

# Kevin's Review - 35 NCLEX Practice Questions

**1. The nursing students are in a simulation lab, observing a high-fidelity manikin that mimics various cardiac conditions. As the manikin's heart sound changes, the nursing instructor uses this as an opportunity to test the students' understanding of cardiac physiology. With an eager tone, the instructor says, "Let's test our understanding, students. Remember our discussion on the different phases of the cardiac cycle?" She then presents the statement: "During Ventricular Systole, atrioventricular valves open, semilunar valves close." The students are asked to evaluate the correctness of this statement. Based on your understanding of cardiac physiology, how would you assess the accuracy of the instructor's statement: "During Ventricular Systole, atrioventricular valves open, semilunar valves close."?**

- A. True
- B. False
- C. Partially true
- D. Partially false

**Correct Answer: B. False**

During ventricular systole, contraction of the ventricles causes pressure in the ventricle to increase. Almost immediately the AV valves close (the first heart sound). The pressure in the ventricle continues to increase. Continued ventricular contraction causes the pressure in the ventricle to exceed in the pulmonary trunk and aorta. As a result, the semilunar are forced open and blood is ejected into the pulmonary trunk and aorta.

- **Option A:** This choice would be inappropriate because the statement provided by the instructor is not accurate in its entirety.
- **Option C:** Choosing this option would indicate that one part of the statement is true. However, neither part of the instructor's statement is correct.
- **Option D:** This choice implies that part of the statement is accurate, but given that the entire statement is incorrect, this option is not the best choice.

**2. A mother of a 14-year-old client receiving chemotherapy for leukemia calls out to the unit concerning her other child having chickenpox. Which of these actions will the nurse anticipate taking next?**

- A. Plan to admit the client to a private room in the hospital.
- B. Teach the mother about contact and airborne precautions.
- C. Educate the mother about the correct use of acyclovir (Zovirax).
- D. Administer varicella-zoster immune globulin to the client.

**Correct Answer: D. Administer varicella-zoster immune globulin to the client**

The development of varicella in high-risk clients can be prevented via administration of varicella-zoster immune globulin prescribed by the physician. Varicella zoster immunoglobulin (VZIG) is a scarce blood product that is offered to individuals at high risk of severe chickenpox following an exposure.

- **Option A:** Hospitalization may be required if the child develops a varicella-zoster virus infection. The incidence of varicella was higher in children with leukemia or lymphoma than in children with other types of cancer. Virus reactivation was uncommon and had a benign course. Varicella mortality in these children could be favorably modified through an active immunization of immunocompetent children.
- **Option B:** Contact and airborne precautions will be implemented to prevent the spread of infection to other children if the child develops varicella. Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely.
- **Option C:** Acyclovir is a medication used in the management and treatment of infections caused by the herpes simplex virus (HSV). It is FDA approved to treat genital herpes and HSV encephalitis. Some off-label uses include cold sores, shingles, and chickenpox. It is in the antiviral class of medications.

**3. Which of the following is characteristic of a preschooler with mild-mental retardation?**

- A. Slow to feed self.
- B. Lack of speech.
- C. Marked motor delays.
- D. Gait disability.

**Correct Answer: A. Slow to feed self.**

Mild mental retardation refers to developmental disability involving an IQ of 50 to 70. Typically, the child is not noted as being retarded, but exhibits slowness in performing tasks, such as self-feeding, walking, and taking.

- **Option B:** A speech delay might be due to an oral impairment, like problems with the tongue or palate (the roof of the mouth) or a short frenulum (the fold beneath the tongue), which can limit tongue movement.
- **Option C:** Gross motor delays are common and vary in severity and outcome. Some children with gross motor delays attain typical milestones at a later age. Other children have a permanent motor disability, such as cerebral palsy, which has a prevalence of 3.3 per 1000.
- **Option D:** Gait disabilities would be seen in more severe forms of mental retardation. During a child's first few years walking, they may have obvious gait abnormalities — disturbances in what is considered the normal walking cycle for that age group.

**4. A nurse is making initial rounds at the beginning of the shift and notices that the parenteral nutrition (PN) bag of an assigned client is empty. Which of the following solutions readily available on the nursing unit should the nurse hang until another PN solution is mixed and delivered to the nursing unit?**

- A. 10% dextrose in water.
- B. 5% dextrose in water.
- C. 5% dextrose in normal saline.
- D. 5% dextrose in lactated Ringer solution.

**Correct Answer: A. 10% dextrose in water.**

The client is at risk of hypoglycemia. Hence the nurse will hang a solution that has the highest amount of glucose until the new parenteral nutrition solution becomes readily available. Crystalloid fluids are a subset of intravenous solutions that are frequently used in the clinical setting. Crystalloid fluids are the first choice for fluid resuscitation in the presence of hypovolemia, hemorrhage, sepsis, and dehydration.

- **Option B:** Option B is also a crystalloid fluid, but contains less glucose than option A. Other clinical applications include acting as a solution for intravenous medication delivery, to deliver maintenance fluid in patients with limited or no enteral nutrition, blood pressure management, and to increase diuresis to avoid nephrotoxic drug or toxin-mediated end-organ damage.
- **Option C:** Dextrose 5 in .9 Sodium Chloride is a prescription medicine used to treat the symptoms of hypoglycemia. Dextrose 5 in .9 Sodium Chloride may be used alone or with other medications. Dextrose 5 in .9 Sodium Chloride belongs to a class of drugs called Glucose-Elevating Agents; Metabolic and Endocrine, Other.
- **Option D:** 5% Dextrose in Lactated Ringer's Injection provides electrolytes and calories, and is a source of water for hydration. It is capable of inducing diuresis depending on the clinical condition of the patient. This solution also contains lactate which produces a metabolic alkalizing effect.

**5. Jose is diagnosed with amphetamine psychosis and was admitted to the emergency room. Nurse Ronald would most likely prepare to administer which of the following medication?**

- A. Librium
- B. Valium
- C. Ativan
- D. Haldol

**Correct Answer: D. Haldol**

The nurse would prepare to administer an antipsychotic medication such as Haldol to a client experiencing amphetamine psychosis to decrease agitation & psychotic symptoms, including delusions, hallucinations & cognitive impairment. Haloperidol is a first-generation (typical) antipsychotic medication that is used widely around the world. Food and Drug Administration (FDA) approved the use of haloperidol is for schizophrenia, Tourette syndrome (control of tics and vocal utterances in adults and children), hyperactivity (which may present as impulsivity, difficulty maintaining attention, severe aggressivity, mood instability, and frustration intolerance), severe childhood behavioral problems (such as combative, explosive hyperexcitability), intractable hiccups. It is a typical antipsychotic because it works on positive symptoms of schizophrenia, such as hallucinations and delusions.

- **Option A:** Chlordiazepoxide is a long-acting benzodiazepine and is an FDA approved medication for adults with mild-moderate to severe anxiety disorder, preoperative apprehension and anxiety, and withdrawal symptoms of acute alcohol use disorder. It is also FDA approved for pediatric patients greater than six years old for anxiety. Chlordiazepoxide has anti-anxiety, sedative, appetite-stimulating, and weak analgesic actions.
- **Option B:** Diazepam is an anxiolytic benzodiazepine, first patented and marketed in the United States in 1963. It is a fast-acting, long-lasting benzodiazepine commonly used in the treatment of anxiety disorders, as well as alcohol detoxification, acute recurrent seizures, severe muscle spasm, and spasticity associated with neurologic disorders. In the setting of acute alcohol withdrawal, diazepam is useful for symptomatic relief of agitation, tremor, alcoholic hallucinosis, and acute

delirium tremens.

- **Option C:** Lorazepam has common use as the sedative and anxiolytic of choice in the inpatient setting owing to its fast (1 to 3 minute) onset of action when administered intravenously. Lorazepam is also one of the few sedative-hypnotics with a relatively clean side effect profile. Lorazepam is FDA approved for short-term (4 months) relief of anxiety symptoms related to anxiety disorders, anxiety-associated insomnia, anesthesia premedication in adults to relieve anxiety, or to produce sedation/amnesia, and treatment of status epilepticus.

**6. Grace is exhibiting withdrawn patterns of behavior. Nurse Johnny is aware that this type of behavior eventually produces a feeling of:**

- A. Repression
- B. Loneliness
- C. Anger
- D. Paranoia

**Correct Answer: B. Loneliness**

The withdrawn pattern of behavior presents the individual from reaching out to others for sharing the isolation produces a feeling of loneliness. Prolonged loneliness can affect mental health, too. It can make any symptoms you're already dealing with worse, for one. But it can also factor into the development of serious mental health conditions, including depression. Loneliness may not feel very comfortable, but it's a transient emotional state that specifically relates to your needs for connection and belonging. Once you meet those needs, you'll probably feel less lonely.

- **Option A:** Repression is a type of psychological defense mechanism that involves keeping certain thoughts, feelings, or urges out of conscious awareness. The goal of this form of defense is to keep unacceptable desires or thoughts out of the conscious mind in order to prevent or minimize feelings of anxiety. This process involves pushing painful or disturbing thoughts into the unconscious in order to remain unaware of them. The concept was first identified and described by Sigmund Freud, who was most famous for the development of psychoanalysis.
- **Option C:** Anger is an emotion characterized by antagonism toward someone or something you feel has deliberately done you wrong. Anger can be a good thing. It can give you a way to express negative feelings, for example, or motivate you to find solutions to problems. But excessive anger can cause problems. Increased blood pressure and other physical changes associated with anger make it difficult to think straight and harm your physical and mental health.
- **Option D:** Paranoia involves intense anxious or fearful feelings and thoughts often related to persecution, threat, or conspiracy. Paranoia occurs in many mental disorders, but is most often present in psychotic disorders. Paranoia can become delusions, when irrational thoughts and beliefs become so fixed that nothing (including contrary evidence) can convince a person that what they think or feel is not true. When a person has paranoia or delusions, but no other symptoms (like hearing or seeing things that aren't there), they might have what is called a delusional disorder. Because only thoughts are impacted, a person with delusional disorder can usually work and function in everyday life, however, their lives may be limited and isolated.

**7. A patient is admitted to the hospital with a diagnosis of primary hyperparathyroidism. A nurse checking the patient's lab results would expect which of the following changes in laboratory findings?**

- A. Elevated serum calcium
- B. Low serum parathyroid hormone (PTH)
- C. Elevated serum vitamin D
- D. Low urine calcium

**Correct Answer: A. Elevated serum calcium**

The parathyroid glands regulate the calcium level in the blood. In hyperparathyroidism, the serum calcium level will be elevated. A normal PTH in the presence of hypercalcemia is considered inappropriate and still consistent with PTH-dependent hypercalcemia. PTH levels should be very low in those patients with PTH-independent hypercalcemia. A comprehensive clinical evaluation complemented by routine laboratory and radiologic studies should be sufficient to establish a diagnosis of primary hyperparathyroidism in a patient with persistent hypercalcemia and an elevated serum level of parathyroid hormone.

- **Option B:** Parathyroid hormone levels may be high or normal but not low. Patients with primary hyperparathyroidism and other causes of PTH-dependent hypercalcemia often have frankly elevated levels of PTH, while some will have values that fall within the reference range for the general population. It is uncommon for clinically occult malignancies to cause hypercalcemia. Most patients with malignancy-associated hypercalcemia are known to have cancer, or cancer is readily detectable on initial evaluation, and PTH levels will be suppressed.
- **Option C:** Parathyroid hormone levels may be high or normal but not low. The body will lower the level of vitamin D in an attempt to lower calcium.
- **Option D:** Urine calcium may be elevated, with calcium spilling over from elevated serum levels. This may cause renal stones. A review of previous medical records can often be of significant value in establishing the cause of hypercalcemia. Most patients with hyperparathyroidism have persistent or intermittent hypercalcemia for many years before a definitive diagnosis is established.

**8. Which of the following measures should the nurse focus on for the client with esophageal varices?**

- A. Recognizing hemorrhage.
- B. Controlling blood pressure.
- C. Encouraging nutritional intake.
- D. Teaching the client about varices.

**Correct Answer: A. Recognizing hemorrhage.**

Recognizing the rupture of esophageal varices, or hemorrhage is the focus of nursing care because the client could succumb to this quickly. A patient with bleeding esophageal varices is to be considered in critical condition. Nursing management is aimed at assisting the physician in controlling bleeding and preventing shock and death.

- **Option B:** Controlling blood pressure is also important because it helps reduce the risk of variceal rupture. As portal pressure increases, blood backs up into the spleen and bypasses the liver, returning to the right atrium via collateral circulation. The result is splenomegaly, ascites, and varicosities of the collateral veins (esophageal and gastric varices).
- **Option C:** It is also important to teach the client what foods he should avoid such as spicy foods. Additional teaching includes abstaining from alcohol, eating a healthy diet, and adhering to

short-term antibiotic therapy to prevent infection. Because rebleeding is common.

- **Option D:** It is also important to teach the client what varices are. Assess for ecchymosis, epistaxis, petechiae, and bleeding gums. Monitor level of consciousness, vital signs, and urinary output to evaluate fluid balance. Use small-gauge needles, and apply pressure or cold for bleeding.

**9. A 45-year-old male patient visits the cardiology clinic for his routine check-up. He mentions feeling palpitations recently and expresses concern about his heart's health due to a family history of cardiac diseases. To better educate the patient on heart anatomy and ensure he's aware of basic cardiac structures, the nurse uses a model of the heart. She asks him to identify specific parts to gauge his knowledge. Taking the model, she poses the question: "Can you point to the lower, pointed tip portion of the heart for me?" Based on the nurse's instruction, the patient should identify the lower, pointed tip portion of the heart commonly referred to as which of the following?**

- A. Aorta
- B. Apex
- C. Base
- D. Ventricular septum

**Correct Answer: B. Apex**

The "apex" in the context of the heart is the lower, pointed tip of the organ. It is located at the bottom of the heart, typically pointing down and to the left, and is responsible for initiating contractions that pump blood into the circulatory system.

- **Option A:** The aorta is the largest artery that carries blood from the left ventricle to the body.
- **Option C:** The larger, flat portion at the opposite is the base.
- **Option D:** The ventricular septum is the muscular wall that separates the right and left ventricles and is not the term used to describe the lower tip of the heart.

**10. While on pentamidine (Pentam) infusion therapy. The nurse must anticipate doing which of the following?**

- A. Secure a 12-lead ECG.
- B. Observe for signs of retinal damage.
- C. Instruct the client on a low potassium diet.
- D. Instruct the client on limiting fluid intake.

**Correct Answer: A. Secure a 12-lead ECG.**

Pentamidine may cause a condition that affects the heart rhythm (QT prolongation). QT prolongation can rarely cause serious fast/irregular heartbeat and other symptoms (such as severe dizziness, fainting) that need urgent medical attention.

- **Options B & D:** These are not related to the use of the medication.
- **Option C:** Low levels of potassium in the blood can increase the risk of QT prolongation.

**11. How will the nurse position a client with a burn wound to the posterior neck to prevent contractures?**

- A. Have the client turn the head from side to side.
- B. Keep the client in a supine position without the use of pillows.
- C. Keep the client in a semi-Fowler's position with her or his arms elevated.
- D. Place a towel roll under the client's neck or shoulder.

**Correct Answer: A. Have the client turn the head from side to side.**

Deformities and contractures can often be prevented by proper positioning. Maintaining proper body alignment when the patient is in bed is vital. The function that would be disrupted by a contracture to the posterior neck is flexion. Moving the head from side to side prevents such a loss of flexion. This movement is what would prevent contractures from occurring.

- **Option B:** The client should not only be in a supine position but there should be a movement to avoid contractures. Splinting and proper positioning will also help achieve the prevention of contractures. As a matter of importance, movement should be incorporated into the patient's daily routine from their inception to the hospital.
- **Option C:** The burns are in the client's posterior neck. Performing active or passive range of motion (ROM) exercises, depending on the patient's level of consciousness is crucial in the prevention of these complications.
- **Option D:** Placing a towel roll under the neck might not help prevent contractures. Immobilization is only allowed when a part of the body has just been grafted. Even then, the area must be kept in an antideformity position.

**12. Which of the following adverse reactions is found more often in volume-depleted elderly clients?**

- A. Bradycardia
- B. Conduction defects
- C. Ankle edema
- D. Hypotension

**Correct Answer: D. Hypotension**

Hypotension is more likely to occur in the elderly. Vital signs can be a key assessment in volume status. The kidneys have an autoregulation system, which allows renal blood flow to remain stable between systolic blood pressures of 80 mm Hg to 180 mm Hg. Hypotension, when blood pressure falls below 80 mm Hg, can diminish renal perfusion and could potentially precipitate renal failure. Other adverse reactions may occur but are not necessarily increased in frequency in elderly clients.

- **Option A:** Vital signs can be a key assessment in volume status. Postural hypotension, leading to dizziness may be indicative of hypovolemia. Tachycardia can be seen with volume depletion, as can orthostatic blood pressure readings. Again, both can be nonspecific for hypovolemia, but orthostatic hypotension will be found with profound hypo-volemia.

- **Option B:** Other medications may require serum monitoring. These medications include antibiotics and antiarrhythmics. As GFR decreases, so does the clearance of renally excreted medication. This is especially important in the old-old where GFR has decreased by 30% to 50% by 80 years of age. Cardiac drugs include digoxin and procainamide.
- **Option C:** The most significant sign of volume depletion is acute weight loss, which is defined as a 3% or greater loss in body weight. Numerous factors can affect the accuracy of daily weights, but a running trend may provide the first indication of volume status.

**13. The nurse is teaching a female client with a leg ulcer about tissue repair and wound healing. Which of the following statements by the client indicates effective teaching?**

- A. "I'll limit my intake of protein."
- B. "I'll make sure that the bandage is wrapped tightly."
- C. "My foot should feel cold."
- D. "I'll eat plenty of fruits and vegetables."

**Correct Answer: D. "I'll eat plenty of fruits and vegetables."**

For effective tissue healing, adequate intake of protein, vitamin A, B complex, C, D, E, and K are needed. Therefore, the client should eat a high protein diet with plenty of fruits and vegetables to provide these nutrients.

- **Option A:** The wound healing process further exacerbates protein loss, therefore during recovery, a high protein diet helps the body in repairing damaged tissues.
- **Option B:** The bandage should be secure but not too tight to impede circulation to the area (needed for tissue repair).
- **Option C:** If the client's foot feels cold, circulation is impaired, thus inhibiting wound healing.

**14. A pregnant woman's last menstrual period began on April 8, 2020, and ended on April 13. Using Naegele's rule her estimated date of birth would be:**

- A. January 15, 2021
- B. January 20, 2021
- C. July 1, 2021
- D. November 5, 2020

**Correct Answer: A. January 15, 2021.**

Naegele's rule requires subtracting 3 months and adding 7 days and 1 year if appropriate to the first day of a Naegele's rule requires subtracting 3 months and adding 7 days and 1 year if appropriate to the first day of a pregnant woman's last menstrual period. When this rule was used on April 8, 2020, the estimated date of birth was January 15, 2021.

- **Option B:** Determining gestational age is one of the most critical aspects of providing quality prenatal care. Knowing the gestational age allows the obstetrician to provide care to the mother without compromising maternal or fetal status. It allows for the correct timing of management, such as administering steroids for fetal lung maturity, starting ASA therapy with a history of



pre-eclampsia in previous pregnancies, starting hydroxyprogesterone caproate (Makena) for previous preterm deliveries.

- **Option C:** Naegele's rule, derived from a German obstetrician, subtracts 3 months and adds 7 days to calculate the estimated due date (EDD).
- **Option D:** 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.

**15. A client is receiving a transfusion of one unit of cryoprecipitate. The nurse will review which of the following laboratory studies to assess the effectiveness of the therapy?**

- A. Serum electrolytes
- B. White blood cell count
- C. Coagulation studies
- D. Hematocrit count

**Correct Answer: C. Coagulation studies**

The evaluation of the effective response of a cryoprecipitate transfusion is assessed by monitoring coagulation studies and fibrinogen levels. Cryoprecipitate Antihemophilic Factor, also called cryo, is a portion of plasma, the liquid part of the blood. Cryo is rich in clotting factors, which are proteins that can reduce blood loss by helping to slow or stop bleeding.

- **Option A:** Crystalloids are the fluids of choice for most minor procedures. They are sterile aqueous solutions that may contain glucose, various electrolytes, organic salts, and nonionic compounds. Some examples of these solutes are sodium chloride, potassium chloride, sodium bicarbonate, calcium carbonate, sodium acetate, sodium lactate, and sodium gluconate.
- **Option B:** White blood cells are transfused to treat life-threatening infections in people who have a greatly reduced number of white blood cells or whose white blood cells are functioning abnormally. The use of white blood cell transfusions is rare because improved antibiotics and the use of cytokine growth factors that stimulate people to produce more of their own white blood cells have greatly reduced the need for such transfusions.
- **Option D:** The average increase in hematocrit per liter of packed red blood cells transfused was 6.4% +/- 4.1%. If 1 "unit" of packed red blood cells is approximately 300 mL, this becomes a change of hematocrit of 1.9% +/- 1.2% per "unit" of blood. The accepted correlation of about 1 "unit" of blood loss per 3% change in hematocrit would be valid for a 500-cc unit, but a typical unit of packed red blood cells is typically 300 cc.

**16. A client who is HIV+ has had a PPD skin test. The nurse notes a 7-mm area of induration at the site of the skin test. The nurse interprets the results as:**

- A. Positive
- B. Negative
- C. Inconclusive
- D. The need for repeat testing.

**Correct Answer: A. Positive**

The client with HIV+ status is considered to have positive results on PPD skin test with an area greater than 5-mm of induration. The client with HIV is immunosuppressed, making a smaller area of induration positive for this type of client. If the PPD is reddened and raised 10mm or more, it's considered positive according to the CDC. If the infection risk is very high, the PPD test need not be repeated. The positive PPD test is usually followed by TB symptom assessment, physical exam, and chest radiograph.

- **Option B:** If the patient is at a high risk of developing an active infection, a repeat test is recommended after an initial negative test to rule out the possibility of missing a case. However, a decision is made based on the risk factors.
- **Option C:** Inconclusive isn't a term used to describe results of a PPD test. It is a time-sensitive test. Tests that are read late are not accurate as they tend to under-estimate the size of the skin reaction. Therefore, the reliability of the test is compromised, and the results are doubtful.
- **Option D:** To avoid this, repeat testing is recommended if the reaction is not read on time. The second test can be administered as soon as possible. However, if repeated, the test should preferably be performed within 7 days of the initial test to avoid boosting effect.

**17. A client is suspected of having hepatitis. Which diagnostic test result will assist in confirming this diagnosis?**

- A. Elevated hemoglobin level
- B. Elevated serum bilirubin level
- C. Elevated blood urea nitrogen level
- D. Decreased erythrocyte sedimentation rate

**Correct Answer: B. Elevated serum bilirubin level.**

Laboratory indicators of hepatitis include elevated liver enzyme levels, elevated serum bilirubin levels, elevated erythrocyte sedimentation rates, and leukopenia. Baseline evaluation in a patient suspected to have viral hepatitis can be started by checking a hepatic function panel. Patients who have a severe disease can have elevated total bilirubin levels. Typically, levels of alkaline phosphatase (ALP) remain in the reference range, but if it is elevated significantly, the clinician should consider biliary obstruction or liver abscess.

- **Option A:** A hemoglobin level is unrelated to this diagnosis. In advanced liver disease, prothrombin time (PT) and international normalized ratio (INR) may appear prolonged. Patients may also have leukopenia and thrombocytopenia. Patients who suffer from easy bruising, variceal bleed, or hemorrhoidal bleed due to advanced liver disease may have anemia with low hemoglobin and hematocrit levels.
- **Option C:** An elevated blood urea nitrogen level may indicate renal dysfunction. Blood urea nitrogen (BUN) and serum creatinine levels are also necessary for patients suspected to have advanced liver disease to look for renal impairment. Patients who present with altered mental status should have serum ammonia levels checked and are usually elevated in the presence of hepatic encephalopathy.
- **Option D:** Elevated erythrocyte sedimentation rate is a laboratory indicator of hepatitis. The increase in the ESR in type A hepatitis could be explained by changes in the serum protein levels in the course of acute viral hepatitis and/or by the different inflammatory activity of the underlying disease.

**18. The nurse is caring for a 20 lbs (9 kg) 6 month-old with a 3-day history of diarrhea, occasional vomiting and fever. Peripheral intravenous therapy has been initiated, with 5% dextrose in 0.33% normal saline with 20 mEq of potassium per liter infusing at 35 ml/hr. Which finding should be reported to the healthcare provider immediately?**

- A. 3 episodes of vomiting in 1 hour.
- B. Periodic crying and irritability.
- C. Vigorous sucking on a pacifier.
- D. No measurable voiding in 4 hours.

**Correct Answer: D. No measurable voiding in 4 hours.**

The concern is possible hyperkalemia, which could occur with continued potassium administration and a decrease in urinary output since potassium is excreted via the kidneys. Successful management of acute hyperkalemia involves protecting the heart from arrhythmias with the administration of calcium, shifting potassium (K+) into the cells, and enhancing the elimination of K+ from the body.

- **Option A:** Episodes of vomiting should be reported, but it is not the priority and is currently being managed with intravenous infusions. Once clinically significant dehydration is present, effective and safe strategies for rehydration are required. Additionally, following rehydration there may be a risk of recurrence of dehydration and appropriate fluid management may reduce the likelihood of that event.
- **Option B:** Crying and irritability is a normal reaction of an infant who is unwell.
- **Option C:** Vigorous sucking is a good sign in an infant who has episodes of vomiting.

**19. When developing a teaching plan for a client with endocarditis, which of the following points is most essential for the nurse to include?**

- A. "Report fever, anorexia, and night sweats to the physician."
- B. "Take prophylactic antibiotics after dental work and invasive procedures."
- C. "Include potassium rich foods in your diet."
- D. "Monitor your pulse regularly."

**Correct Answer: A. "Report fever, anorexia, and night sweats to the physician."**

An essential teaching point is to report signs of relapse, such as fever, anorexia, and night sweats, to the physician. An early manifestation of the disease is mild. Prolonged duration of fever that persists for several months without other manifestations may be the only symptom. On the other hand, the onset can be acute and severe with high, intermittent fever.

- **Option B:** To prevent further endocarditis episodes, prophylactic antibiotics are taken before and sometimes after dental work, childbirth, or GU, GI, or gynecologic procedures. Antibiotic therapy can be adjusted depending on the clinical status of the patient and laboratory findings regarding antibiogram. Antibiotics should be administered intravenously to achieve reliable sustained therapeutic levels.
- **Option C:** A potassium-rich diet is not necessary for patients with endocarditis. In 2007, the AHA modified their infective endocarditis prophylaxis guidelines, and the indications for prophylaxis were

reduced for dental procedures, genitourinary, and gastrointestinal tract procedures.

- **Option D:** Daily pulse monitoring isn't necessary for a client with endocarditis. The presence of a new heart murmur or sounds of changing heart murmur is associated with heart failure. Splenomegaly, Roth spots, Janeway lesions, splinter hemorrhage, Osler nodes, and petechial are frequently seen.

**20. A nurse is preparing to initiate a bladder training program for a client who has a voiding disorder. Which of the following actions should the nurse take? Select all that apply.**

- A. Establish a schedule of voiding prior to meal times.
- B. Have the client record voiding times.
- C. Gradually increase the voiding intervals.
- D. Reminded client to hold urine until next scheduled voiding time.
- E. Provide a sterile container for voiding.

**Correct Answer: B, C, and D**

Ask the client to keep track of voiding times is an appropriate nursing action. Gradually increasing the voiding interval is an appropriate nursing action. The client should be reminded to hold urine until the next scheduled voiding time. Bladder training involves voiding at scheduled in frequent intervals and gradually increasing these intervals to four hours.

- **Option A:** Mealtimes are not regular, and the intervals may be longer than every four hours. Bladder training requires following a fixed voiding schedule, whether or not one feels the urge to urinate. If one feels an urge to urinate before the assigned interval, he should use urge suppression techniques — such as relaxation and Kegel exercises.
- **Option B:** Keeping a diary of bladder activity is very important. This helps the health care provider determine the correct place to start the training and to monitor progress throughout the program.
- **Option C:** Bladder training is an important form of behavior therapy that can be effective in treating urinary incontinence. The goals are to increase the amount of time between emptying the bladder and the amount of fluids the bladder can hold. It also can diminish leakage and the sense of urgency associated with the problem.
- **Option D:** When the client feels the urge to urinate before the next designated time, he should use “urge suppression” techniques or try relaxation techniques like deep breathing. Focus on relaxing all other muscles. If possible, he must sit down until the sensation passes. If the urge is suppressed, adhere to the schedule. If the client cannot suppress the urge, wait five minutes then slowly make way to the bathroom. After urinating, re-establish the schedule. Repeat this process every time an urge is felt.
- **Option E:** A sterile container is not used in a bladder training program. When the client has accomplished the initial goal, he should gradually increase the time between emptying the bladder by 15-minute intervals. He should try to increase the interval each week. However, he will be the best judge of how quickly he can advance to the next step. Increase the time between each urination until he reaches a three- to four-hour voiding interval.

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

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

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

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

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

**22. Jordin is a client with jaundice who is experiencing pruritus. Which nursing intervention would be included in the care plan for the client?**

- A. Administering vitamin K subcutaneously
- B. Applying pressure when giving I.M. injections
- C. Decreasing the client's dietary protein intake
- D. Keeping the client's fingernails short and smooth

**Correct Answer: D. Keeping the client's fingernails short and smooth**

The client with pruritus experiences itching, which may lead to skin breakdown and possibly infection from scratching. Keeping his fingernails short and smooth helps prevent skin breakdown and infection from scratching. Encourage the patient to adopt skin care routines to decrease skin irritation. One of the first steps in the management of pruritus is promoting healthy skin and healing of skin lesions.

- **Option A:** Administering vitamin K subcutaneously is important if the client develops bleeding problems. Instruct the client to bathe or shower using lukewarm water and mild soap or nonsoap cleansers. Long bathing or showering in hot water causes drying of the skin and can aggravate itching through vasodilation.
- **Option B:** Applying pressure when giving I.M. injections is important if the client develops bleeding problems. Instruct the client to allow the skin to air dry or gently pat the skin dry after bathing. Avoid rubbing or brisk drying. Rubbing the skin with a towel can irritate the skin and exacerbate the itch-scratch cycle.

- **Option C:** Decreasing the client's dietary intake is appropriate if the client's ammonia levels are increased. The patient who scratches the skin to relieve intense itching may cause open skin lesions with an increased risk for infection. Characteristic patterns associated with scratching include reddened papules that run together and become confluent, widespread erythema, and scaling or lichenification.

**23. A client with macrocytic anemia has a burn on her foot and states that she had been watching television while lying on a heating pad. What is the nurse's first response?**

- A. Assess for potential abuse.
- B. Check for diminished sensations.
- C. Document the findings.
- D. Clean and dress the area.

**Correct Answer: B. Check for diminished sensations**

Macrocytic anemias can result from deficiencies in vitamin B12 or ascorbic acid. Only vitamin B12 deficiency causes diminished sensations of peripheral nerve endings. The nurse should assess for peripheral neuropathy and instruct the client in self-care activities for her diminished sensation to heat and pain. Vitamin B12 deficiency can lead to hematologic and neurological symptoms. Vitamin B12 is stored in excess in the liver, decreasing the likelihood of deficiency.

- **Option A:** The burn could be related to abuse, but this conclusion would require more supporting data. A complete neurologic exam should evaluate for dementia, peripheral neuropathy, ataxia, and a loss of proprioception. A mental status exam may also be useful to evaluate any neuropsychiatric changes.
- **Option C:** The findings should be documented, but the nurse would want to address the client's sensations first. A thorough evaluation of vitamin B12 deficiency should include a complete history and physical with an increased emphasis on gastrointestinal (GI) and neurologic findings. B12 deficiency manifests as macrocytic anemia, and thus, the presenting symptoms often include signs of anemia, such as fatigue and pallor.
- **Option D:** The decision of how to treat the burn should be determined by the physician. Treatment of vitamin B12 deficiency involves repletion with B12. However, depending on the etiology of the deficiency, the duration and route of treatment vary. In patients who are deficient due to a strict vegan diet, an oral supplement of B12 is adequate for repletion.

**24. The nurse is teaching basic infant care to a group of first-time parents. The nurse should explain that a sponge bath is recommended for the first 2 weeks of life because:**

- A. New parents need time to learn how to hold the baby.
- B. The umbilical cord needs time to separate.
- C. Newborn skin is easily traumatized by washing.
- D. The chance of chilling the baby outweighs the benefits of bathing.

**Correct Answer: B. The umbilical cord needs time to separate.**

The umbilical cord needs time to dry and fall off before putting the infant in the tub. The first bath will be a sponge bath. Pick a warm room with a flat surface, like a bathroom or kitchen counter, a changing table, or a bed. Cover the surface with a thick towel. Make sure the room temperature is at least 75 degrees Fahrenheit, because babies chill easily.

- **Option A:** Taking the baby away for a bath too soon can interrupt skin-to-skin care, mother-child bonding, and early breastfeeding success. One study showed a 166% increase in hospital breastfeeding success after implementing a 12-hour delay in the baby's first bath compared to those bathed within the first couple hours.
- **Option C:** Gentle sponge baths are perfect for the first few weeks until the umbilical cord falls off, the circumcision heals, and the navel heals completely. Once the umbilical cord falls off, and the circumcision and the navel are completely healed, it's time to try a tub bath.
- **Option D:** Although these statements might be important, they are not the primary answer to the question. The World Health Organization (WHO) recommends delaying baby's first bath until 24 hours after birth—or waiting at least 6 hours if a full day isn't possible for cultural reasons. Babies who get baths right away may be more likely to become cold and develop hypothermia. The minor stress of an early bath can also make some babies more likely to have a drop in blood sugar (hypoglycemia).

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

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

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

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

**26. A client tells the nurse that the television newscaster is sending a secret message to her. The nurse suspects the client is experiencing:**

- A. A delusion
- B. Flight of ideas
- C. Ideas of reference
- D. Hallucination

**Correct Answer: C. Ideas of reference**

Ideas of reference refers to the mistaken belief that neutral stimuli have special meaning to the individual such as the television newscaster sending a message directly to the individual. In people with bipolar disorder, mania and hypomania can comprise various symptoms, from reckless spending to sexual promiscuity. In addition, some more subtle symptoms may also occur, such as the belief held by some patients that everything occurring around them is related somehow to them when in fact it isn't. This symptom is known as ideas of reference.

- **Option A:** A delusion is a false belief. Delusions are defined as fixed, false beliefs that conflict with reality. Despite contrary evidence, a person in a delusional state can't let go of their convictions. Delusions are often reinforced by the misinterpretation of events. Many delusions also involve some level of paranoia. For example, someone might contend that the government is controlling our every move via radio waves despite evidence to the contrary.
- **Option B:** Flight of ideas is a speech pattern in which the client skips from one unrelated subject to another. A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent. It is part of the DSM -5 criteria for Manic episodes.
- **Option D:** A hallucination is a sensory perception, such as hearing voices and seeing objects, that only the client experiences. Hallucinations involve sensing things such as visions, sounds, or smells that seem real but are not. These things are created by the mind. Common hallucinations can include feeling sensations in the body, such as a crawling feeling on the skin or the movement of internal organs; hearing sounds, such as music, footsteps, windows or doors banging; hearing voices when no one has spoken (the most common type of hallucination). These voices may be positive, negative, or neutral. They may command someone to do something that may cause harm to themselves or others.

**27. Mike is admitted to a psychiatric unit with a diagnosis of undifferentiated schizophrenia. Which of the following defense mechanisms is probably used by Mike?**

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

**Correct Answer: C. Regression**

Regression, a return to earlier behavior to reduce anxiety, is the basic defense mechanism in schizophrenia. Adapting one's behavior to earlier levels of psychosocial development. For example, a stressful event may cause an individual to regress to bed-wetting after they have already outgrown this behavior.



- **Option A:** Projection is a defense mechanism in which one blames others and attempts to justify actions; it's used primarily by people with paranoid schizophrenia and delusional disorder. Attributing one's own maladaptive inner impulses to someone else. For example, someone who commits an episode of infidelity in their marriage may then accuse their partner of infidelity or may become more suspicious of their partner.
- **Option B:** Rationalization is a defense mechanism used to justify one's action. The justification of one's behavior through attempts at a rational explanation. This defense mechanism may be present in someone who steals money but feels justified in doing so because they needed the money more than the person from whom they stole.
- **Option D:** Repression is the basic defense mechanism in the neuroses; it's an involuntary exclusion of painful thoughts, feelings, or experiences from awareness. Subconsciously blocking ideas or impulses that are undesirable. This defense mechanism may be present in someone who has no recollection of a traumatic event, even though they were conscious and aware during the event.

**28. A client at 36 weeks gestation is scheduled for a routine ultrasound prior to amniocentesis. After teaching the client about the purpose of the ultrasound, which of the following client statements would indicate to the nurse in charge that the client needs further instruction?**

- A. The ultrasound will help to locate the placenta.
- B. The ultrasound identifies blood flow through the umbilical cord.
- C. The test will determine where to insert the needle.
- D. The ultrasound locates a pool of amniotic fluid.

**Correct Answer: B. The ultrasound identifies blood flow through the umbilical cord.**

Before amniocentesis, a routine ultrasound is valuable in locating the placenta, locating a pool of amniotic fluid, and showing the physician where to insert the needle. Color Doppler imaging ultrasonography identifies blood flow through the umbilical cord. A routine ultrasound does not accomplish this.

- **Option A:** As early as 10 weeks, the placenta can be detected by an ultrasound. The normal placenta is discoid with uniform echogenicity and rounded margins. It is usually located along the anterior or posterior uterine walls, extending into the lateral walls.
- **Option C:** Ultrasound is done before and during amniocentesis to ensure that the needle can safely pass through the walls of the abdomen and womb.
- **Option D:** The sample of amniotic fluid is removed through a fine needle inserted into the uterus through the abdomen, under ultrasound guidance.

**29. Alkalosis is characterized by overexcitement of the nervous system.**

- A. True
- B. False
- C. The major effect of Alkalosis is a depression of the central nervous system.
- D. Both Acidosis and Alkalosis result in overexcitement of the central nervous system.

**Correct Answer: A. True**

The muscles may go into a state of tetany and convulsions.

**30. A nurse is caring for a client with unstable ventricular tachycardia. The nurse instructs the client to do which of the following, if prescribed, during an episode of ventricular tachycardia?**

- A. Breathe deeply, regularly, and easily.
- B. Inhale deeply and cough forcefully every 1 to 3 seconds.
- C. Lie down flat in bed.
- D. Remove any metal jewelry.

**Correct Answer: B. Inhale deeply and cough forcefully every 1 to 3 seconds.**

Cough Cardiopulmonary Resuscitation (CPR) sometimes is used in the client with unstable ventricular tachycardia. The nurse tells the client to use cough CPR, if prescribed, by inhaling deeply and coughing forcefully every 1 to 3 seconds. Cough CPR may terminate the dysrhythmia or sustain the cerebral and coronary circulation for a short time until other measures can be implemented. A nurse or physician can instruct and coach the patients to cough forcefully every one to three seconds during the initial seconds of a sudden arrhythmia. But because it's not effective in all patients, it shouldn't delay definitive treatment.

- **Option A:** Asymptomatic patients with non-sustained ventricular tachycardia (VT) and no underlying cardiac comorbidities require no additional therapy. Patients that are symptomatic and without cardiac comorbidities should be started on a beta-blocker due to favorable efficacy and safety profile.
- **Option C:** If these patients continue to have episodes of non-sustained VT despite beta-blocker therapy, or cannot tolerate beta-blocker therapy, a calcium channel with atrioventricular nodal action such as verapamil or diltiazem can be used.
- **Option D:** Patients with sustained monomorphic ventricular tachycardia (SMVT) that are unstable should be managed following advanced cardiac life support (ACLS) guidelines. Hemodynamically stable patients should be pharmacologically cardioverted using an antiarrhythmic medication. Intravenous amiodarone or procainamide can be used for this purpose.

**31. In acid-base balance, the normal plasma PCO<sub>2</sub> and bicarbonate levels are disturbed. Match the changes in this parameter with the disorders in the given choices: Decreased plasma bicarbonate (HCO<sub>3</sub><sup>-</sup>)**

- A. Metabolic Acidosis
- B. Respiratory Alkalosis
- C. Metabolic Alkalosis
- D. Respiratory Acidosis

**Correct Answer: A. Metabolic Acidosis**

The body compensates by using body fat for energy, producing abnormal amounts of ketone bodies. In an effort to neutralize the ketones and maintain the acid-base balance of the body, plasma bicarbonate

is exhausted. This condition can develop in anyone who does not eat an adequate diet and whose body fat must be burned for energy. Symptoms include headache and mental dullness.

**32. The nurse is caring for a client who is receiving a chemotherapy. Which of the following would be expected as a result of the massive cell destruction that occurred from the chemotherapy?**

- A. Leukopenia
- B. Anemia
- C. Thrombocytopenia
- D. Hyperuricemia

**Correct Answer: D. Hyperuricemia.**

Increased levels of uric acid (Hyperuricemia) in the body is common following the treatment for leukemias and lymphomas because chemotherapy results in massive cell destruction.

- **Options A, B, & C:** These are usually noted, but an increased uric acid level is specifically related to massive cell destruction.

**33. A client underwent ileostomy, when should the drainage appliance be applied to the stoma?**

- A. 24 hours later, when edema has subsided
- B. In the operating room
- C. After the ileostomy begins to function
- D. When the client is able to begin self-care procedures

**Correct Answer: B. In the operating room**

The stoma drainage bag is applied in the operating room. Drainage from the ileostomy contains secretions that are rich in digestive enzymes and highly irritating to the skin. Protection of the skin from the effects of these enzymes is begun at once. Skin exposed to these enzymes even for a short time becomes reddened, painful, and excoriated.

- **Option A:** If the application of the drainage appliance is delayed after surgery, the skin around the stoma would be most likely irritated and damaged due to the digestive enzymes present in the secretions of the drainage.
- **Option C:** An ileostomy needs a drainage bag before it starts to function so that the secretions from the drainage would be caught up by the bag, preventing contamination of the skin.
- **Option D:** The client would have irritated, damaged skin once the drainage comes out from the stoma and comes into contact with the skin.

**34. The nurse can best ensure the safety of a demented client who wanders from the room by:**

- A. Repeatedly reminding the client of time and place.

- B. Explaining the risks of becoming lost.
- C. Using soft restraints.
- D. Attaching a wander guard sensor band to the client's wrist.

**Correct Answer: D. Attaching a wander guard sensor band to the client's wrist.**

This type of identification band easily tracks the client's movements and ensures safety while wandering on the unit. Install bed alarms or pressure-sensitive doormats; this provides alarm to alert nurses of movement and help prevent injury to the patient. Avoid using restraints if at all possible. Restraints increase agitation, anxiety, and cause complications of immobility, feelings of powerlessness, and actual increased tendency for wandering.

- **Option A:** Assess patient for presence of wandering behavior, noting time, place, and people with whom he ambulates with. Helps to identify the gravity of the problem and to establish a plan of care. Purposeful wandering occurs when the patient has some intent for his movement, such as to escape boredom, or for exercises. Aimless wandering is usually purposeless and involves disoriented patients who may enter other patients' rooms and take their belongings. The escapist wandering usually has a destination in mind and is able to leave the premises undetected even though closely supervised.
- **Option B:** Instruct family regarding installing deadbolt locks, fences, locks on gates, and locks on doors and windows. Helps to prevent unsafe exits from home and for the protection of the patient. Instruct the family to notify neighbors and/or local police regarding the patient's condition and penchant for wandering. Provides awareness of others to prevent the patient from becoming lost or injured.
- **Option C:** Maintain a safe environment and structured routine for the patient. Allow the patient to wander within boundaries in a safe environment. Structure in the patient's routine may decrease wandering tendencies. Encourage the patient to participate in activities if able to do so. Exercise helps to decrease restlessness and may decrease potential wandering.

**35. The nurse develops the following hypothesis: *Elderly women receive less aggressive treatment for breast cancer than do younger women. Which variable would be considered to be the dependent variable?***

- A. Degree of treatment received.
- B. Age of the patient.
- C. Type of cancer being treated.
- D. Use of inpatient treatment.

**Correct Answer: A. Degree of treatment received.**

The degree of treatment received is considered the dependent variable. Dependent variable is the variable that depends on other factors that are measured. These variables are expected to change as a result of experimental manipulation of the independent variable or variables. It is the presumed effect.

- **Option B:** The age of the patient is an independent variable. Independent variable is the variable that is stable and unaffected by the other variables the researcher is trying to measure. It refers to the condition of an experiment that is systematically manipulated by the investigator. It is the presumed cause.
- **Option C:** The type of cancer being treated can be a predictor variable. Predictor variables can be used to predict the value of a dependent variable. Predictor variable is the name given to an

independent variable used in regression analyses. The predictor variable provides information on an associated dependent variable regarding a particular outcome. At the most fundamental level, predictor variables are variables that are linked with particular outcomes.

- **Option D:** The use of inpatient treatment is not specified. Researchers often use charts or graphs to visualize the results of their studies. The norm is to place the independent variable on the “x” or horizontal axis and the dependent variable on the “y” or vertical axis.