

Kevin's Review - 35 NCLEX Practice Questions

1. 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.

2. The client has recently returned from having a thyroidectomy. The nurse should keep which of the following at the bedside?

- A. A tracheostomy set
- B. A padded tongue blade
- C. An endotracheal tube
- D. An airway

Correct Answer: A. A tracheotomy set

The client who has recently had a thyroidectomy is at risk for tracheal edema.

- **Option B:** A padded tongue blade is used for seizures and not for the client with tracheal edema.
- **Options C and D:** If the client experiences tracheal edema, the endotracheal tube or airway will not correct the problem.

3. For a client complaining of periocular aching after a surgical repair of a detached retina, which medication would be the most appropriate analgesic?

- A. Acetaminophen
- B. Codeine
- C. Meperidine
- D. Morphine

Correct Answer: A. Acetaminophen

Because the discomfort is typically mild after surgery to repair a detached retina, a mild analgesic such as acetaminophen would be used. Acetaminophen (APAP) is considered a non-opioid analgesic and antipyretic agent used to treat pain and fever. Clinicians can use it for their patients as a single agent for mild to moderate pain and in combination with an opioid analgesic for severe pain.

- **Option B:** Codeine is constipating and may lead to straining and increased intraocular pressure (IOP). Constipation is one of the most common adverse effects of codeine. Most patients report some constipation following the initiation of therapy or increases in dose. With continued exposure, the resolution of constipation does not occur.
- **Option C:** Meperidine often causes nausea and vomiting, further adding to the client's level of discomfort, and vomiting may lead to increased IOP. Patients can have shallow or no breathing, signs of cyanosis like blue lips or fingernails, fatigue, convulsion, low blood pressure, bradycardia, constipation, stomach cramps, nausea and vomiting, cold and clammy skin, drowsiness, lightheadedness, and twitching muscles.
- **Option D:** Morphine causes nausea, vomiting, and constipation, which should be avoided after surgery. Among the more common unwanted effects of morphine use is constipation. This effect occurs via stimulation of mu-opioid receptors on the myenteric plexus, which in turn inhibits gastric emptying and reduces peristalsis.

4. A 70-year-old woman is admitted to the orthopedic ward following a minor fall at home that resulted in a fractured wrist. Her medical history reveals a recent diagnosis of osteoporosis. As the nurse conducts a comprehensive

assessment, she anticipates certain clinical manifestations commonly associated with osteoporosis. Which of the following findings would the nurse most likely expect to observe in this patient?

- A. Joint deformities
- B. Muscle atrophy
- C. Decreased bone density
- D. Increased range of motion

- **Option A:** Joint deformities are more commonly associated with conditions such as rheumatoid arthritis or osteoarthritis, where chronic inflammation and joint damage occur.
- **Option B:** Muscle atrophy refers to the loss of muscle mass and strength, which can be caused by factors such as immobilization or disuse. While osteoporosis may lead to decreased muscle strength over time, it is not a direct characteristic of the condition.
- **Option D:** Increased range of motion is not a typical finding in osteoporosis. In fact, decreased range of motion may occur if fractures or pain limit the client's mobility.

5. You are the preceptor for an RN who is undergoing orientation to the intensive care unit. The RN is providing care for a patient with ARDS who has just been intubated in preparation for mechanical ventilation. You observe the nurse perform all of these actions. For which action must you intervene immediately?

- A. Assessing for bilateral breath sounds and symmetrical chest movements.
- B. Auscultating over the stomach to rule out esophageal intubation.
- C. Marking the tube 1 cm from where it touches the incisor tooth or nares.
- D. Ordering a chest radiograph to verify that tube placement is correct.

Correct Answer: C. Marking the tube 1 cm from where it touches the incisor tooth or nares

The endotracheal tube should be marked at the level where it touches the incisor tooth or nares. This mark is used to verify that the tube has not shifted. If the patient has an endotracheal tube, check for tube slippage into the right mainstem bronchus, as well as inadvertent extubation.

- **Option A:** Auscultate over the epigastrium to assess for the absence of sounds in the stomach. The presence of an enlarging abdomen or audible air inflation into the stomach with each positive-pressure ventilation may be the initial sign of an ET tube in the esophagus or an esophageal intubation.
- **Option B:** Since the advent of ET intubation, the use of physical examination methods has been the mainstay for the initial evaluation of proper ET tube placement. Direct visualization of the insertion of the ET tube through the vocal cords and into the trachea is the first method to confirm proper ET tube placement.
- **Option D:** A chest X-ray is often acquired following placement of an endotracheal tube (ET tube) to determine the position of its tip. The priority at this time is to verify that the tube has been correctly placed. The trachea, carina and main bronchi are almost always identifiable on a chest X-ray image, as long as the image is viewed on a high quality screen in a darkened room.

6. What is a characteristic of a hypothesis?

- A. It flows from interpretation of the data collected.
- B. It operationally defines the variable to be studied.
- C. It eliminates the need to designate a dependent variable.
- D. It implies a causative or associative relationship.

Correct Answer: D. It implies a causative or associative relationship.

A hypothesis implies a causative or associative relationship. Investigators conducting studies need research questions and hypotheses to guide analyses. Starting with broad research questions (RQs), investigators then identify a gap in current clinical practice or research. Any research problem or statement is grounded in a better understanding of relationships between two or more variables.

- **Option A:** A hypothesis guides the research design and collection of data. To test a hypothesis, researchers obtain data on a representative sample to determine whether to reject or fail to reject a null hypothesis. In most research studies, it is not feasible to obtain data for an entire population. Using a sampling procedure allows for statistical inference, though this involves a certain possibility of error.
- **Option B:** Operational definitions are not included in the hypothesis. A hypothesis is a predetermined declaration regarding the research question in which the investigator(s) makes a precise, educated guess about a study outcome. This is sometimes called the alternative hypothesis and ultimately allows the researcher to take a stance based on experience or insight from medical literature.
- **Option C:** The hypothesis indicates the dependent variable. A hypothesis states a presumed relationship between two variables in a way that can be tested with empirical data. It may take the form of a cause-effect statement, or an "if x, ... then y" statement.

7. What is the priority nursing diagnosis for a patient experiencing a migraine headache?

- A. Acute pain related to biologic and chemical factors
- B. Anxiety related to change in or threat to health status
- C. Hopelessness related to deteriorating physiological condition
- D. Risk for Side effects related to medical therapy

Correct Answer: A. Acute pain related to biologic and chemical factors

The priority for interdisciplinary care for the patient experiencing a migraine headache is pain management.

- **Option B:** Anxiety is a correct diagnosis, but it is not the priority. Tension headaches are common for people that struggle with severe anxiety or anxiety disorders. Tension headaches can be described as a heavy head, migraine, head pressure, or feeling like there is a tight band wrapped around their head. These headaches are due to a tightening of the neck and scalp muscles.
- **Option C:** Hopelessness should be addressed as part of the nursing care plan, but it does not require urgency. Hopelessness can result when someone is going through difficult times or unpleasant experiences. A person may feel overwhelmed, trapped, or insecure, or may have a lot of self-doubts due to multiple stresses and losses. He or she might think that challenges are

unconquerable or that there are no solutions to the problems and may not be able to mobilize the energy needed to act on his or her own behalf.

- **Option D:** The risk for side effects is accurate, but it is not as urgent as the issue of pain, which is often incapacitating. Focus: Prioritization

8. Incomplete development of teeth, bones, and ligaments is the result of:

- A. Congenital hip dysplasia
- B. Duchenne's muscular dystrophy
- C. Osteogenesis imperfecta
- D. Osteomyelitis

Correct Answer: C. Osteogenesis imperfecta

Osteogenesis imperfecta (OI), also known as brittle bone disease, is a group of genetic disorders that principally affect the bones. It results in bones that break quickly. The severity may be mild to severe. Other symptoms may include problems with the teeth, loose joints, a blue tinge to the whites of the eye, short height, hearing loss, and breathing problems.

- **Option A:** Congenital hip dislocation (CHD) occurs when a child is born with an unstable hip. It is caused by abnormal formation of the hip joint during the early stages of fetal development. CHD is also known as Developmental Dysplasia of the Hip (DDH).
- **Option B:** Duchenne muscular dystrophy (DMD) is a genetic condition marked by progressive weakening of voluntary muscles. DMD worsens more rapidly than other types of muscular dystrophy.
- **Option D:** A bone infection, also called osteomyelitis, can result when bacteria or fungi penetrate a bone. In children, bone infections usually occur in the long bones of the arms and legs. In adults, they usually appear in the hips, spine, and feet.

9. A male client has jugular distention. In what position should the nurse place the head of the bed to obtain the most accurate reading of jugular vein distention?

- A. High Fowler's
- B. Raised 10 degrees
- C. Raised 30 degrees
- D. Supine position

Correct Answer: C. Raised 30 degrees

Jugular venous pressure is measured with a centimeter ruler to obtain the vertical distance between the sternal angle and the point of highest pulsation with the head of the bed inclined between 15 to 30 degrees.

- **Option A:** In high Fowler's position, the veins would be barely discernible above the clavicle.
- **Option B:** Increased pressure can't be seen when the head of the bed is raised 10 degrees because the point that marks the pressure level is above the jaw (therefore, not visible).

- **Option D:** Supine position does not make the increased pressure level seen.

10. A nurse is preparing to care for a female client with esophageal varices who just had a Sengstaken-Blakemore tube inserted. The nurse gathers supplies, knowing that which of the following items must be kept at the bedside at all times?

- A. An obturator
- B. Kelly clamp
- C. An irrigation set
- D. A pair of scissors

Correct Answer: D. A pair of scissors

When the client has a Sengstaken-Blakemore tube, a pair of scissors must be kept at the client's bedside at all times. The client needs to be observed for sudden respiratory distress, which occurs if the gastric balloon ruptures and the entire tube moves upward. If this occurs, the nurse immediately cuts all balloon lumens and removes the tube. Sengstaken-Blakemore tube placement is indicated for unstable patients with uncontrolled hemorrhage. Sengstaken-Blakemore tube placements can temporarily control the hemorrhage.

- **Option A:** An obturator is kept at the bedside of a client with a tracheostomy. This is a piece of rigid plastic, silicone, or metal that fits inside the outer cannula when a tracheostomy tube is being inserted. It helps guide the tracheostomy tube into place, causing less damage to the tissues.
- **Option B:** A Kelly clamp is kept at the bedside of a client with a tracheostomy. Clinicians must be prepared in case of emergency as the medical condition of a patient with tracheostomy and/or mechanical ventilation may change quickly. Emergency equipment is necessary at the bedside as well as during the transportation.
- **Option C:** An irrigation set may be kept at the bedside, but it is not the priority item. Airway protection remains the foremost focus. If the patient is requiring a Sengstaken-Blakemore tube placement, they have likely already been intubated for airway protection, but if not, endotracheal intubation should be performed prior to placement. Following intubation, the patient should be placed in the supine position with the head of the bed elevated to 45 degrees.

11. A nurse is reinforcing instructions to a client following a total laryngectomy about caring for the stoma. Choose the instructions that the nurse provides to the client. Select all that apply.

- A. Protect the stoma from water.
- B. Soaps should be avoided near the stoma.
- C. Wash the stoma daily using a washcloth.
- D. Use diluted alcohol on the stoma to clean it.
- E. Apply a thin layer of petroleum jelly to the skin surrounding the stoma.
- F. Use soft tissues to clean any secretions that accumulate around the stoma.

Correct Answer: A, B, C, & E.

An ostomy is a surgically created opening from the urinary tract or intestines, where effluent (fecal matter, urine, or mucous) is rerouted to the outside of the body using an artificially created opening called a stoma. A stoma typically protrudes above the skin, is pink to red in color, moist, and round, with no nerve sensations.

- **Option A:** The client is instructed to protect the stoma from water. Clean the skin around the stoma with water. Dry the skin completely before putting on the skin barrier or pouch.
- **Option B:** Soap will not irritate it, but soap may interfere with the skin barrier sticking to the skin. It's best to only use water while cleaning the skin around the stoma.
- **Option C:** The client with a stoma should be instructed to wash the stoma daily with a washcloth. Normal exposure to air or contact with soap and water won't harm the stoma. Water will not flow into the stoma.
- **Option D:** The client should be instructed to avoid applying alcohol to a stoma because it is both drying and irritating. Do not use alcohol or any other harsh chemicals to clean the skin or stoma. They may irritate the skin. Do not use baby wipes or towelettes that contain lanolin or other oils, as these can interfere with the skin barrier adhesive and may irritate the skin.
- **Option E:** A thin layer of petroleum jelly applied to the skin around the stoma helps prevent cracking. Large areas of skin that are red, sore, and weeping (always wet) will keep from getting a good seal around the stoma. It's important to treat minor irritations right away.
- **Option F:** Cotton swabs or tissues should be avoided because their particles may enter and obstruct the airway.

12. Which research process steps may be noted in an article's abstract? Select all that apply.

- A. Identifying the phenomenon
- B. Research question study purpose
- C. Literature review
- D. Design
- E. Sample
- F. Legal-ethical issues
- G. Data-collection procedure

Correct Answers: A, B, D

Scientific research involves a systematic process that focuses on being objective and gathering a multitude of information for analysis so that the researcher can come to a conclusion. This process is used in all research and evaluation projects, regardless of the research method (scientific method of inquiry, evaluation research, or action research).

- **Option A:** The first step in the process is to identify a problem or develop a research question. The research problem may be something the agency identifies as a problem, some knowledge or information that is needed by the agency, or the desire to identify a recreation trend nationally.
- **Option B:** Many times the initial problem identified in the first step of the process is too large or broad in scope. In step 3 of the process, the researcher clarifies the problem and narrows the scope of the study. This can only be done after the literature has been reviewed.

- **Option C:** This step provides foundational knowledge about the problem area. The review of literature also educates the researcher about what studies have been conducted in the past, how these studies were conducted, and the conclusions in the problem area.
- **Option D:** The plan for the study is referred to as the instrumentation plan. The instrumentation plan serves as the road map for the entire study, specifying who will participate in the study; how, when, and where data will be collected; and the content of the program.
- **Option E:** Research projects can focus on a specific group of people, facilities, park development, employee evaluations, programs, financial status, marketing efforts, or the integration of technology into the operations. For example, if a researcher wants to examine a specific group of people in the community, the study could examine a specific age group, males or females, people living in a specific geographic area, or a specific ethnic group.
- **Option F:** The main role of human participants in research is to serve as sources of data. Researchers have a duty to 'protect the life, health, dignity, integrity, right to self-determination, privacy and confidentiality of personal information of research subjects'.
- **Option G:** Once the instrumentation plan is completed, the actual study begins with the collection of data. The collection of data is a critical step in providing the information needed to answer the research question. Every study includes the collection of some type of data—whether it is from the literature or from subjects—to answer the research question.

13. An individual with depression has a deficiency in which neurotransmitters, based on the biogenic amine theory?

- A. Dopamine and thyroxine
- B. GABA and acetylcholine
- C. Cortisone and epinephrine
- D. Serotonin and norepinephrine

Correct Answer: D. Serotonin and norepinephrine

The biogenic amine theory of depression describes deficiencies in the neurotransmitters serotonin and norepinephrine. Antidepressant medications increase the levels of these neurotransmitters and therefore help to relieve depressive symptoms.

- **Option A:** Clinical and preclinical trials suggest a disturbance in central nervous system serotonin (5-HT) activity as an important factor. Other neurotransmitters implicated include norepinephrine (NE), dopamine (DA), glutamate, and brain-derived neurotrophic factor (BDNF).
- **Option B:** The role of CNS 5-HT activity in the pathophysiology of major depressive disorder is suggested by the therapeutic efficacy of selective serotonin reuptake inhibitors (SSRIs). Research findings imply a role for neuronal receptor regulation, intracellular signaling, and gene expression over time, in addition to enhanced neurotransmitter availability.
- **Option C:** According to current research, dopamine, thyroxin, GABA, acetylcholine, cortisone, and epinephrine are not directly related to depression. The underlying pathophysiology of major depressive disorder has not been clearly defined. Current evidence points to a complex interaction between neurotransmitter availability and receptor regulation and sensitivity underlying the affective symptoms.

14. Isaiah, a 16-year-old high school student, presented to the school clinic complaining of a sore throat that began 2 days ago. He is worried as he has a big track meet the next day. Upon examination, the nurse found that he had a temperature of 101.8°F and enlarged, tender cervical lymph nodes. His pharynx is markedly erythematous with exudate. A Rapid Antigen Detection Test (RADT) for Group A Streptococcus is performed and comes back positive, confirming a diagnosis of streptococcal pharyngitis or “strep throat.” Considering the assessment data and Isaiah’s confirmed diagnosis, which of the following clinical manifestations would the nurse most likely expect?

- A. A fiery red pharyngeal membrane and fever.
- B. Pain over the sinus area and purulent nasal secretions.
- C. Foul-smelling breath and noisy respirations.
- D. Weak cough and high-pitched noise on respirations.
- E. Tender, swollen anterior cervical lymph nodes.
- F. Chest discomfort and a productive cough with yellow sputum.
- G. Dry, scratchy throat and hoarseness lasting more than a week.

Correct Answer: A. A fiery red pharyngeal membrane and fever.

The clinical manifestations of strep throat (streptococcal pharyngitis) typically include a sore throat, painful swallowing, and fever. On examination, the pharyngeal membrane often appears red and swollen, sometimes with a “fiery” appearance. This choice represents the classical clinical presentation of strep throat, making it the most likely manifestation expected by the nurse.

- **Option B:** Pain over the sinus area and purulent nasal secretions are more indicative of sinusitis, which is an infection or inflammation of the paranasal sinuses.
- **Option C:** Foul-smelling breath and noisy respirations may be indicative of other respiratory or oropharyngeal infections but are not typically associated with strep throat.
- **Option D:** Weak cough and high-pitched noise on respirations could be associated with other respiratory conditions such as croup or a foreign body aspiration, but these symptoms are not typical of strep throat.
- **Option E:** Tender, swollen anterior cervical lymph nodes can be associated with strep throat due to the local infection and the body’s immune response. However, this choice doesn’t capture the quintessential manifestations of strep throat as comprehensively as Option A.
- **Option F:** Chest discomfort and a productive cough with yellow sputum are more indicative of a lower respiratory infection such as bacterial pneumonia rather than a strep throat.
- **Option G:** A dry, scratchy throat and hoarseness lasting more than a week may suggest other conditions such as viral pharyngitis, laryngitis, or even gastroesophageal reflux disease (GERD) rather than strep throat.

15. She decides to illustrate the organizational structure. Which of the following elements is not included?

- A. Level of authority

- B. Lines of communication
- C. Span of control
- D. Unity of direction

Correct Answer: D. Unity of direction

Unity of direction is a management principle, not an element of an organizational structure. The principle of unity of direction implies that there should be "one head and one plan for a group of activities having the same objective". In other words, each group of activities having the same objectives must have one plan of action and must be under the control of one manager or superior. An organization or group having different plans and more than one head cannot achieve the desired results.

- **Option A:** Distributing authority is another important building block in structuring organizations. Authority in the organization is the right in a position and, through it, the right of the person occupying the position to exercise discretion in making decisions affecting others.
- **Option B:** Organizational structures also rest somewhere on a spectrum of centralization. Generally, more conservative corporate entities adopt a centralized structure. In this design, C-level managers make all the decisions, management designs a plan for execution, and front-line employees carry out that plan.
- **Option C:** An organization's span of control defines how many employees each manager is responsible for within the company. There is no single type of span of control that's ideal for all companies or even for all businesses in a specific industry.

16. When assessing a client during her first prenatal visit, the nurse discovers that the client had a reduction mammoplasty. The mother indicates she wants to breast-feed. What information should the nurse give to this mother regarding breastfeeding success?

- A. "It's contraindicated for you to breastfeed following this type of surgery."
- B. "I support your commitment; however, you may have to supplement each feeding with formula."
- C. "You should check with your surgeon to determine whether breast-feeding would be possible."
- D. "You should be able to breastfeed without difficulty."

Correct Answer: B. "I support your commitment; however, you may have to supplement each feeding with formula."

Recent breast reduction surgeries are done in a way to protect the milk sacs and ducts, so breastfeeding after surgery is possible. Still, it's good to check with the surgeon to determine what breast reduction procedure was done. There is the possibility that reduction surgery may have decreased the mother's ability to meet all of her baby's nutritional needs, and some supplemental feeding may be required. Preparing the mother for this possibility is extremely important because the client's psychological adaptation to mothering may be dependent on how successfully she breast-feeds.

- **Option A:** While there is evidence that both breastfeeding and breast reduction surgery are beneficial, it is unknown whether breast reduction surgery impacts breastfeeding and whether any breast reduction technique differentially preserves the ability to breastfeed.

- **Option C:** Women considering breast reduction surgery should be told not only the name of the proposed breast reduction technique but its characteristics, including the extent the column of subareolar parenchyma will be preserved and pedicle width, to allow them to gain a better understanding of its impact on breastfeeding.
- **Option D:** Breast reduction techniques have been in a continuous state of development since the early 1900s, with new techniques developed, refined, and modified by subsequent plastic surgeons. This has led to many diverse breast reduction techniques. Its effect on breastfeeding remains entirely unclear, so telling the client that she could breastfeed without difficulty would give her a false sense of reassurance.

17. Which of the following assessment findings in a client with leukemia would indicate that cancer has invaded the brain?

- A. Hypervigilant and anxious behavior
- B. Increased heart rate and decreased blood pressure
- C. Headache and vomiting
- D. Hypervigilant and anxious behavior

Correct Answer: C. Headache and vomiting

- **Option C:** The usual effect of leukemic infiltration of the brain is increased intracranial pressure. The proliferation of cells interferes with the flow of cerebrospinal fluid in the subarachnoid space and at the base of the brain. The increased fluid pressure causes dilation of the ventricles, which creates symptoms of severe headache, vomiting, irritability, lethargy, and eventually, coma.
- **Option B:** Increasing intracranial pressure in brain metastasis would result in symptoms of high blood pressure, decreased pulse rate, and abnormal respirations known as Cushing triad.
- **Options A and D:** Often children with a variety of illnesses are hypervigilant and anxious when hospitalized.

18. A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of:

- A. Hematoma
- B. Placenta previa
- C. Uterine atony
- D. Placental separation

Correct Answer: D. Placental separation

As the placenta separates, it settles downward into the lower uterine segment. The umbilical cord lengthens, and a sudden trickle or spurt of blood appears. Delivery of the placenta usually happens within 5-10 minutes after delivery of the fetus, but it is considered normal up to 30 minutes after delivery of the fetus.

- **Option A:** A hematoma is a bad bruise. It happens when an injury causes blood to collect and pool under the skin. The pooling blood gives the skin a spongy, rubbery, lumpy feel. A hematoma

usually is not a cause for concern. It is not the same thing as a blood clot in a vein, and it does not cause blood clots.

- **Option B:** Placenta previa occurs when a baby's placenta partially or totally covers the mother's cervix — the outlet for the uterus. Placenta previa can cause severe bleeding during pregnancy and delivery. If the woman has placenta previa, she might bleed throughout her pregnancy and during her delivery.
- **Option C:** Atony of the uterus, also called uterine atony, is a serious condition that can occur after childbirth. It occurs when the uterus fails to contract after the delivery of the baby, and it can lead to a potentially life-threatening condition known as postpartum hemorrhage.

19. Which of the following should be included in a plan of care for a client receiving total parenteral nutrition (TPN)?

- A. Withhold medications while the TPN is infusing.
- B. Change TPN solution every 24 hours.
- C. Flush the TPN line with water prior to initiating nutritional support.
- D. Keep the client on complete bed rest during TPN therapy.

Correct Answer: B. Change TPN solution every 24 hours.

TPN solutions should be changed every 24 hours in order to prevent bacterial overgrowth due to the hypertonicity of the solution. Because the central venous catheter needs to remain in place for a long time, a strict sterile technique must be used during the insertion and maintenance of the TPN line. The TPN line should not be used for any other purpose. External tubing should be changed every 24 hours with the first bag of the day. In-line filters have not been shown to decrease complications. Dressings should be kept sterile and are usually changed every 48 hours using strict sterile techniques.

- **Option A:** Medication therapy can continue during TPN therapy. Progress of patients with a TPN line should be followed on a flowchart. An interdisciplinary nutrition team, if available, should monitor patients. Weight, complete blood count, electrolytes, and blood urea nitrogen should be monitored often (eg, daily for inpatients). Plasma glucose should be monitored every 6 hours until patients and glucose levels become stable. Fluid intake and output should be monitored continuously. When patients become stable, blood tests can be done much less often.
- **Option C:** Flushing is not required because the initiation of TPN does not require a client to remain on bed rest during therapy. Catheter-related sepsis rates have decreased since the introduction of guidelines that emphasize sterile techniques for catheter insertion and skincare around the insertion site. The increasing use of dedicated teams of physicians and nurses who specialize in various procedures including catheter insertion also has accounted for a decrease in catheter-related infection rates.
- **Option D:** However, other clinical conditions of the client may affect mobility issues and warrant the client's being on bed rest. Place the client in a semi-Fowler's or high-Fowler's position. Maintaining the head of the bed elevated will promote ease in breathing. This position also allows the pooling of fluid in the bases and for gas exchange to be more available to the lung tissue.

20. A pregnant patient asks the nurse if she can take castor oil for her constipation. How should the nurse respond?

- A. "Yes, it produces no adverse effect."

- B. "No, it can initiate premature uterine contractions."
- C. "No, it can promote sodium retention."
- D. "No, it can lead to increased absorption of fat-soluble vitamins."

Correct Answer: B. "No, it can initiate premature uterine contractions."

Castor oil can initiate premature uterine contractions in pregnant women. It also can produce other adverse effects, but it does not promote sodium retention.

- **Option A:** Castor oil is a harsh stimulant laxative that relieves constipation by forced bowel movements. Side effects may include nausea, stimulation of uterine activity, meconium-stained fluid, and amniotic fluid embolism.
- **Option C:** There is no evidence that suggests that castor oil can promote sodium retention.
- **Option D:** Castor oil is not known to increase absorption of fat-soluble vitamins, although laxatives, in general, may decrease absorption if intestinal motility is increased.

21. How should the nurse prepare an injection for a patient who takes both regular and NPH insulin?

- A. Draw up the NPH insulin, then the regular insulin, in the same syringe.
- B. Draw up the regular insulin, then the NPH insulin, in the same syringe.
- C. Use two separate syringes.
- D. Check with the physician.

Correct Answer: B. Draw up the regular insulin, then the NPH insulin, in the same syringe.

Drugs that are compatible may be mixed together in one syringe. In the case of insulin, the shorter-acting, clear insulin (regular) should be drawn up before the longer-acting, cloudy insulin (NPH) to ensure accurate measurements.

- **Option A:** Insulin, regular when administered subcutaneously, it should be injected 30 to 40 minutes before each meal. Avoid cold injections. The injection is in the buttocks, thighs, arms, or abdomen; it is necessary to rotate injection sites to avoid lipodystrophy. Do not inject if the solution is viscous or cloudy; use only if clear and colorless.
- **Option C:** When administered intravenously, U-100 administration should be with close monitoring of serum potassium and blood glucose. Do not use if the solution is viscous or cloudy; administration should only take place if it is colorless and clear.
- **Option D:** For intravenous infusions, to minimize insulin adsorption to plastic IV tubing, flush the intravenous tube with priming infusion of 20 mL from a 100 mL-polyvinyl chloride bag insulin, every time a new intravenous tubing is added to the insulin infusion container.

22. What is the priority nursing diagnosis during the first 24 hours for a client with full-thickness chemical burns on the anterior neck, chest, and all surfaces of the left arm?

- A. Risk for Ineffective Breathing Pattern
- B. Decreased Tissue Perfusion

C. Risk for Disuse Syndrome

D. Disturbed Body Image

Correct Answer: C. Risk for Disuse Syndrome

During the emergent phase, fluid shifts into interstitial tissue in burned areas. When the burn is circumferential on an extremity, the swelling can compress blood vessels to such an extent that circulation is impaired distal to the injury, necessitating the intervention of an escharotomy. Chemical burns do not cause inhalation injury.

- **Option A:** Chemical burns do not cause inhalation injury and a disrupted breathing pattern. The most common findings represent structural changes to the tissue directly affected, for example, the eye, oral mucosa, skin, esophagus, and lower intestinal system, especially the stomach and pylorus, respiratory system, among others.
- **Option B:** During the emergent phase, fluid shifts into interstitial tissue in burned areas. When the burn is circumferential on an extremity, the swelling can compress blood vessels to such an extent that circulation is impaired distal to the injury, causing decreased tissue perfusion and necessitating the intervention of an escharotomy.
- **Option D:** Disturbed body image can develop. Assist the patient to identify the extent of actual change in appearance and body function. This helps begin the process of looking to the future and how life will be different.

23. An infant with a patent ductus arteriosus is admitted to the pediatric unit ward. The nurse anticipates which of the following medications will be given to the infant?

A. Prednisone

B. Ibuprofen

C. Penicillin

D. Albuterol

Correct Answer: B. Ibuprofen

When surgical ligation is not indicated, prostaglandin inhibitors (e.g. nonsteroidal anti-inflammatory drugs [NSAIDs]) are used to close the ductus arteriosus. In April 2006, the US Food and Drug Administration approved the use of ibuprofen lysine (NeoProfen) for the closure of clinically significant PDA in premature neonates. Ibuprofen's mechanism of action for closure of PDA is believed to be through the inhibition of prostaglandins.

- **Option A:** Prednisone is an FDA-approved, delayed-release corticosteroid indicated as an anti-inflammatory or immunosuppressive agent to treat a broad range of diseases, including immunosuppressive/endocrine, rheumatic, collagen, dermatologic, allergic states, ophthalmic, respiratory, hematologic, neoplastic, edematous, gastrointestinal, acute exacerbations of multiple sclerosis, and as an anti-inflammatory and an antineoplastic agent.
- **Option C:** Penicillin is one of the most commonly used antibiotics globally, as it has a wide range of clinical indications. Penicillin is effective against many different types of infections involving gram-positive cocci, gram-positive rods (e.g., *Listeria*), most anaerobes, and gram-negative cocci (e.g., *Neisseria*).
- **Option D:** Albuterol is used for the treatment and prevention of bronchospasm (acute or severe) in patients with reversible obstructive airway disease. It also has an indication for the prevention of

exercise-induced bronchospasm.

24. A nurse is assessing a newborn infant who was born to a mother who is addicted to drugs. Which of the following assessment findings would the nurse expect to note during the assessment of this newborn?

- A. Sleepiness
- B. Cuddles when being held
- C. Lethargy
- D. Incessant crying

Correct Answer: D. Incessant crying.

- **Option D:** A newborn infant born to a woman using drugs is irritable. The infant is overloaded easily by sensory stimulation. The infant may cry incessantly and posture rather than cuddle when being held.

25. Dobutamine (Dobutrex) improves cardiac output and is indicated for use in all of the following conditions except:

- A. Septic shock
- B. Congestive heart failure
- C. Arrhythmias
- D. Pulmonary congestion

Correct Answer: C. Arrhythmias

Dobutamine (Dobutrex) is not used to treat arrhythmias. Dobutamine is approved by the Food and Drug Administration (FDA) for short-term use in patients with decreased contractility due to heart failure or cardiac surgical procedures leading to cardiac decompensation.

- **Option A:** Short-term intravenous inotropic support should be given to patients in cardiogenic shock to preserve systemic blood flow and protect from end-organ damage.
- **Option B:** Patients can reasonably receive dobutamine in continuous intravenous form for inotropic support to bridge patients with late-stage heart failure, stage D, that is refractory to guideline-directed medical therapy until patients who are candidates for and awaiting cardiac transplantation or mechanical circulatory support receive the appropriate long-term treatment.
- **Option D:** In addition to the well-known beta-1 activity, dobutamine has shown to have some beta-2 activity, which contributes to the reduction in the systemic vascular resistance, and alpha-1 activity, to an even lesser extent, whose vasoconstrictive effects are negated by the baroreceptor mediated response and beta-2 activity.

26. In acid-base balance, the normal plasma PCO₂ and bicarbonate levels are disturbed. Match the changes in this parameter with the disorders in the given choices: High plasma PaCO₂

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

Correct Answer: D. Respiratory Acidosis

An excess of carbon dioxide (hypercapnia) can cause carbon dioxide narcosis. In this condition, carbon dioxide levels are so high that they no longer stimulate respirations but depress them.

27. The nurse understands that the therapeutic effects of typical antipsychotic medications are associated with which neurotransmitters change?

- A. Decreased dopamine level
- B. Increased acetylcholine level
- C. Stabilization of serotonin
- D. Stimulation of GABA

Correct Answer: A. Decreased dopamine level

Excess dopamine is thought to be the chemical cause of psychotic thinking. The typical antipsychotics act to block dopamine receptors and therefore decrease the amount of neurotransmitter at the synapses. First-generation antipsychotics are dopamine receptor antagonists (DRA) and are known as typical antipsychotics. They include phenothiazines (trifluoperazine, perphenazine, prochlorperazine, acetophenazine, triflupromazine, mesoridazine), butyrophenones (haloperidol), thioxanthenes (thiothixene, chlorprothixene), dibenzoxazepines (loxapine), dihydroxyindole (molindone), and diphenylbutylpiperidine (pimozide).

- **Option B:** The first-generation antipsychotics work by inhibiting dopaminergic neurotransmission. Their effectiveness is best when they block about 72% of the D2 dopamine receptors in the brain. They also have noradrenergic, cholinergic, and histaminergic blocking action. Second-generation antipsychotics work by blocking D2 dopamine receptors as well as serotonin receptor antagonist action. the 5-HT2A subtype of serotonin receptor is most commonly involved.
- **Option C:** Second-generation antipsychotics are serotonin-dopamine antagonists and are also known as atypical antipsychotics. The Food and Drug Administration (FDA) has approved 12 atypical antipsychotics as of the year 2016. They are risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, paliperidone, asenapine, lurasidone, iloperidone, cariprazine, brexpiprazole, and clozapine.
- **Option D:** The typical antipsychotics do not increase acetylcholine, stabilize serotonin, stimulate GABA. GABA (gamma-aminobutyric acid) is a common neurotransmitter in the brain, and GABA-ergic neurons are thought to interact with antipsychotic medications, contributing to side effects such as tardive dyskinesia.

28. Clara is under evaluation for imminent suicide risk, which information given by her would be most significant?

- A. At least a 2-year history of feeling depressed more days than not.
- B. Divorced from spouse six (6) months ago.

- C. Feeling loss of energy and appetite.
- D. Reference to suicide as best solution to identified problems.

Correct Answer: D. Reference to suicide as best solution to identified problems.

An individual who talks about suicide as a solution to a problem is at high risk. This client's suicidal threats need to be taken seriously because he does not see any other variable solutions to problems in living. Determine whether the person has any thoughts of hurting him or herself. Suicidal ideation is highly linked to completed suicide.

- **Option A:** A clear and complete evaluation and clinical interview provide the information upon which to base a suicide intervention. Although risk factors offer major indications of the suicide danger, nothing can substitute for a focused patient inquiry. However, although all the answers a patient gives may be inclusive, a therapist often develops a visceral sense that his or her patient is going to commit suicide. The clinician's reaction counts and should be considered in the intervention.
- **Option B:** A host of thoughts and behaviors are associated with self-destructive acts. Although many assume that people who talk about suicide will not follow through with it, the opposite is true; a threat of suicide can lead to the completed act, and suicidal ideation is highly correlated with suicidal behaviors.
- **Option C:** All of the factors included in the other options would increase the client's risk for depression; however, actual statements about suicidal intent are red flags indicating imminent danger.

29. Which of the following causes of infertility in the female is primarily psychological in origin?

- A. Vaginismus
- B. Dyspareunia
- C. Endometriosis
- D. Impotence

Correct Answer: A. Vaginismus

Vaginismus is primarily psychological in origin. Vaginismus is involuntary contraction of muscles around the opening of the vagina in women with no abnormalities in the genital organs. The tight muscle contraction makes sexual intercourse or any sexual activity that involves penetration painful or impossible.

- **Option B:** Dyspareunia is usually caused by infection, endometriosis, or hormonal changes in menopause although may sometimes be psychological in origin. Dyspareunia is pain when sexual intercourse or other sexual activity that involves penetration is attempted or pain during these activities.
- **Option C:** Endometriosis is a condition that is caused by organic abnormalities. Endometriosis is defined as the presence of normal endometrial mucosa (glands and stroma) abnormally implanted in locations other than the uterine cavity. Approximately 30-40% of women with endometriosis will be subfertile.
- **Option D:** Erectile dysfunction (impotence) is the inability to get and keep an erection firm enough for sex. Having erection trouble from time to time isn't necessarily a cause for concern. If erectile dysfunction is an ongoing issue, however, it can cause stress, affect self-confidence and contribute

to relationship problems.

30. Before administering ephedrine, Nurse Tony assesses the patient's history. Because of ephedrine's central nervous system (CNS) effects, it is not recommended for:

- A. Patients with an acute asthma attack.
- B. Patients with narcolepsy.
- C. Patients under age
- D. Elderly patients.

Correct Answer: D. Elderly patients

Ephedrine is not recommended for elderly patients, who are particularly susceptible to CNS reactions (such as confusion and anxiety) and to cardiovascular reactions (such as increased systolic blood pressure, coldness in the extremities, and anginal pain). Ephedrine is also arrhythmogenic, and caution should be used during administration to patients who are predisposed to arrhythmias or taking other arrhythmogenic medications, particularly digitalis.

- **Option A:** Ephedrine is used for its bronchodilator effects with acute and chronic asthma. Oral formulations of ephedrine have been used historically to treat asthma via pulmonary vasoconstriction and reduction in airway edema along with beta-induced bronchodilation, but it is rarely used for this purpose in modern medicine due to unwanted cardiac effects and availability of more selective beta-agonists such as albuterol.
- **Option B:** Ephedrine is used occasionally for its CNS stimulant actions for narcolepsy. Ephedrine acts as both a direct and indirect sympathomimetic. It binds directly to both alpha and beta receptors; however, its primary mode of action is achieved indirectly, by inhibiting neuronal norepinephrine reuptake and by displacing more norepinephrine from storage vesicles. This action allows norepinephrine to be present in the synapse longer to bind postsynaptic alpha and beta receptors.
- **Option C:** It can be administered to children age 2 and older. The FDA has not formally established safety and effectiveness in pediatric populations. Additionally, ephedrine is distributed by the manufacturer in 50mg/mL vials and requires dilution before intravenous use.

31. When a client has a lobectomy, what fills the space where the lobe was?

- A. The remaining lobe or lobes over expand to fill the space
- B. The lung space fills up with serous fluid
- C. The space stays empty
- D. The surgeon fills the space with gel

Correct Answer: A. The remaining lobe or lobes over expand to fill the space

- **Option A:** The remaining lobe or lobes over expand slightly to fill the space previously occupied by the removed tissue. The diaphragm is carried higher on the operative side to further reduce the empty space.
- **Option C:** The space can't remain "empty" because truly empty would imply a vacuum, which would interfere with the intrathoracic pressure changes that allow breathing.

- **Option B:** Serous fluid overproduction would compress the remaining lobes, diminish their function and possibly, cause a mediastinal shift.
- **Option D:** The surgeon doesn't use a gel to fill the space.

32. Nurse Janus enters a room and finds a client lying on the floor. Which of the following actions should the nurse perform first?

- A. Call for help to get the client back in bed
- B. Establish whether the client is responsive
- C. Assist the client back to bed
- D. Ask the client what happened

Correct Answer: B. Establish whether the client is responsive

Assess the client's current level of consciousness first to determine whether the patient has had a loss of consciousness then do the remaining choices if possible. The initial step is to evaluate for reactivity using objective measures. Address the patient verbally, progress to light shaking, then progress to more intense mechanical stimulation.

- **Option A:** After establishing the client's ABCs, the nurse may call for help. The initial step in the evaluation of an unconscious patient is to evaluate for the basic signs of life. The American Heart Association recommends examining for a pulse, followed by assessing airway patency and breathing pattern.
- **Option C:** If the client is stable and has been seen by a physician, the nurse may assist him back to his bed. The best practice for reporting level of responsiveness is to document specifically how the patient reacted to the external stimulus provided for testing.
- **Option D:** History regarding an unconscious patient is based on supplementary data. Questioning a person who has good knowledge of the recent history of the patient is preferable. The physical exam should be repeated at least daily, in a sequential fashion, and documented systematically.

33. Daniel who is a marathon runner is at high risk for fluid volume deficit. Which one of the following is a related factor?

- A. Decreased diuresis
- B. Disease-related process
- C. Decreased breathing and perspiration
- D. Increased breathing and perspiration

Correct Answer: D. Increased breathing and perspiration

Excessive fluid can be lost if breathing and perspiration are at an increased rate for a prolonged period. Identify the possible cause of the fluid disturbance or imbalance. Establishing a database of history aids accurate and individualized care for each patient.

- **Option A:** Assess color and amount of urine. Report urine output less than 30 ml/hr for 2 consecutive hours. A normal urine output is considered normal not less than 30ml/hour. Concentrated urine denotes fluid deficit.

- **Option B:** Monitor for the existence of factors causing deficient fluid volume (e.g., gastrointestinal losses, difficulty maintaining oral intake, fever, uncontrolled type II diabetes mellitus, diuretic therapy). Early detection of risk factors and early intervention can decrease the occurrence and severity of complications from deficient fluid volume. The gastrointestinal system is a common site of abnormal fluid loss.
- **Option C:** Oral fluid replacement is indicated for mild fluid deficit and is a cost-effective method for replacement treatment. Older patients have a decreased sense of thirst and may need ongoing reminders to drink. Being creative in selecting fluid sources (e.g., flavored gelatin, frozen juice bars, sports drink) can facilitate fluid replacement. Oral hydrating solutions (e.g., Rehydralyte) can be considered as needed.

34. Sheila tells the community nurse that her boyfriend has been abusive and she is afraid of him, but she doesn't want to leave. The client asks the nurse for assistance. Which nursing interventions are appropriate in this situation? Select all that apply.

- A. Help Sheila to develop a plan to ensure safety, including phone numbers for emergency help.
- B. Help Sheila to get her boyfriend into an appropriate treatment program.
- C. Communicate acceptance, avoiding any implication that Sheila is at fault for not leaving.
- D. Help Sheila to explore available options, including shelters and legal protection.
- E. Tell Sheila that she should leave because things will not improve.
- F. Reinforce concern for Sheila's safety and her right to be free of abuse.

Correct Answer: A, C, D, F

These are all appropriate nursing interventions for the victim of domestic violence. The client is not responsible for seeking help for the abuser, and encouraging her to do so may reinforce the client's feeling responsible for the abuse. Advising the client must decide for herself whether to leave, and the nurse must respect any decision the client makes. Making the decision for the client will erode her self-esteem and reinforce her sense of powerlessness.

- **Option A:** Initiate referral to a social worker, public health nurse, psychological counselor before discharge to home. Provides support to the client and family, and monitors behaviors following discharge. A considerable body of empirical data (cited earlier) indicates that women's readiness to act in ways that help them achieve nonviolence is shaped by (a) the level of violence they experience, (b) the supports and resources available to them, and (c) their appraisals of the nature of the abuse and the costs and benefits of taking action.
- **Option B:** Nurses can raise women's awareness that they are in abusive relationships and that they do not deserve to be in them by expressing concern for women's (and their children's) safety and pointing out the degree of vulnerability and danger they face. It can be useful in this context to note Walker's concept of "the cycle of violence, in which periods of violence alternate with periods of reconciliation" (1979).
- **Option C:** In the third stage, preparation, Brown (1997) claimed that women realize the abuse is not their fault and become determined to end the violence. Many acknowledge the loss of the relationship, begin to let go of the hope that abuse will end, and start to work through the associated grief. At this point, women may shift from reevaluating the violent components of the relationship to reevaluating the entire relationship and its meaning for them (Mills, 1985).

- **Option D:** Health care providers in most states cannot intervene directly to prevent women's partners' use of violence (the exceptions are a few states where reporting is mandatory and could lead to the arrest of an abusive partner). Nevertheless, they can intervene in ways that "shore up" women's resources, modify their appraisals of abuse, and help them consider taking actions that may prove beneficial in their quest for nonviolence. Ultimately, it is the responsibility of nurses to help women themselves determine what strategies will work best to achieve nonviolence in their specific situations and then provide support for those actions.
- **Option E:** Barriers to change may include fears related to retaliation from the intimate partner and loss of child custody, employment, or financial support and housing. Each setting should have a plan for assisting women in immediate danger, social service resources for dealing with economic issues, and protocols for providing effective safety planning. Women's past safety strategies should be assessed, and planning should build on strategies they have found effective.
- **Option F:** Self-liberation involves supporting women's own plans to achieve safety in their lives by listening to their deliberations about the meaning of change, identifying resources that will support change, discussing means for removing barriers to change, and providing safety planning. All health care settings should have a list of resources that are available to victims of IPV; these include hot lines, shelters, legal advisors, as well as counselors with experience in IPV.

35. A nurse in the labor room is performing a vaginal assessment on a pregnant client in labor. The nurse notes the presence of the umbilical cord protruding from the vagina. Which of the following would be the initial nursing action?

- Place the client in Trendelenburg's position.
- Call the delivery room to notify the staff that the client will be transported immediately.
- Gently push the cord into the vagina.
- Find the closest telephone and stat page the physician.

Correct Answer: A. Place the client in Trendelenburg's position.

When cord prolapse occurs, prompt actions are taken to relieve cord compression and increase fetal oxygenation. The mother should be positioned with the hips higher than the head to shift the fetal presenting part toward the diaphragm. Oxygen at 8 to 10 L/min by face mask is delivered to the mother to increase fetal oxygenation.

- **Option B:** The definitive management of umbilical cord prolapse is expedient delivery; this is usually by cesarean section. In rare cases, vaginal delivery or operative vaginal delivery may be faster and, thus, preferable, but this should only occur under the presence and guidance of an experienced obstetrician.
- **Option C:** No attempt should be made to replace the cord. The examiner, however, may place a gloved hand into the vagina and hold the presenting part off of the umbilical cord. Decompression should be done manually by the medical provider through the placement of their finger or hand in the vaginal vault and gentle elevation of the presenting part off the umbilical cord. The provider should be conscientious not to place any additional pressure on the cord, as this can cause vasospasm and worsen outcomes.
- **Option D:** The nurse should push the call light to summon help, and other staff members should call the physician and notify the delivery room. If the cord is visibly protruding from the introitus, it should remain warm and moist because the ambient temperature is significantly colder than the temperature in the uterus and can result in vasospasm of the umbilical arteries, contributing to fetal hypoxia. One method described preventing this is the replacement of the cord into the vaginal vault.

followed by insertion of a moist tampon to keep it in place.