamination can significantly reduce the time and resources needed for mass decontamination.
- **Option D:** Set up or assign an area or building as a safe refuge/observation area for victims who do not require medical attention. Here they can be monitored for a delayed outbreak of symptoms or indications of residual contamination.

34. A 3-year old boy with vesicoureteral reflux is scheduled for ureteral reimplantation. His father plans to go home during the surgery to get his favorite toy. When the father left, the boy asked the nurse when will his father be back? The nurse’s best response is:

- A. “Your daddy will be back later this afternoon”
- B. “Your daddy will be back at 11 am”

- C. "Your daddy will be back after you wake up"
- D. "Your daddy will be back within 2 ½ hours"

Correct Answer: C. "Your daddy will be back after you wake up."

A preschool child understands the concept of time through events and symbols. Following and being involved with a familiar sequence of routines and schedules enhances their time awareness of the present, past, and future. Preschoolers also need to build on these experiences, because time is such an abstract concept for young children. For them, it is rather intangible.

- **Option A:** Between ages 4-5, a child begins to have an understanding of time but it is still vague. Before and after are time concepts understood by preschoolers. Although 3- and 4-year-olds have the ability to describe events that happen in the past and know specific words that describe past events ("last week" or "a few days ago"), they may not always get the duration of the time exactly right.
- **Option B:** Between ages 6 to 8 years old, children learn the concept of minutes in an hour, number of hours in a day, and can compare time. Of course, recognizing the parts of the day is the most basic way children become aware of the passage of time. Their capacity to learn about time increases as they become aware of how events reoccur at specific times during the day.
- **Option D:** Kindergartners want to know what time it is and are beginning to understand that certain things (like the start and end of school) happen at a defined time each day. Make a photographic timeline for the day at school, marking each event with a picture of the clock at that time and the time written numerically.

35. A nurse is caring for a client who has returned to the recovery unit following a craniotomy. The nurse can safely place the client in which position?

- A. Trendelenburg position.
- B. Fowler's position with the head leaning on the left side.
- C. Semi-fowler's position with the head in a midline position.
- D. Supine position with the neck flexed.

Correct Answer: C. Semi-Fowler's position with the head in a midline position.

Post-craniotomy clients should be placed in a semi-Fowler's position and the head is in a midline position to facilitate venous drainage from the head. For nearly all types of craniotomy, the patient is observed for at least the first 24 hours in a neurological intensive care unit (NICU) or general surgical ICU. Basic laboratory tests are sent (complete blood cell count and basic metabolic panel). Neurological examinations are performed by the nursing staff every 1-2 hours and any changes in neurologic status.

- **Option A:** Placing the client in a Trendelenburg position may increase the swelling of the brain. Frequent neurological checks will be done by the nursing and medical staff to test the brain function and to make sure the body systems are functioning properly after the surgery. The client will be asked to follow a variety of basic commands, such as moving the arms and legs, to assess brain function.
- **Option B:** The client's head must be placed in a midline position to facilitate venous drainage from the head and reduce the swelling. The recovery process will vary depending upon the type of procedure done and the type of anesthesia given. Once the client's blood pressure, pulse, and breathing are stable and he is alert, he may be taken to the ICU or the hospital room.

- **Option D:** The head of the bed may be elevated to prevent swelling of the face and head. Some swelling is normal. The client will be encouraged to move around as tolerated while in bed and to get out of bed and walk around, with assistance at first, as his strength improves. A physical therapist (PT) may be asked to evaluate the client's strength, balance, and mobility, and give him suggestions for exercises to do both in the hospital and at home.