

Kevin's Review - 35 NCLEX Practice Questions

1. The nurse is aware that a neonate of a mother with diabetes is at risk for what complication?

- A. Anemia
- B. Hypoglycemia
- C. Nitrogen loss
- D. Thrombosis

Correct Answer: B. Hypoglycemia.

- **Option B:** Neonates of mothers with diabetes are at risk for hypoglycemia due to increased insulin levels. During gestation, an increased amount of glucose is transferred to the fetus across the placenta. The neonate's liver cannot initially adjust to the changing glucose levels after birth. This may result in an overabundance of insulin in the neonate, resulting in hypoglycemia.

2. Blood sugar is well controlled when Hemoglobin A1C is:

- A. Below 5.7%
- B. Between 12%-15%
- C. Less than 180 mg/dL
- D. Between 90 and 130 mg/dL

Correct Answer: A. Below 5.7%

HbA1c measures the percentage of hemoglobin that is glycosylated and determines average blood glucose during the 2 to 3 months prior to testing. A1C of 6% to 6.5% is considered prediabetes. Tighter control is shown by levels of HbA1c in the 7% range or lower, were correlated with a 35-76% decrease in microvascular complications, like retinopathy, nephropathy, and neuropathy, in patients with type 1 diabetes.

- **Option B:** Used as a diagnostic tool, A1C levels of 6.5% or higher on two tests indicate diabetes. Anyone with an HbA1c value of 5.7 % to 6.4 % is considered to be prediabetic, while diabetes can be diagnosed with an HbA1c of 6.5% or higher.
- **Option C:** Patients who are at the borderline of these criteria for diabetes are considered prediabetic. The ADA criteria define prediabetes as impaired fasting glucose (IFG) defined as fasting plasma glucose of 100 mg/dL to 125 mg/dL or impaired glucose tolerance (IGT) 2-hour plasma glucose (in OGTT) of 140 mg/dL to 199 mg/dL or A1c of 5.7 to 6.4%.
- **Option D:** Normal plasma glucose levels are defined as under 100 mg/dL during fasting and less than 140 mg/dL 2-hours postprandial. Additionally, glucose levels in healthy individuals can vary with age. Fasting plasma glucose in adults tends to increase with age starting in the third decade of life but does not increase significantly beyond 60 years of age.

3. What's the first intervention for a patient experiencing chest pain and a pO2 of 89%?

- A. Administer morphine
- B. Administer oxygen

- C. Administer sublingual nitroglycerin
- D. Obtain an electrocardiogram (ECC)

Correct Answer: B. Administer oxygen

Administering supplemental oxygen to the patient is the first priority. Administer oxygen to increase SpO₂ to greater than 90% to help prevent further cardiac damage.

- **Options A and C:** Sublingual nitroglycerin and morphine are commonly administered after oxygen.
- **Option D:** Obtaining an ECG may occur after administering the oxygen to provide baseline data.

4. Before Jacob undergoes arthroscopy, the nurse reviews the assessment findings for contraindications for this procedure. Which finding is a contraindication?

- A. Joint pain
- B. Joint deformity
- C. Joint flexion of less than 50%
- D. Joint stiffness

Correct Answer: C. Joint flexion of less than 50%

Arthroscopy is contraindicated in clients with joint flexion of less than 50% because of technical problems in inserting the instrument into the joint to see it clearly. Other contraindications for this procedure include skin and wound infections.

- **Option A:** Joint pain may be an indication, not a contraindication, for arthroscopy.
- **Option B:** Joint deformity is not a contraindication for the procedure. Joint surgery can improve the appearance of deformed joints, especially in the hands.
- **Option D:** Joint stiffness is not a contraindication for this procedure. Arthroscopic surgery usually results in less joint pain and stiffness.

5. Which of the following would be the priority nursing diagnosis for the adult client with acute leukemia?

- A. Oral mucous membrane, altered related to chemotherapy
- B. Risk for injury related to thrombocytopenia
- C. Fatigue related to the disease process
- D. Interrupted family processes related to life-threatening illness of a family member

Correct Answer: B. Risk for injury related to thrombocytopenia

The client with acute leukemia has bleeding tendencies due to decreased platelet counts, and any injury would exacerbate the problem.

- **Option A:** Alterations in the oral mucous membrane may occur with chemotherapy but it is not a priority.
- **Option C:** Fatigue is common among patients receiving chemotherapy but not a priority.

- **Option D:** Interrupted family processes can also be a diagnosis but not a priority.

6. A 17-year-old client is taking phenytoin (Dilantin) for the treatment of seizures. Phenytoin blood level reveals to be 25 mcg/ml. Which of the following symptoms would be expected as a result of the laboratory result?

- A. No symptoms, because the value is within the normal range.
- B. Hyperactivity.
- C. Tremors.
- D. Nystagmus.

Correct Answer: D. Nystagmus.

- **Option D:** Phenytoin levels of 20 to 30 mg/L result in nystagmus (Involuntary eye movement).
- **Option A:** The therapeutic level of phenytoin is 10-20mcg/ml. No symptoms will be noted.
- **Options B & C:** Hyperactivity and tremors would occur in phenytoin levels of more than 30 mcg/mL.

7. Which of the following is TRUE in Rh incompatibility?

- A. The condition can occur if the mother is Rh(+) and the fetus is Rh(-).
- B. Every pregnancy of an Rh(-) mother will result in erythroblastosis fetalis.
- C. On the first pregnancy of the Rh(-) mother, the fetus will not be affected.
- D. RhoGam is given only during the first pregnancy to prevent incompatibility.

Correct Answer: C. On the first pregnancy of the Rh(-) mother, the fetus will not be affected

On the first pregnancy, the mother still has no contact with Rh(+) blood thus it has not antibodies against Rh(+). After the first pregnancy, even if terminated into an abortion, there is already the possibility of mixing of maternal and fetal blood so this can trigger the maternal blood to produce antibodies against Rh(+) blood. The fetus takes its blood type usually from the father.

- **Option A:** The most common cause of Rh incompatibility is exposure from an Rh-negative mother by Rh-positive fetal blood during pregnancy or delivery. As a consequence, blood from the fetal circulation may leak into the maternal circulation, and, after a significant exposure, sensitization occurs leading to maternal antibody production against the foreign Rh antigen.
- **Option B:** In women who are prone to Rh incompatibility, the second pregnancy with an Rh-positive fetus often produces a mildly anemic infant, whereas succeeding pregnancies produce more seriously affected infants who ultimately may die in utero from massive antibody-induced hemolytic anemia.
- **Option D:** The exact mechanism by which passive administration of Rh IgG prevents Rh immunization is unknown. The most likely hypothesis is that the Rh immune globulin coats the surface of fetal RBCs containing Rh antigens. These exogenous antibody-antigen complexes cross the placenta before they can stimulate the maternal endogenous immune system B cells to produce IgG antibodies.

8. The following are all nursing diagnoses appropriate for a gravida 1 para 0 in labor. Which one would be most appropriate for the primigravida as she completes the early phase of labor?

- A. Impaired gas exchange related to hyperventilation
- B. Alteration in placental perfusion related to maternal position
- C. Impaired physical mobility related to fetal-monitoring equipment
- D. Potential fluid volume deficit related to decreased fluid intake

Correct Answer: D. Potential fluid volume deficit related to decreased fluid intake

Clients admitted in labor are told not to eat during labor, to avoid nausea and vomiting. Ice chips may be allowed, but this amount of fluid might not be sufficient to prevent fluid volume deficit. Provide clear fluids (e.g., clear broth, tea, cranberry juice, jell-O, popsicles) and ice chips, as permitted. Helps promote hydration and may provide some calories for energy production.

- **Option A:** Impaired gas exchange related to hyperventilation would be indicated during the transition phase. Assess FHR changes during a contraction, noting decelerations and accelerations. Detects severity of hypoxia and possible cause. The fetus is vulnerable to potential injury during labor, owing to situations that reduce oxygen levels, such as cord prolapse, prolonged head compression, or uteroplacental insufficiency.
- **Option B:** Instead of Impaired physical mobility, Risk for ineffective coping would be more appropriate at this stage of labor. Reinforce breathing and relaxation techniques during contractions. Minimizes anxiety and provides a distraction, which may block the perception of pain impulses within the cerebral cortex.
- **Option C:** Fluid volume deficit is not correct in relation to the stem. Monitor intake & output. Note urine specific gravity. Encourage the client to empty the bladder at least once every 1 1/2–2 hr. Intake and output should be approximately equal, depending on degree of hydration. Concentration of urine increases as urine output decreases and may warn of dehydration. Fetal descent may be impaired if the bladder is distended.

9. Where would nurse Kristine place the call light for a male client with a right-sided brain attack and left homonymous hemianopsia?

- A. On the client's right side
- B. On the client's left side
- C. Directly in front of the client
- D. Where the client like

Correct Answer: A. On the client's right side

The client has left visual field blindness. The client will see only from the right side. Homonymous hemianopsia is a condition in which a person sees only one side?right or left?of the visual world of each eye. The person may not be aware that the vision loss is happening in both eyes, not just one. An injury to the right part of the brain produces loss of the left side of the visual world of each eye.

- **Option B:** The client would not be able to see the call light on his right side because he can only see the left side.
- **Option C:** Only the right half of the visual world can be seen by the client.

- **Option D:** The most ideal place to put the call light is on the client's right side to avoid any injuries.

10. A maternity nurse is caring for a client with abruptio placenta and is monitoring the client for disseminated intravascular coagulopathy. Which assessment finding is least likely to be associated with disseminated intravascular coagulation?

- A. Swelling of the calf in one leg
- B. Prolonged clotting times
- C. Decreased platelet count
- D. Petechiae, oozing from injection sites, and hematuria

Correct Answer: A. Swelling of the calf in one leg

DIC is a state of diffuse clotting in which clotting factors are consumed, leading to widespread bleeding. Swelling and pain in the calf of one leg are more likely to be associated with thrombophlebitis.

- **Option B:** Fibrin plugs may clog the microvasculature diffusely, rather than in an isolated area. Derangement of the fibrinolytic system further contributes to intravascular clot formation, but in some cases, accelerated fibrinolysis may cause severe bleeding. Hence, a patient with DIC can present with a simultaneously occurring thrombotic and bleeding problem, which obviously complicates the proper treatment.
- **Option C:** Platelets are decreased because they are consumed by the process; coagulation studies show no clot formation (and are thus normal to prolong). Exposure to tissue factor (TF) in the circulation occurs via endothelial disruption, tissue damage, or inflammatory or tumor cell expression of procoagulant molecules (including TF). TF activates coagulation via the extrinsic pathway involving factor VIIa. The TF-VIIa complex activates thrombin, which cleaves fibrinogen to fibrin while simultaneously causing platelet aggregation..
- **Option D:** The presence of petechiae, oozing from injection sites, and hematuria are signs associated with DIC. With acute DIC, the physical findings are usually those of the underlying or inciting condition; however, patients with the acute disease (ie, the hemorrhagic variety associated with excess plasmin formation) have petechiae on the soft palate, trunk, and extremities from thrombocytopenia and ecchymosis at venipuncture sites. These patients also manifest ecchymosis in traumatized areas.

11. The nurse is assessing an infant with Hirschsprung's disease. The nurse can expect the infant to:

- A. Fixed plantar flexion (equinus) of the ankle
- B. Sonorous seal-bark cough
- C. Strawberry tongue
- D. Abdominal distention

Correct Answer: D. Abdominal distention

- **Option D:** Hirschsprung's disease (aganglionic megacolon) is a condition where certain nerve cells in the wall of the colon do not form properly, which results in the blockage of the intestine. Symptoms in infants will show an absence of bowel movement in the first 48 hours and abdominal

distention.

- Option A: Fixed plantar flexion (equinus) of the ankle is a classic sign of clubfoot.
- Option B: A sonorous seal-bark cough in an infant is a sign of croup or transesophageal atresia.
- Option C: A strawberry tongue is indicative of Kawasaki disease.

12. A patient has undergone an amniocentesis for evaluation of fetal well-being. Which intervention would be included in the nurse's plan of care after the procedure? Select all that apply.

- A. Perform ultrasound to determine fetal positioning.
- B. Observe the patient for possible uterine contractions.
- C. Administer RhoGAM to the patient if she is Rh-negative.
- D. Perform a mini catheterization to obtain a urine specimen to assess for bleeding.

Correct Answer: B & C

Ultrasound is used prior to the procedure as a visualization aid to assist with insertion of the transabdominal needle. RhoGAM is a prescription medicine that is used to prevent Rh immunization, a condition in which an individual with Rh-negative blood develops antibodies after exposure to Rh-positive blood. RhoGAM is administered by intramuscular (IM) injection. RhoGAM is purified from human plasma containing anti-Rh (anti-D).

- **Option A:** The position of the baby in the uterus is called the presentation of the fetus. Ideally for labor, the baby is positioned head-down, facing the mother's back with the chin tucked to its chest and the back of the head ready to enter the pelvis. This position is called cephalic presentation.
- **Option D:** There is no need to assess the urine for bleeding as this is not considered to be a typical presentation or complication.

13. A pediatric client with asthma has just received omalizumab (Xolair). The nurse determines that the client might be suffering a life-threatening effect in which of the following?

- A. Headache and dizziness
- B. Nausea and vomiting
- C. Swelling of the tongue
- D. Joint pain

Correct Answer: C. Swelling of the lips

Omalizumab (Xolair) Xolair is an anti-inflammatory that is used to treat moderate to severe asthma that is caused by allergies. An anaphylactic reaction may happen such as flushing, rash, wheezing, or swelling of the face, lips, or tongue.

- **Options A, B, & D:** These are some of the side effects but will not alert the nurse for an anaphylactic reaction.

14. An 8.5 lb, 6 oz infant is delivered to a diabetic mother. Which nursing intervention would be implemented when the neonate becomes jittery and lethargic?

- A. Administer insulin.
- B. Administer oxygen.
- C. Feed the infant glucose water (10%).
- D. Place the infant in a warmer.

Correct Answer: C. Feed the infant glucose water (10%)

After birth, the infant of a diabetic mother is often hypoglycemic. Treatment will depend on the baby's gestational age and overall health. Treatment includes giving the baby a fast-acting source of glucose. This may be as simple as a glucose and water mixture or formula as an early feeding. Or the baby may need glucose given through an IV. The baby's blood glucose levels are checked after treatment to see if the hypoglycemia occurs again.

- **Option A:** Second-line therapies for the treatment of persistent hypoglycemia include the use of corticosteroids or glucagon, not insulin. Glucagon is a hormone that stimulates endogenous glucose production via glycogenolysis and gluconeogenesis; thus its effectiveness depends on the infant having adequate glycogen stores. It is most useful in term infants and infants of diabetic mothers. Glucagon dosing is as a 30 mcg/kg bolus or 300 mcg/kg per minute continuous infusion.
- **Option B:** Oxygen is not administered to hypoglycemic neonates. Early initiation of breastfeeding is crucial for all infants. For asymptomatic infants at risk of neonatal hypoglycemia, the AAP recommends initiating feeds within the first hour of life and performing initial glucose screening 30 minutes after the first feed. The AAP recommends goal blood glucose levels equal to or greater than 45 mg/dL prior to routine feedings, and intervention for blood glucose <40 mg/dL in the first 4 hours of life and <45 mg/dL at 4 to 24 hours of life.
- **Option D:** Placing the infant in a warmer does not manage the hypoglycemia. In infants of diabetic mothers, lower glucose infusions rates of 3 to 5 mg/kg/minute may be used to minimize pancreatic stimulation and endogenous insulin secretion. Infants requiring higher rates of intravenous dextrose (>12 to 16 mg/kg/minute) or for more than 5 days are more likely to have a persistent cause of hypoglycemia.

15. The nurse would monitor a patient using sodium bicarbonate to treat gastric hyperacidity for signs and symptoms of:*A. Metabolic alkalosis*

- A. Metabolic alkalosis
- B. Metabolic acidosis
- C. Hyperkalemia
- D. Hypercalcemia

Correct Answer: A. Metabolic alkalosis

Solutions containing sodium bicarbonate (a base) can cause metabolic alkalosis. Serum K and serum calcium would decrease with alkalosis, not increase. Due to rapid alkalotic effects, sodium bicarbonate is contraindicated in those with signs/symptoms or laboratory values indicating underlying metabolic or respiratory alkalosis due to the potential for exacerbation of symptoms.

- **Option B:** Sodium bicarbonate is indicated for acute metabolic acidosis. If pH is less than 7.1 or pH less than 7.1 to 7.2 in patients with severe acute kidney injury (oliguria or 2-fold or larger increase in serum creatinine level). It is also indicated for chronic metabolic acidosis. 50-100 mEq oral tablet can be initiated and titrated according to the ongoing evaluation of acid-base balance.
- **Option C:** When patients with severe hyperkalemia (serum potassium level of more than 6 mEq/L or more than 5.5 mEq/L with arrhythmia or EKG changes) have metabolic acidosis, sodium bicarbonate should be administered. The dose needed is empirical and is unpredictable. Initially, 150 mEq of sodium bicarbonate can be given in 1 liter of 5% dextrose over 4 hours. More can be given if acidosis does not correct with this regimen.
- **Option D:** Sodium bicarbonate administration in a rapid infusion or as large boluses can result in acute metabolic alkalosis resulting in reduced serum ionized calcium. This acute shift in ionized calcium can result in tetany. This severe alkalosis is potentially treatable with ammonium chloride. Hypocalcemia may be addressed with calcium gluconate. An addition of 0.9 % NS infusion and potassium supplementation may also be indicated.

16. Which of the following cardiac conditions does a fourth heart sound (S4) indicate?

- A. Dilated aorta
- B. Normally functioning heart
- C. Decreased myocardial contractility
- D. Failure of the ventricle to eject all the blood during systole

Correct Answer: D. Failure of the ventricle to eject all the blood during systole

An S4 occurs as a result of increased resistance to ventricular filling after atrial contraction. This increased resistance is related to decreased compliance of the ventricle.

- **Option A:** A dilated aorta doesn't cause an extra heart sound, though it does cause a murmur. The aorta is considered pathologically dilated if the diameters of the ascending aorta and the aortic root exceed the norms for a given age and body size. A 50% increase over the normal diameter is considered aneurysmal dilatation.
- **Option C:** Decreased myocardial contractility is heard as a third heart sound. Optimal myocardial contractility is dependent on an optimal filling pressure, afterload, and the presence and availability of inotropic substances (eg, epinephrine, norepinephrine, or calcium). Calcium influx and binding to troponin C is essential for cardiac contraction.
- **Option B:** An S4 isn't heard in a normally functioning heart. The fourth heart sound is a low-pitched sound coincident with the late diastolic filling of the ventricle due to atrial contraction. It thus occurs shortly before the first heart sound. Although it is also called the atrial sound, and its production requires an effective atrial contraction, the fourth heart sound is the result of vibrations generated within the ventricle.

17. The nurse is assigned to a client who has a draining sacral wound infected by MRSA. Which personal protective equipment (PPE) will the nurse plan to use in preparing to change the linens of the client? Select all that apply.

- A. Gloves

- B. Goggles
- C. Gown
- D. N95 respirator
- E. Surgical mask
- F. Shoe covers

Correct Answer: A and C

Gloves and a gown should be applied when coming in contact with linens that may be contaminated by the client's wound secretions. Contact precautions include the use of gowns, gloves, and possibly masks during clinical encounters with patients with MRSA infection. Infection control also may include keeping patients in isolated rooms or the same rooms of other patients who have an MRSA infection.

- **Option B:** Goggles are the primary protectors intended to shield the eyes against liquid or chemical splash, irritating mists, vapors, and fumes. They form a protective seal around the eyes, and prevent objects or liquids from entering under or around the goggles. This is especially important when working with or around liquids that may splash, spray, or mist.
- **Option D:** An N95 respirator protects against dust, fumes, mists, and other microorganisms. This can be used when working with live animals or infectious materials in BSL-2 level labs with known airborne transmissible disease (e.g. tuberculosis, also required for influenza (flu)).
- **Option E:** Surgical masks protect against large droplets and splashes. It does not require fit-testing. This can be used when working with live animals; working with infectious material in BSL-2+ level labs but only protects your sample from you, not the other way around.
- **Option F:** A shoe cover is not necessary, because transmission by splashes, droplets, or airborne means will not occur when the bed is changed. The inclusion of protective shoe covers or footwear as a component of PPE for prevention of acquisition and dissemination of pathogenic microbial agents by healthcare staff derives from documentation of extensive floor contamination with bacterial pathogens.

18. The planning step of the nursing process includes which of the following activities?

- A. Assessing and diagnosing.
- B. Evaluating goal achievement.
- C. Performing nursing actions and documenting them.
- D. Setting goals and selecting interventions.

Correct Answer: D. Setting goals and selecting interventions.

The planning stage is where goals and outcomes are formulated that directly impact patient care based on EDP guidelines. These patient-specific goals and the attainment of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs.

- **Option A:** Assessment is the first step and involves critical thinking skills and data collection; subjective and objective. Data may come from the patient directly or from primary caregivers who may or may not be direct relation family members. Friends can play a role in data collection. Electronic health records may populate data in and assist in assessment. The formulation of a nursing diagnosis by employing clinical judgment assists in the planning and implementation of

patient care.

- **Option B:** This final step of the nursing process is vital to a positive patient outcome. Whenever a healthcare provider intervenes or implements care, they must reassess or evaluate to ensure the desired outcome has been met. Reassessment may frequently be needed depending upon overall patient condition. The plan of care may be adapted based on new assessment data.
- **Option C:** Implementation is the step that involves action or doing and the actual carrying out of nursing interventions outlined in the plan of care. This phase requires nursing interventions such as applying a cardiac monitor or oxygen, direct or indirect care, medication administration, standard treatment protocols, and EDP standards.

19. During a nursing lecture on renal physiology, the instructor discusses the processes of filtration, reabsorption, and secretion within the urinary system. To assess the students' understanding, which of the following statements about these processes should the instructor ask them to identify as TRUE?

- A. Filtration is the movement of materials across the wall of the nephron into Bowman's capsule to form a filtrate.
- B. In reabsorption, the solutes are reabsorbed across the filtration membrane into the interstitial fluid by transport processes, such as active transport and cotransport.
- C. In secretion, solutes are secreted across the wall of the nephron into the filtrate.
- D. All statements need further evaluation.

Correct Answer: C. In secretion, solutes are secreted across the wall of the nephron into the filtrate.

In the process of secretion within the nephron, solutes are actively transported from the bloodstream into the filtrate to facilitate the elimination of specific substances from the body. This mechanism allows the nephron to further regulate the composition of urine by removing additional waste products, excess ions, and certain drugs or toxins that were not adequately filtered during the initial glomerular filtration process.

- **Option A:** Filtration is the movement of materials across the filtration membrane into Bowman's capsule to form a filtrate.
- **Option B:** In reabsorption, the solutes are reabsorbed across the wall of the nephron into the interstitial fluid by transport processes, such as active transport and cotransport.

20. A child with known hemophilia A was brought to the emergency room with complaints of nose bleeding and some bruises in the joints. Which of the following should the nurse anticipate to be given to the child?

- A. Oral iron supplement
- B. Cyclosporine
- C. Factor X
- Factor VIII

Correct Answer: D. Factor VIII

Hemophilia A, also called factor VIII (FVIII) deficiency or classic hemophilia, is a genetic disorder caused by missing or defective factor VIII, a clotting protein. The initial treatment is the administration of factor VIII to replace the missing factor and decrease the bleeding episode.

- **Option A:** Oral iron supplement is not used in the management of hemophilia. Other pharmaceutical adjuvant therapies for hemophilia A-induced bleeding include desmopressin, tranexamic acid, epsilon aminocaproic acid, and management of factor VIII inhibitors.
- **Option B:** Cyclosporine is an immunosuppressive agent used to treat organ rejection post-transplant. It also has use in certain other autoimmune diseases, treatment of organ rejection in kidney, liver, and heart allogeneic transplants, rheumatoid arthritis when the condition has not adequately responded to methotrexate.
- **Option C:** Hemophilia, which means love (philia) of blood (hemo), is the most common severe hereditary hemorrhagic disorder. Both hemophilia A and B result from factor VIII and factor IX protein deficiency or dysfunction, respectively, and are characterized by prolonged and excessive bleeding after minor trauma or sometimes even spontaneously.

21. Gravida refers to which of the following descriptions?

- A. A serious pregnancy.
- B. Number of times a female has been pregnant.
- C. Number of children a female has delivered.
- D. Number of term pregnancies a female has had.

Correct Answer: B. Number of times a female has been pregnant.

Gravida refers to the number of times a female has been pregnant, regardless of pregnancy outcome or the number of neonates delivered.

- **Option A:** The term gravida comes from the Latin word gravidus. It is used to describe a woman who is pregnant and is also a medical term for the total number of confirmed pregnancies a woman has had, regardless of the outcome of the pregnancy.
- **Option C:** Parity is defined as the number of times that she has given birth to a fetus with a gestational age of 24 weeks or more, regardless of whether the child was born alive or was stillborn.
- **Option D:** ACOG and SMFM use these definitions to describe term pregnancies: Early term: The baby is born between 37 weeks, 0 days and 38 weeks, 6 days. Full term: The baby is born between 39 weeks, 0 days and 40 weeks, 6 days. Late-term: The baby is born between 41 weeks, 0 days and 41 weeks, 6 days.

22. A priority nursing diagnosis for a child being admitted from surgery following a tonsillectomy is:

- A. Body image disturbance
- B. Impaired verbal communication
- C. Risk for aspiration
- D. Pain

Correct Answer: C. Risk for aspiration

Always remember your ABCs (airway, breathing, circulation) when selecting an answer. Place the child prone or side-lying position. Promotes drainage of blood and unswallowed saliva from the mouth that can potentially be aspirated.

- **Option A:** Does not apply for a child who has undergone a tonsillectomy. Assess for signs and symptoms of inadequate oxygenation. Early signs of hypoxia include confusion, irritability, headaches, pallor, tachycardia, and tachypnea.
- **Option B:** Observe the child for nonverbal indications of pain such as crying, grimacing, irritability. Provides additional information about pain. The child may find discomfort in speaking.
- **Option D:** Although these nursing diagnoses might be appropriate for this child, risk for aspiration should have the highest priority. Apply an ice collar on the neck or encourage the child to eat popsicles. Cold promotes vasoconstriction and decreases swelling that contributes to pain.

23. A client with cancer of the pancreas has undergone a Whipple procedure. The nurse is aware that during the Whipple procedure, the doctor will remove the:

- A. Head of the pancreas
- B. Proximal third section of the small intestines
- C. Stomach and duodenum
- D. Esophagus and jejunum

Correct Answer: A. Head of the pancreas

During a Whipple procedure the head of the pancreas, which is a part of the stomach, the jejunum, and a portion of the stomach is removed and anastomosed. It is the most often used surgery to treat pancreatic cancer that's confined to the head of the pancreas. After performing the Whipple procedure, the surgeon reconnects the remaining organs to allow the client to digest food normally after surgery.

- **Option B:** Small bowel resection is surgery to remove a part of the small bowel. It is done when part of the small bowel is blocked or diseased.
- **Option C:** A gastrectomy is the surgical removal of all or part of the stomach. The stomach is a J-shaped organ in the upper abdomen. It is part of the digestive system, which processes nutrients (vitamins, minerals, carbohydrates, fats, proteins, and water) in foods that are eaten and help pass waste material out of the body. A partial gastrectomy is the removal of only part of the stomach. The remaining portion then continues with its digestive role. If the entire stomach is removed, the esophagus is connected directly to the small intestine, where digestion now begins. Patients must make significant dietary changes when a gastrectomy is performed.
- **Option D:** Jejunal interposition is a procedure in which surgeons replace the missing section of a child's esophagus with a section of the jejunum (the middle part of the small intestine). It is used to treat children who have already undergone failed repair of long-gap esophageal atresia and for whom the Foker process isn't an option.

24. Assessing a client who has developed atelectasis postoperatively, the nurse will most likely find:

- A. A flushed face.

- B. Dyspnea and pain.
- C. Decreased temperature.
- D. Severe cough and no pain.

Correct Answer: B. Dyspnea and pain

Atelectasis is a collapse of the alveoli due to obstruction or hypoventilation. Clients become short of breath, have a high temperature, and usually experience severe pain but do not have a severe cough. The shortness of breath is a result of decreased oxygen-carbon dioxide exchange at the alveolar level. Postoperative atelectasis typically occurs within 72 hours of general anesthesia and is a well-known postoperative complication.

- **Option A:** The definition of atelectasis is a partial collapse of the lung. It can cause people to feel short of breath. It can be a consequence of several different processes, most commonly when there is a poor inspiratory effort, an obstruction blocking airflow into the lung, extra pressure exerted on the outside of the lung, or deficient production or function of a specific protein in the lung.
- **Option C:** Postoperative fever has historically been attributed to atelectasis, but there is no evidence supporting the finding that atelectasis is a causative mechanism for fever. For patients with atelectasis, the prognosis varies greatly, and the primary determination is the underlying etiology and patient co-morbidities.
- **Option D:** Inadequate pain control can contribute to the development of atelectasis by inducing shallow breathing (“splinting”) and/or inhibiting coughing. Typically, atelectasis is asymptomatic. However, a patient might also present with decreased or absent breath sounds, crackles, cough, sputum production, dyspnea, tachypnea, and/or diminished chest expansion.

25. The nurse is conducting nutrition counseling for a patient with cholecystitis. Which of the following information is important to communicate?

- A. The patient must maintain a low-calorie diet.
- B. The patient must maintain a high protein/low carbohydrate diet.
- C. The patient should limit sweets and sugary drinks.
- D. The patient should limit fatty foods.

Correct Answer: D. The patient should limit fatty foods.

Cholecystitis, inflammation of the gallbladder, is most commonly caused by the presence of gallstones, which may block bile (necessary for fat absorption) from entering the intestines. Patients should decrease dietary fat by limiting foods like fatty meats, fried foods, and creamy desserts to avoid irritation of the gallbladder.

- **Option A:** The patient may maintain a moderate to a high-calorie diet, as a very low-calorie diet may increase the risk for gallstones that predisposes to cholecystitis.
- **Option B:** Both animal fat and animal protein may contribute to the formation of gallstones. Vitamin C, which is abundant in plants and absent from meat affects the rate-limiting step in the catabolism of cholesterol to bile acids and is inversely related to the risk of gallstones and cholecystitis. Individuals consuming the most refined carbohydrates have a 60% greater risk for developing gallstones, compared with those who consumed the least.

- **Option C:** Replacing sugary drinks with drinks high in fiber would reduce the risk of gallbladder stones by 15%.

26. A client with BPH is being treated with terazosin (Hytrin) 2 mg at bedtime. The nurse should monitor the client's:

- A. Urinary nitrites
- B. White blood cell count
- C. Blood pressure
- D. Pulse

Correct Answer: C. Blood pressure

Terazosin (Hytrin) is an antihypertensive drug that is also used in the treatment of BPH. Blood pressure must be monitored to ensure that the client does not develop hypotension, syncope, or postural hypotension. The client should be instructed to change positions slowly. Statistically significant adverse effects associated with terazosin detected in placebo-controlled trials listed in the FDA database include dizziness, headache, weakness, postural hypotension, and nasal congestion.

- **Option A:** If used for lower urinary tract symptoms associated with benign prostatic hyperplasia, standard clinical assessment of patients may be used to determine efficacy. According to the FDA, post-marketing surveys also found priapism, atrial fibrillation, anaphylaxis, intraoperative floppy iris syndrome to be associated with terazosin use, though instances of such occurrences were extremely rare.
- **Option B:** The use of terazosin does not require plasma/blood drug level monitoring. Orthostatic vital signs should be obtained after the first dose to exclude postural hypotension. Overdose of terazosin may lead to hypotension, and standard life-support protocols should be in place for instances of hemodynamic instability.
- **Option D:** If used for hypertension, orthostatic blood pressures may be checked regularly during the titration interval to confirm efficacy. First-dose syncope is rare and may be mitigated by bedtime use. Orthostatic hypotension is common and should merit strong consideration when prescribing terazosin.

27. The client with chronic renal failure tells the nurse he takes magnesium hydroxide (milk of magnesia) at home for constipation. The nurse suggests that the client switch to psyllium hydrophilic mucilloid (Metamucil) because:

- A. MOM can cause magnesium toxicity.
- B. MOM is too harsh on the bowel.
- C. Metamucil is more palatable.
- D. MOM is high in sodium.

Correct Answer: A. MOM can cause magnesium toxicity.

Magnesium is normally excreted by the kidneys. When the kidneys fail, magnesium can accumulate and cause severe neurologic problems. The kidney has a vital role in magnesium homeostasis and, although the renal handling of magnesium is highly adaptable, this ability deteriorates when renal function declines significantly. In moderate chronic kidney disease (CKD), increases in the fractional

excretion of magnesium largely compensate for the loss of glomerular filtration rate to maintain normal serum magnesium levels.

- **Option B:** MOM is harsher than Metamucil, but magnesium toxicity is a more serious problem. As such, renal failure patients might be more vulnerable to changes in magnesium intake via the diet or via medication (e.g. antacids or phosphate binders) and/or the use of diuretics. Furthermore, intestinal absorption of magnesium can also be influenced by calcium and vice versa
- **Option C:** A client may find both MOM and Metamucil unpalatable. People of all ages should drink a full glass, or 8 ounces, of water with each dose of milk of magnesia. If anyone experienced diarrhea after taking a dose of milk of magnesia, they should avoid taking it again.
- **Option D:** MOM is not high in sodium. Milk of magnesia is a type of hyperosmotic laxative. This kind of oral laxative works by drawing water to the bowel from nearby tissue. This softens and moistens the stool. It also helps increase bowel activity.

28. 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.

29. Terry with mania is skipping up and down the hallway practically running into other clients. Which of the following activities would the nurse in charge expect to include in Terry's plan of care?

- A. Watching TV
- B. Cleaning dayroom tables
- C. Leading group activity
- D. Reading a book

Correct Answer: B. Cleaning dayroom tables

The client with mania is very active & needs to have this energy channeled in a constructive task such as cleaning or tidying the room. Mania, or a manic phase, is a period of 1 week or more in which a person experiences a change in normal behavior that drastically affects their functioning. Mania is different from hypomania because hypomania does not cause a major deficit in social or occupational functioning, and it is a period of at least 4 days rather than 1 week. The defining characteristics of mania are increased talkativeness, rapid speech, decreased the need for sleep (unlike depression or anxiety in which the need for sleep exists, but there is an inability to sleep), racing thoughts, distractibility, increase in goal-directed activity, and psychomotor agitation.

- **Option A:** Maintain a low level of stimuli in the client's environment (e.g., loud noises, bright light, low-temperature ventilation). Helps minimize the escalation of anxiety. Provide structured solitary activities with the assistance of a nurse or aide. Structure provides focus and security.
- **Option C:** Provide frequent rest periods to prevent exhaustion. Acute mania might warrant the use of phenothiazines and seclusions to decrease any physical harm. Exhaustion and death result from dehydration, lack of sleep, and constant physical activity.
- **Option D:** When less manic, the client might join one or two other clients in quiet, non-stimulating activities (e.g., drawing, board games, cards). As mania subsides, involvement in activities that provide a focus and social contact becomes more appropriate. Competitive games can stimulate aggression and can increase psychomotor activity.

30. The nurse is reviewing the physician's orders written for a client admitted with acute pancreatitis. Which physician order would the nurse question if noted on the client's chart?

- A. NPO status
- B. Insert a nasogastric tube
- C. An anticholinergic medication
- D. Morphine for pain

Correct Answer: D. Morphine for pain

Meperidine (Demerol) rather than morphine is the medication of choice because morphine can cause spasms in the sphincter of Oddi. Meperidine is usually effective in relieving pain and may be preferred over morphine, which can have a side effect of biliary-pancreatic spasms. Paravertebral block has been used to achieve prolonged pain control.

- **Option A:** Maintain NPO status and gastric suctioning in acute phase; prevents stimulation and release of pancreatic enzymes (secretin), released when chyme and HCl enter the duodenum. Administer hyperalimentation and lipids, if indicated. IV administration of calories, lipids, and amino acids should be instituted before nutrition and nitrogen depletion are advanced.

- **Option B:** Oral feedings given too early in the course of illness may exacerbate symptoms. Loss of pancreatic function and reduced insulin production may require the initiation of a diabetic diet.
- **Option C:** Provide medium-chain triglycerides (MCTs) (MCT, Portagen). MCTs are elements of enteral feedings (NG or J-tube) that provide supplemental calories and nutrients that do not require pancreatic enzymes for digestion and absorption.

31. A 36-year-old man with lymphoma presents with signs of impending septic shock 9 days after chemotherapy. The nurse would expect which of the following to be present?

- A. Low-grade fever, chills, tachycardia
- B. Elevated temperature, oliguria, hypotension
- C. Flushing, decreased oxygen saturation, mild hypotension
- D. High-grade fever, normal blood pressure, increased respirations

Correct Answer: A. Low-grade fever, chills, tachycardia

- **Option A:** Nine days after chemotherapy, one would expect the client to be immunocompromised. The clinical signs of shock reflect changes in cardiac function, vascular resistance, cellular metabolism, and capillary permeability. Low-grade fever, tachycardia, and flushing may be early signs of shock.
- **Option B:** Oliguria and hypotension are late signs of shock. Urine output can be initially normal or increased.
- **Options C and D:** The client with impending signs of septic shock may not have decreased oxygen saturation levels and normal blood pressure.

32. A client arrives in the emergency with complaints of chest pain and is diagnosed with acute MI. A morphine 4mg IV was given 5 minutes ago. Which of the following assessments made by the nurse indicates a further immediate action?

- A. Respiratory rate from 20 bpm to 12 bpm.
- B. Blood pressure from 120/70 to 100/60 mmHg.
- C. The client still complains of chest pain with a pain scale of 2/10.
- D. Cardiac rate of 103 bpm and a normal sinus rhythm of the ECG.

Correct Answer: C. The client still complains of chest pain with a pain scale of 2/10.

The goal for the client with an acute myocardial infarction is to eliminate the pain. Even pain related to a level of 2/10 should be managed with an additional dose of morphine.

- **Options A, B, & D:** Although hypotension, respiratory depression, and tachycardia are the side effects of morphine, they do not require further action at this time.

33. A patient arrives at the emergency department complaining of midsternal chest pain. Which of the following nursing actions should take priority?

- A. A complete history with emphasis on preceding events.
- B. An electrocardiogram.
- C. Careful assessment of vital signs.
- D. Chest exam with auscultation.

Correct Answer: C. Careful assessment of vital signs.

The priority nursing action for a patient arriving at the ED in distress is always an assessment of vital signs. This indicates the extent of the physical compromise and provides a baseline by which to plan further assessment and treatment. Monitor vital signs every 5 min during the initial anginal attack. Blood pressure may initially rise because of sympathetic stimulation, then fall if cardiac output is compromised. Tachycardia also develops in response to sympathetic stimulation and may be sustained as a compensatory response if cardiac output falls.

- **Option A:** A thorough medical history, including the onset of symptoms, will be necessary. Identify precipitating events, if any: frequency, duration, intensity, and location of the pain. Helps differentiate this chest pain, and aids in evaluating possible progression to unstable angina.
- **Option B:** It is likely that an electrocardiogram will be performed as well, but this is not the first priority. Monitor heart rate and rhythm. Patients with unstable angina have an increased risk of acute life-threatening dysrhythmias, which occur in response to ischemic changes and/or stress.
- **Option D:** Similarly, chest exams with auscultation may offer useful information after vital signs are assessed. Observe for associated symptoms: dyspnea, nausea, and vomiting, dizziness, palpitations, desire to micturate. Decreased cardiac output (which may occur during an ischemic myocardial episodes) stimulates sympathetic and parasympathetic nervous systems, causing a variety of vague sensations that the patient may not identify as related to the anginal episode.

34. Tara is an 11-year-old girl diagnosed with type 1 diabetes mellitus (DM). She asks her attending nurse why she can't take a pill rather than shots like her grandmother does. Which of the following would be the nurse's best reply?

- A. "If your blood glucose levels are controlled, you can switch to using pills."
- B. "The pills correct fat and protein metabolism, not carbohydrate metabolism."
- C. "Your body does not make insulin, so the insulin injections help to replace it."
- D. "The pills work on the adult pancreas, you can switch when you are 18."

Correct Answer: C. "Your body does not make insulin, so the insulin injections help to replace it."

The child has type 1 DM, indicating a lack of functioning pancreatic beta cells and an absolute insulin deficiency. Type 1 diabetes is an autoimmune condition that leads to the destruction of pancreatic beta cells which in turn causes insufficient insulin production, resulting in hyperglycemia. Type 1 diabetes is a chronic disease requiring insulin replacement and intensive effort by the patient.

- **Option A:** Oral antidiabetics are indicated only for those with some functioning beta cells, as in those with type 2 DM. Therefore, injections are indicated to supply insulin that is lacking in type 1 diabetes.
- **Option B:** Oral antidiabetics do not correct metabolism. Healthcare practitioners encourage patients to combine lifestyle modifications with oral pharmacologic agents for optimal glycemic

control, particularly as type 2 diabetes mellitus progresses with continued loss of pancreatic beta-cell function and insulin production.

- **Option D:** A child with type 1 DM cannot substitute an oral antidiabetic for insulin, regardless of age. Insulin delivery is by multiple daily injections (MDI) or an insulin pump to simulate endogenous insulin physiology. Multiple daily injections include basal insulin once or twice daily, and bolus insulin typically is given at meals three or more times daily and is based on carbohydrate content and current blood glucose.

35. A priority nursing diagnosis for the client who is being discharged home 3 days after a TURP would be:

- A. Deficient fluid volume
- B. Imbalanced Nutrition: Less than Body Requirements
- C. Impaired Tissue Integrity
- D. Ineffective Airway Clearance

Correct Answer: A. Deficient fluid volume

Deficient Fluid Volume is a priority diagnosis because the client needs to drink a large amount of fluid to keep the urine clear. The urine should be almost without color. About two (2) weeks after a TURP, when desiccated tissue is sloughed out, a secondary hemorrhage could occur. The client should be instructed to call the surgeon or go to the ED if at any time the urine turns bright red.

- **Option B:** The client is not specifically at risk for nutritional problems after a TURP. Encourage fluid intake to 3000 mL as tolerated. Limit fluids in the evening, once the catheter is removed. Maintains adequate hydration and renal perfusion for urinary flow. Reducing fluid intake at the right schedule decreases the need to void and interrupt sleep during the night.
- **Option C:** The client is not specifically at risk for impaired tissue integrity because there is no external incision. Maintain a sterile catheter system. Provide regular catheter and meatal care with soap and water. Apply antibiotic ointment around the catheter site. Measures to prevent the introduction of bacteria that may cause infection or sepsis.
- **Option D:** The client is not specifically at risk for airway problems because the procedure is done after spinal anesthesia. Monitor vital signs, noting low-grade fever, chills, rapid pulse and respiration, restlessness, irritability, disorientation. Patient who has had a cystoscopy and/or TURP is at increased risk for surgical or septic shock related to manipulation and instrumentation.