

Kevin's Review - 35 NCLEX Practice Questions

1. ACEs participate in the renin-angiotensin-aldosterone system to have which of the following physiologic effects?

- A. Inhibit conversion of angiotensin II to angiotensin I.
- B. Vasoconstriction and sodium depletion.
- C. Promote sodium and water retention.
- D. Stimulate vasodilation and inhibit sodium depletion.

Correct Answer: C. Promote sodium and water retention.

Angiotensin is a potent vasoconstrictor that stimulates the release of aldosterone. Aldosterone release promotes sodium and water retention. The renin–angiotensin–aldosterone system (RAAS) is a critical regulator of blood volume and systemic vascular resistance. While the baroreceptor reflex responds in a short-term manner to decreased arterial pressure, the RAAS is responsible for more chronic alterations. It is composed of three major compounds: renin, angiotensin II, and aldosterone.

- **Option A:** The conversion of angiotensin I to II is not inhibited. The conversion of angiotensin I to angiotensin II is catalyzed by an enzyme called angiotensin-converting enzyme (ACE). ACE is found primarily in the vascular endothelium of the lungs and kidneys. After angiotensin I is converted to angiotensin II, it has effects on the kidney, adrenal cortex, arterioles, and brain by binding to angiotensin II type I (AT) and type II (AT) receptors.
- **Option B:** Aldosterone promotes sodium retention, not depletion. Aldosterone is a steroid hormone that causes an increase in sodium reabsorption and potassium excretion at the distal tubule and collecting duct of the nephron. Aldosterone works by stimulating the insertion of luminal Na channels and basolateral Na-K ATPase proteins. The net effect is an increased level of sodium reabsorption.
- **Option D:** The effect of angiotensin II on vasoconstriction takes place in systemic arterioles. Here, angiotensin II binds to G protein-coupled receptors, leading to a secondary messenger cascade that results in potent arteriolar vasoconstriction. This acts to increase total peripheral resistance, causing an increase in blood pressure.

2. Nurse Emma is planning a client education program for sickle cell disease (SCD); What topic should be included in the plan of care?

- A. Aerobic exercise to improve oxygenation
- B. Fluid restraint to 1 qt (1 L)/day
- C. A high-iron, high-protein diet
- D. Proper hand washing and infection avoidance

Correct Answer: D. Proper handwashing and infection avoidance

Prevention of infection is vital in the prevention of sickle cell crisis. Patients with SCD are especially at risk for infections with encapsulated organisms because of their functional asplenia, as well as because of functionally immunocompromised state (increased bone marrow turnover and altered complement activation).

- **Option A:** Strenuous activities and exercises should be withdrawn to lessen the risk of increased tissue ischemia. Because acute intense exercise may alter these pathophysiological mechanisms, physical activity is usually contraindicated in patients with SCD.

- **Option B:** Proper hydration should be encouraged to prevent crises secondary to dehydration. Erythrocytes are more likely to sickle and become rigid in the presence of dehydration. This process is in large part caused by changes in cation homeostasis, specifically increased potassium and water efflux mediated by potassium-chloride cotransport and Gardos channels (calcium-dependent potassium channel).
- **Option C:** A high-iron, high-protein diet would have no impact on the disease or prevention of a crisis. Patients with sickle cell anemia have greater than average requirements for both calories and micronutrients and therefore need to eat more to avoid being deficient in immune-boosting nutrients.

3. Which of the following positions would best aid breathing for a client with acute pulmonary edema?

- A. Lying flat in bed.
- B. Left side-lying.
- C. In high Fowler's position.
- D. In semi-Fowler's position.

Correct Answer: C. In high Fowler's position

A high Fowler's position promotes ventilation and facilitates breathing by reducing venous return. Gravity improves lung expansion by lowering diaphragm and shifting fluid to the lower abdominal cavity. Turn or reposition, and provide skin care at regular intervals. Decreases pressure and friction on edematous tissue, which is more prone to breakdown than normal tissue.

- **Option A:** Lying flat on bed may worsen the patient's breathing. Edema can be either a cause or a result of various pathological conditions reflecting four competing forces: blood hydrostatic and osmotic pressures and interstitial fluid hydrostatic and osmotic pressures. The dynamic interaction of these four forces allows fluid to shift from one body compartment to another. Edema may be generalized or localized in dependent areas. Elderly clients may develop dependent edema with relatively little excess fluid.
- **Option B:** Left side-lying position worsens the breathing and increases the workload of the heart. Encourage adequate bed rest. Limited cardiac reserves result in fatigue and activity intolerance. Rest, particularly lying down, favors diuresis and reduction of edema.
- **Option D:** Semi-Fowler's position won't reduce the workload of the heart as well as Fowler's position will. Note the presence of neck and peripheral vein distention, along with pitting edema, and dyspnea. Signs of cardiac decompensation and heart failure. Auscultate lung and heart sounds. Adventitious sounds (crackles) and extra heart sounds (S3) are indicative of fluid excess, possibly returning in the rapid development of pulmonary edema.

4. The ambulance has transported a man with severe chest pain. As the man is being transferred to the emergency stretcher, the nurse assessed the following: unresponsiveness, cessation of breathing, and absence of palpable pulse. Which of the following tasks is proper to assign to the nursing assistant?

- A. Aiding with oral intubation
- B. Performing chest compressions

- C. Placing the defibrillator pads
- D. Starting bag valve mask ventilation

Correct Answer: B. Performing chest compressions

Basic cardiac life support is learned by nursing assistants so they can perform chest compressions. Certified nursing assistants deal directly with the patients so they must be cardiopulmonary resuscitation certified. It is the nursing assistant who witnesses the victims of cardiac arrests and becomes an immediate responder. A trained certified assistant can easily cater the instantaneous needs of the patient.

- **Option A:** The nurse or the respiratory therapist should provide assistance as needed during intubation. Assisting with tracheal intubation is an aspect of clinical practice that requires knowledge and skill if the procedure is to be carried out in a timely and safe manner.
- **Option C:** The defibrillator pads are accurately labeled; nevertheless, the responsibility of placing them should be done by the RN or physician because of the potential for skin damage and electrical arcing.
- **Option D:** The use of the bag valve mask demands practice, and normally, a respiratory therapist will implement this measure. If bag-valve-mask ventilation is used for a prolonged period of time or if improperly performed, air may be introduced into the stomach. If this occurs and gastric distention is noted, a nasogastric tube should be inserted to evacuate the accumulated air in the stomach.

5. A nurse is caring for a 46-year-old male patient with Chronic Lymphocytic Leukemia who, after several days of admission, exhibits new-onset disorientation and complains of persistent headaches. What should the nurse prioritize as an initial action?

- A. Notify the primary healthcare provider immediately.
- B. Accurately document the new symptoms in the patient's medical records.
- C. Initiate oxygen therapy in anticipation of physician's orders.
- D. Elevate the side rails to ensure patient safety.

Correct Answer: D. Elevate the side rails to ensure patient safety.

A patient who is disoriented is at risk of falling out of bed. The initial action of the nurse should be raising the side rails to ensure patients' safety.

- **Option A:** Calling the physician would be unnecessary. These findings can be reported after ensuring the patient's safety first.
- **Option B:** After notifying the physician, the nurse should document these findings.
- **Option C:** Oxygen treatment would be needed as ordered by the physician.

6. Gail is scheduled for a cholecystectomy. After completion of preoperative teaching, Gail states, "If I lie still and avoid turning after the operation, I'll avoid pain. Do you think this is a good idea?" What is the best response?

- A. "You'll need to turn from side to side every 2 hours."
- B. "It's always a good idea to rest quietly after surgery."

C. "The doctor will probably order you to lie flat for 24 hours."

D. "Why don't you decide about activity after you return from the recovery room?"

Correct Answer: A. "You'll need to turn from side to side every 2 hours."

To prevent venous stasis and improve muscle tone, circulation, and respiratory function, encourage her to move after surgery. Insufflation of the abdominal cavity with carbon dioxide during laparoscopic surgery increases abdominal pressure, which may cause stasis of the blood flow in inferior vena cava and common iliac veins. Moreover, the reverse Trendelenburg position, in which laparoscopic cholecystectomy is performed, decreases venous return.

- **Option B:** The patient may need to walk around the same day of surgery, or the day after. The movement will help prevent blood clots. She may also be given exercises to do in bed. The patient should not get out of bed on her own until the healthcare provider says you can. She should talk to healthcare providers before she gets up the first time. They may need to help the patient stand up safely.
- **Option C:** The patient should take deep breaths and cough 10 times each hour. This will decrease the risk of a lung infection. She should take a deep breath and hold it for as long as she can. Let the air out and then cough strongly. Deep breaths help open the airway. The patient may be given an incentive spirometer to help take deep breaths.
- **Option D:** The patient may be taken to a recovery room, where she will stay until she is fully awake. Healthcare providers will watch closely for problems. She should not attempt to get out of bed until the healthcare provider says it is okay. When healthcare providers see that she is okay, she will be taken back to a hospital room.

7. A nurse is developing a care plan for a client with an injury to the frontal lobe of the brain. Which nursing interventions should be included as part of the care plan? Select all that apply.

- A. Keep instructions simple and brief because the client will have difficulty concentrating.
- B. Speak clearly and slowly because the client will have difficulty hearing.
- C. Assist with bathing because the client will have vision disturbances.
- D. Orient the client to person, place, and time as needed because of memory problems.
- E. Assess vital signs frequently because vital bodily functions are affected.

Correct Answer: A & D.

Damage to the frontal lobe affects personality, memory, reasoning, concentration, and motor control of speech. The cortex of the frontal lobe is the largest of the four and in many ways the lobe which participates most in making us human.

- **Option A:** The prefrontal cortex is known to be the higher-order association center of the brain as it is responsible for decision making, reasoning, personality expression, maintaining social appropriateness, and other complex cognitive behaviors.
- **Option B:** Damage to the temporal lobe, not the frontal lobe, causes hearing and speech problems. Another study divides the temporal area into 4 major subregions: a) dorsal, mostly language and auditory/somatosensory networks b) ventromedial, mostly visual network c) medial, connected to paralimbic structures and d) anterolateral, associated with a default-semantic network. These areas have many important functions such as processing of language, social cues, and emotions, facial recognition (auditory and visual aspects), emotional processing of different

stimuli (auditory, olfactory, and visual), and theory of mind.

- **Option C:** Damage to the occipital lobe causes vision disturbances. The occipital lobe is the visual processing area of the brain. It is associated with visuospatial processing, distance and depth perception, color determination, object and face recognition, and memory formation.
- **Option D:** Research has proven that the dominant (left) superior frontal gyrus is a key component in the neural network of working memory as well as spatial processing. Research has proven that the dominant (left) superior frontal gyrus is a key component in the neural network of working memory as well as spatial processing.
- **Option E:** Damage to the brain stem affects vital functions. The brainstem is the structure that connects the cerebrum of the brain to the spinal cord and cerebellum. It is composed of four sections in descending order: the diencephalon, midbrain, pons, and medulla oblongata. It is responsible for many vital functions of life, such as breathing, consciousness, blood pressure, heart rate, and sleep.

8. Which of the following laboratory values would be the most important to monitor for a patient with pancreatic cancer?

- A. Serum glucose
- B. Radioimmunoassay (RIA)
- C. Creatine phosphokinase (CPK)
- D. Carcinoembryonic antigen (CEA)

Correct Answer: A. Serum glucose

In pancreatitis, hypersecretion of the insulin from a tumor may affect the islets of Langerhans, resulting in hyperinsulinemia, a complication of pancreatic cancer. Pancreatitis damages the cells that produce insulin and glucagon, which are the hormones that control the amount of glucose in the blood. This can lead to an increase in blood glucose levels.

- **Option B:** RIA should also be monitored to measure the effects of therapy, but hypoglycemia may be life-threatening. Determination of serum pancreatic enzymes remains the gold standard for the diagnosis of acute pancreatitis. More expensive and cumbersome methods such as RIA or ELISA for pancreatic elastase are useful only in special clinical circumstances.
- **Option C:** Creatine phosphokinase is an enzyme that reflects normal tissue catabolism. Elevated serum levels indicate trauma to cells with high CPK content. CPK and CPK-isoenzymes are used to detect myocardial infarction. Serum CPK is elevated in most alcoholics including patients with delirium tremens (6, 9) or acute pancreatitis, a finding which possibly reflects a certain degree of myopathy known to occur in patients with acute alcohol intoxication as well as with chronic alcoholism
- **Option D:** Carcinoembryonic antigen (CEA) is one of the most widely used tumor markers and is increased in 30%–60% of patients with pancreatic cancer. Although carbohydrate antigen 19-9 (CA19-9) is the most important serum biomarker in pancreatic cancer, the diagnostic and prognostic value of CEA is gradually being recognized.

9. When assessing a client for obstructive sleep apnea (OSA), the nurse understands the most common symptom is:

- A. Headache
- B. Early awakening
- C. Impaired reasoning
- D. Excessive daytime sleepiness

Correct Answer: D. Excessive daytime sleepiness

Excessive daytime sleepiness is the most common complaint of people with OSA. Persons with severe OSA may report taking daytime naps and experiencing a disruption in their daily activities because of sleepiness. OSA is associated with daytime somnolence and affects millions of people. The apneic episodes may occur hundreds of times each night and are associated with alterations in heart rate, drop in oxygen saturation, and loud breathing sounds.

- **Option A:** Obstructive sleep apnea (OSA) is characterized by episodes of the complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep. This disturbance results in fragmented, nonrestorative sleep. Other symptoms include loud, disruptive snoring, witnessed apneas during sleep, and excessive daytime sleepiness.
- **Option B:** They may also complain of waking to gasp for breath or choking, sleep maintenance insomnia, night sweats, nighttime reflux, and nocturia in the absence of excessive nighttime liquid intake.
- **Option C:** The typical adult obstructive sleep apnea patient is an overweight or obese middle-aged male or postmenopausal female with excessive daytime sleepiness and loud nightly snoring.

10. Nurse Aleli is planning to perform percussion and postural drainage. Which is an important aspect of planning the clients' care?

- A. Percussion and postural drainage should be done before lunch.
- B. The order should be coughing, percussion, positioning, and then suctioning.
- C. A good time to perform percussion and postural drainage is in the morning after breakfast when the client is well rested.
- D. Percussion and postural drainage should always be preceded by three minutes of 100% oxygen.

Correct Answer: A. Percussion and postural drainage should be done before lunch.

Postural drainage results in expectoration of large amounts of mucus. Clients sometimes ingest part of the secretions. The secretions may also produce an unpleasant taste in the oral cavity, which could result in nausea/vomiting. This procedure should be done on an empty stomach to decrease client discomfort.

- **Option B:** PD & P involves a combination of techniques, including multiple positions to drain the lungs, percussion, vibration, deep breathing and coughing. When the person with CF is in one of the positions, the caregiver can clap on the person's chest wall. This is usually done for three to five minutes and is sometimes followed by vibration over the same area for approximately 15 seconds (or during five exhalations). The person is then encouraged to cough or huff forcefully to get the mucus out of the lungs.
- **Option C:** Generally, each treatment session can last for 20 to 40 minutes. PD & P is best done before meals or one and a half to two hours after eating, to decrease the chance of vomiting. Early morning and bedtimes are usually recommended. The length of PD & P and the number of times of day it is done may need to be increased if the person is more congested or getting sick.

- **Option D:** When the person with CF is in one of the positions, the caregiver can clap on the person's chest wall. This is usually done for three to five minutes and is sometimes followed by vibration over the same area for approximately 15 seconds (or during five exhalations). The person is then encouraged to cough or huff forcefully to get the mucus out of the lungs.

11. Nurse Christine is teaching an adolescent health class about the dangers of inhalant abuse; the nurse warns about the possibility of:

- A. Contracting an infectious disease, such as hepatitis or AIDS.
- B. Recurrent flashback events.
- C. Psychological dependence after initial use.
- D. Sudden death from cardiac or respiratory depression

Correct Answer: D. Sudden death from cardiac or respiratory depression.

Inhalants are CNS depressants; if taken in an excess amount, they can cause cardiac and respiratory depressions. It is impossible to control the inhalant dosage; therefore, death can occur. Prognosis depends upon follow up and motivational and cognitive behavior therapy. Support like Alcoholics-Anonymous groups play an important role in prognosis. Substance use leads to a number of problems among youth, including accidents, death, health effects, crime, unplanned pregnancy, and lower achievement.

- **Option A:** Substance use and/or substance use disorders (SUDs) are associated with many negative consequences among youth, including accidents, death, health effects, crime, unplanned pregnancy, and lower achievement. Substance use contributes to accidents, death, and a variety of hazardous behaviors. Sexual behaviors are increased during adolescent substance use.
- **Option B:** Posttraumatic stress disorder (PTSD) is a syndrome that results from exposure to real or threatened death, serious injury, or sexual assault. The symptoms of PTSD include persistently re-experiencing the traumatic event, intrusive thoughts, nightmares, flashbacks, dissociation(detachment from oneself or reality), and intense negative emotional (sadness, guilt) and physiological reaction on being exposed to the traumatic reminder.
- **Option C:** As with most behavioral and psychiatric disorders, the interplay between genetic risk, temperamental traits, and the environment may predispose to early use of substances of abuse. Once exposed to substances, brain reward systems reinforce substance use, resulting in repeated use and lower ability to control substance use.

12. A client is admitted to the birthing suite in early active labor. The priority nursing intervention on the admission of this client would be:

- A. Auscultating the fetal heart
- B. Taking an obstetric history
- C. Asking the client when she last ate
- D. Ascertaining whether the membranes were ruptured

Correct Answer: A. Auscultating the fetal heart.

Determining the fetal well-being supersedes all other measures. If the FHR is absent or persistently decelerating, immediate intervention is required. During labor, cardiotocographic monitoring is often

employed to monitor uterine contractions and fetal heart rate over time. Clinicians monitor fetal heart tracings to evaluate for any signs of fetal distress that would warrant intervention as well as the adequacy or inadequacy of contractions.

- **Option B:** When women first present to the labor and delivery unit, vital signs, including temperature, heart rate, oxygen saturation, respiratory rate, and blood pressure, should be obtained and reviewed for any abnormalities. The patient should be placed on continuous cardiotocographic monitoring to ensure fetal wellbeing. The patient's prenatal record, including obstetric history, surgical history, medical history, laboratory, and imaging data, should undergo review. Finally, a history of present illness, review of systems, and physical exam, including a sterile speculum exam, will need to take place.
- **Option C:** Labor is a natural process, but it can suffer interruption by complicating factors, which at times necessitate clinical intervention. The management of low-risk labor is a delicate balance between allowing the natural process to proceed while limiting any potential complications.
- **Option D:** Cervical exams are usually performed every 2 to 3 hours unless concerns arise and warrant more frequent exams. Frequent cervical exams are associated with a higher risk of infection, especially if a rupture of membranes has occurred. Women should be allowed to ambulate freely and change positions if desired.

13. A nurse is providing instructions to a mother who has been diagnosed with mastitis. Which of the following statements, if made by the mother, indicates a need for further teaching?

- A. "I need to take antibiotics, and I should begin to feel better in 24-48 hours."
- B. "I can use analgesics to assist in alleviating some of the discomfort."
- C. "I need to wear a supportive bra to relieve the discomfort."
- D. "I need to stop breastfeeding until this condition resolves."

Correct Answer: D. "I need to stop breastfeeding until this condition resolves."

In most cases, the mother can continue to breastfeed with both breasts. If the affected breast is too sore, the mother can pump the breast gently. Regular emptying of the breast is important to prevent abscess formation. Continuing to fully empty the breasts has shown to decrease the duration of symptoms in patients treated both with and without antibiotics. Patients should be encouraged to continue to breastfeed, pump, or hand express. If the patient stops draining the milk, further stasis occurs, and the infection will progress.

- **Option A:** Antibiotic therapy assists in resolving the mastitis within 24-48 hours. If the symptoms of lactational mastitis persist beyond 12 to 24 hours, antibiotics should be administered. Because *S. aureus* is the most common cause, antibiotic therapy should be tailored accordingly. In the setting of mild infection without MRSA risk factors, outpatient treatment can be initiated with dicloxacillin or cephalexin.
- **Option B:** The doctor may recommend an over-the-counter pain reliever, such as acetaminophen (Tylenol, others) or ibuprofen (Advil, Motrin IB, others). Lactational mastitis occurs due to a combination of inadequate drainage of milk, and the introduction of bacteria. Common scenarios leading to poor milk drainage include infrequent feeding, an oversupply of milk, rapid weaning, illness in mother or child, and a clogged duct. The inadequately drained milk stagnates, and organisms grow, leading to infection. It is thought that bacteria (usually from the infant's mouth, or mother's skin) gain entry to the milk via cracks in the nipple.

- **Option C:** Additional supportive measures include ice packs, breast supports, and analgesics. Non-steroidal anti-inflammatory drugs (NSAIDs) can be used for pain control. Heat applied to the breast just before emptying can help increase milk letdown and facilitate emptying. Cold packs applied to the breast after emptying can help reduce edema and pain.

14. An 11-year-old girl with celiac disease was discharged from the hospital. An appropriate teaching was carried out by the nurse if the parents are aware of avoiding which of the following?

- A. Chicken
- B. Wheat
- C. Milk
- D. Rice

Correct Answer: B. Wheat

Children with celiac disease cannot tolerate or digest gluten. Therefore, because of its gluten content, wheat and wheat-containing products must be avoided. Celiac disease is an autoimmune condition that causes severe damage to the lining of the small intestine. Gluten — a protein found in wheat, barley, and rye — triggers its symptoms.

- **Option A:** All animal proteins, fruits, vegetables, nuts, seeds, legumes, herbs, and spices are naturally gluten-free. There are many naturally gluten-free grains and specialty products, too.
- **Option C:** All types of plain cow's milk are naturally free of gluten. However, some dairy products are not gluten-free. Once flavorings or other ingredients have been added to milk it may no longer be gluten-free, so it's important to read the label to see if the product contains gluten or not.
- **Option D:** Rice is generally gluten-free. This includes all varieties, such as white or brown, long or short grain, and fragranced or not fragranced. There are thousands of types of rice, but only about 100 kinds are sold around the world.

15. A male client with a nagging cough makes an appointment to see the physician after reading that this symptom is one of the seven warning signs of cancer. What is another warning sign of cancer?

- A. Rash
- B. Indigestion
- C. Chronic ache or pain
- D. Persistent nausea

Correct Answer: B. Indigestion

- **Option B:** Indigestion, or difficulty swallowing, is one of the seven warning signs of cancer. The other six are a change in bowel or bladder habits, a sore that does not heal, unusual bleeding or discharge, a thickening or lump in the breast or elsewhere, an obvious change in a wart or mole, and a nagging cough or hoarseness.
- **Options A and C:** Rash and chronic ache or pain seldom indicate cancer.

- **Option D:** Persistent nausea may signal stomach cancer but isn't one of the seven major warning signs.

16. The nurse is discussing meal planning with the mother of a 2-year-old toddler. Which of the following statements, if made by the mother, would require a need for further instruction?

- A. "It is okay to give my child white grape juice for breakfast."
- B. "My child can have a grilled cheese sandwich for lunch."
- C. "We are going on a camping trip this weekend, and I have bought hot dogs to grill for his lunch."
- D. "For a snack, my child can have ice cream."

Correct Answer: C. "We are going on a camping trip this weekend, and I have bought hot dogs to grill for his lunch."

Remember the ABCs (airway, breathing, circulation) when answering this question. A hotdog is the size and shape of the child's trachea and poses a risk of aspiration. It is important to avoid foods that may cause choking like slippery foods such as whole grapes; large pieces of meat, poultry, and hot dogs; candy, and cough drops.

- **Option A:** A white grape juice does not pose a risk for aspiration. The toddler years are full of exploring and discovery. The best thing you can do is offer your toddler a variety of foods from each food group with different tastes, textures, and colors.
- **Option B:** A grilled cheese sandwich would not aspirate a toddler. Always cut up foods into small pieces and watch your child while he or she is eating. Offer new foods one at a time, and remember that children may need to try a new food 10 or more times before they accept it.
- **Option D:** Ice cream does not pose a risk of aspiration for a child. Make food simple, plain, and recognizable. Some kids don't like food that is mixed (like a casserole) or food that is touching. Plan regular meals and snacks and give kids enough time to eat.

17. During a hematology clinical rotation, a nursing student is assigned to care for a patient diagnosed with Chronic Lymphocytic Leukemia (CLL). The complexity of the case leads to a detailed exploration of the lymphocytic lineage, particularly B cells, which are implicated in this disease. The medical team discusses the pathological proliferation of B cells and the ensuing immunodeficiency that characterizes CLL. The nursing instructor later expounds on the origin, maturation, and function of B cells within the immune system during a supplementary immunology session. Given the clinical scenario and the theoretical elucidation, which of the following statements is TRUE about B cells?

- A. are lymphocytes
- B. become mature in the thymus
- C. are responsible for cell-mediated immunity
- D. are produced in the adult spleen

Correct Answer: A. are lymphocytes

B cells are indeed a type of white blood cell known as lymphocytes. They play a central role in the humoral immunity component of the adaptive immune system by producing antibodies.

- **Option B:** B cells mature in the bone marrow, whereas T cells mature in the thymus. This distinct maturation process is crucial for the functional divergence between B and T cells within the immune response.
- **Option C:** B cells are primarily involved in humoral immunity, which is antibody-driven. On the other hand, T cells are central to cell-mediated immunity, which is focused on the direct destruction of infected or malignant cells.
- **Option D:** B cells originate and mature in the bone marrow. The spleen acts as a secondary lymphoid organ where B cells can encounter antigens and become activated, but it is not the primary site of B cell production or maturation.

18. A newly admitted client diagnosed with obsessive-compulsive disorder (OCD) washes hands continually. This behavior prevents unit activity attendance. Which nursing statement best addresses this situation?

- A. "Everyone diagnosed with OCD needs to control their ritualistic behaviors."
- B. "It is important for you to discontinue these ritualistic behaviors."
- C. "Why are you asking for help if you won't participate in unit therapy?"
- D. "Let's figure out a way for you to attend unit activities and still wash your hands."

Correct Answer: D. "Let's figure out a way for you to attend unit activities and still wash your hands."

The most appropriate statement by the nurse is, "Let's figure out a way for you to attend unit activities and still wash your hands." This statement reflects the therapeutic communication technique of formulating a plan of action. The nurse attempts to work with the client to develop a plan without damaging the therapeutic relationship or increasing the client's anxiety.

- **Option A:** Disapproving or denouncing the client's behavior is nontherapeutic. Disapproval implies that the nurse has a right to pass judgement on the client's actions. It further implies that the client is expected to please the nurse.
- **Option B:** Advising refers to telling the client what to do; giving an opinion or making decisions for the client is inappropriate. It implies that the client cannot handle life decisions and only the nurse knows what is best for the client.
- **Option C:** Requesting an explanation or asking the client to provide reasons for thoughts, feelings, behaviors or events is nontherapeutic. There is a difference between asking the client to describe what is occurring or has taken place and asking him to explain why. Usually, a "why" question is intimidating.

19. The nurse is performing an admission assessment on a client with a diagnosis of a detached retina. Which of the following is associated with this eye disorder?

- A. Pain in the affected eye.

- B. Total loss of vision.
- C. A sense of a curtain falling across the field of vision.
- D. A yellow discoloration of the sclera.

Correct Answer: C. A sense of a curtain falling across the field of vision

A characteristic manifestation of retinal detachment described by the client is the feeling that a shadow or curtain is falling across the field of vision. They may also have significant photopsia (flashes of light) in their vision. The patient often presents with slowly progressive or fixed visual field loss, typically starting in the periphery and then moving centrally.

- **Option A:** No pain is associated with detachment of the retina. Other essential aspects of the history include the timing of the onset of the symptoms, if the patient has the same visual loss symptoms in the fellow eye, whether central visual acuity is affected, prior surgery, or previous trauma.
- **Option B:** Total loss of vision is not a characteristic of this disorder. A retinal detachment is an ophthalmic emergency and even more so if visual acuity is still normal. Essential aspects of the physical exam include getting the patient's best-corrected visual acuity of each eye, checking the pupillary reaction of each eye, and ensuring that there is no relative afferent pupillary defect and confrontational visual field testing.
- **Option D:** If the entire sclera turns yellow, it is often a sign of jaundice. Jaundice is caused by a buildup of old red blood cells, called bilirubin. These cells are normally filtered out by the liver and turned into bile. That bile is stored in the gallbladder and eventually excreted by the body. But when the liver, gallbladder, or pancreas are not working properly, jaundice can develop.

20. The nurse is evaluating the discharge teaching for a client who has an ileal conduit. Which of the following statements indicates that the client has correctly understood the teaching? Select all that apply.

- A. "If I limit my fluid intake I will not have to empty my ostomy pouch as often."
- B. "I can place an aspirin tablet in my pouch to decrease odor."
- C. "I can usually keep my ostomy pouch on for 3 to 7 days before changing it."
- D. "I must use a skin barrier to protect my skin from urine."
- E. "I should empty my ostomy pouch of urine when it is full."

Correct Answer: C & D

The client with an ileal conduit must learn self-care activities related to the care of the stoma and ostomy appliances. The client should be taught to increase fluid intake to about 3,000 ml per day and should not limit intake. The ostomy appliance should be changed approximately every 3 to 7 days and whenever a leak develops. A skin barrier is essential to protecting the skin from the irritation of the urine.

- **Option A:** Adequate fluid intake helps to flush mucus from the ileal conduit. Monitor intake and output (I&O;) carefully, measure liquid stool. Weigh regularly. Provides direct indicators of fluid balance. Greatest fluid losses occur with an ileostomy, but they generally do not exceed 500–800 mL/day.
- **Option B:** An aspirin should not be used as a method of odor control because it can be an irritant to the stoma and lead to ulceration. Apply corticosteroid aerosol spray and prescribed antifungal

powder as indicated. Assists in healing if peristomal irritation persists and/or fungal infection develops. Note: These products can have potent side effects and should be used sparingly.

- **Option C:** Empty, irrigate, and cleanse ostomy pouch on a routine basis, using appropriate equipment. Frequent pouch changes are irritating to the skin and should be avoided. Emptying and rinsing the pouch with the proper solution not only removes bacteria and odor-causing stool and flatus but also deodorizes the pouch.
- **Option D:** Apply appropriate skin barrier: hydrocolloid wafer, karaya gum, extended-wear skin barrier, or similar products. Protects skin from pouch adhesive, enhances adhesiveness of pouch, and facilitates removal of pouch when necessary.
- **Option E:** The ostomy pouch should be emptied when it is one-third to one-half full to prevent the weight from pulling the appliance away from the skin. Use a transparent, odor-proof drainable pouch. A transparent appliance during the first 4–6 wk allows easy observation of stoma without the necessity of removing pouch/irritating skin.

21. The client is admitted to the hospital with BPH, and a transurethral resection of the prostate is performed. Four hours after surgery the nurse takes the client's VS and empties the urinary drainage bag. Which of the following assessment findings would indicate the need to notify the physician?

- A. Red bloody urine
- B. Urinary output of 200 ml greater than intake
- C. Blood pressure of 100/50 and pulse 130.
- D. Pain related to bladder spasms.

Correct Answer: C. Blood pressure of 100/50 and pulse 130.

A rapid pulse with low blood pressure is a potential sign of excessive blood loss. The physician should be notified. Class III of hemorrhagic shock includes a volume loss from 30% to 40% of total blood volume, from 1500 mL to 2000 mL. A significant drop in blood pressure and changes in mental status occurs. Heart rate and respiratory rate are significantly elevated (more than 120 BPM). Urine output declines. Capillary refill is delayed.

- **Option A:** Frank bleeding (arterial or venous) may occur during the first few days after surgery. In the first two days after surgery, your urine might have blood or clumps of blood in it – particularly following TURP. It is important to drink a lot of water in the first few days in order to rinse the bladder and speed up the healing process. Mild bleeding may occur later too, for example when scabs break away and are flushed out.
- **Option B:** Some hematuria is usual for several days after surgery. Urinary output of 200 ml of greater than intake is adequate. It can take a few months for everything to return to normal. During this time you may have urinary problems, such as an urge to urinate or temporary loss of bladder control. Your organs need some time to adjust to the changes in the operated area and to start working normally again, so it's important to be patient.
- **Options D:** Bladder spasms are expected to occur after surgery. To prevent the healing wound from coming into contact with urine, a urinary catheter is needed for a few days after surgery. A catheter is a thin plastic tube that drains the bladder through the urethra. The tube is held in place by a small water-filled balloon in the bladder. This can lead to painful bladder spasms, mainly in the first few hours and days. Antibiotics are sometimes used to prevent infections.

22. The nurse is caring for the client with increased intracranial pressure. The nurse would note which of the following trends in vital signs if the ICP is rising?

- A. Increasing temperature, increasing pulse, increasing respirations, decreasing blood pressure.
- B. Increasing temperature, decreasing pulse, decreasing respirations, increasing blood pressure.
- C. Decreasing temperature, decreasing pulse, increasing respirations, decreasing blood pressure.
- D. Decreasing temperature, increasing pulse, decreasing respirations, increasing blood pressure.

Correct Answer: B. Increasing temperature, decreasing pulse, decreasing respirations, increasing blood pressure.

A change in vital signs may be a late sign of increased intracranial pressure. Trends include increasing temperature and blood pressure and decreasing pulse and respirations. Respiratory irregularities also may arise. Cushing triad is a clinical syndrome consisting of hypertension, bradycardia and irregular respiration and is a sign of impending brain herniation. This occurs when the ICP is too high the elevation of blood pressure is a reflex mechanism to maintain CPP.

- **Option A:** High blood pressure causes reflex bradycardia and brain stem compromise affecting respiration. Ultimately the contents of the cranium are displaced downwards due to the high ICP, causing a phenomenon known as herniation which can be potentially fatal.
- **Option C:** Nursing care must pay close attention to changes in neurologic status, any change in vitals such as an increasingly erratic heart rate, development of bradycardia, accurate and equal intake and output when having diuresis, and maintenance of proper blood pressure.
- **Option D:** Clinical suspicion for intracranial hypertension should be raised if a patient presents with the following signs and symptoms: headaches, vomiting, and altered mental status varying from drowsiness to coma.

23. After having transurethral resection of the prostate (TURP), Mr. Lim returns to the unit with a three-way indwelling urinary catheter and continuous closed bladder irrigation. Which finding suggests that the client's catheter is occluded?

- A. The urine in the drainage bag appears red to pink.
- B. The client reports bladder spasms and the urge to void.
- C. The normal saline irrigant is infusing at a rate of 50 drops/minute.
- D. About 1,000 ml of irrigant have been instilled; 1,200 ml of drainage have been returned.

Correct Answer: B. The client reports bladder spasms and the urge to void.

Reports of bladder spasms and the urge to void suggest that a blood clot may be occluding the catheter. Bladder blood clot formation is a common emergency in urological practice. Severe hematuria can lead to blood clot formation in the bladder cavity and consequent urinary retention. Patients may develop pain if the clots cannot be evacuated in a timely manner.

- **Option A:** After TURP, urine normally appears red to pink. Within the first few weeks after surgery, the scab where prostate tissue has been removed may sometimes loosen and cause some bleeding. By resting when this happens and drinking plenty of fluid, the bleeding will usually stop.

- **Option C:** The normal saline irrigant usually is infused at a rate of 40 to 60 drops/minute or according to facility protocol. Manual bladder washout using a Foley catheter and syringe is the most common method of removing such blood clots. However, this method fails in some patients.
- **Option D:** The amount of retained fluid (1,200 ml) should correspond to the amount of instilled fluid, plus the client's urine output (1,000 ml + 200 ml), which reflects catheter patency. Immediately after the operation, the catheter is connected to irrigation fluids to wash blood and blood clots out of the bladder. As the urine clears the irrigation will be slowed and eventually stopped. The catheter will be removed when the urine is clear and this will usually occur on the second morning after the surgery.

24. You are preparing to change the linens on the bed of a client who has a draining sacral wound infected by MRSA. Which PPE items will you plan to use. Select all that apply

- A. N95 respirator
- B. Surgical Mask
- C. Gloves
- D. Goggles
- E. Gown

Correct Answer: C & E

A gown and gloves should be used when coming in contact with linens that may be decontaminated by the client's wound secretions.

- **Options A, B, and D:** The other items are not necessary because transmission by splashes, droplets, or airborne means will not occur when the bed is changed.

25. The nurse prepares discharge instructions for a male client following cryosurgery for the treatment of a malignant skin lesion. Which of the following should the nurse include in the instruction?

- A. Avoid showering for 7 to 10 days
- B. Apply ice to the site to prevent discomfort
- C. Apply alcohol-soaked dressing twice a day
- D. Clean the site with hydrogen peroxide to prevent infection

Correct Answer: D. Clean the site with hydrogen peroxide to prevent infection

Cryosurgery involves the local application of liquid nitrogen to isolated lesions and causes cell death and tissue destruction. The nurse informs the client that swelling and increased tenderness of the treated area can occur when the skin thaws. Tissue freezing is followed by hemorrhagic blister formation in 1 to 2 days. The nurse instructs the client to clean the treatment site with hydrogen peroxide to prevent secondary infection. A topical antibiotic also may be prescribed.

- **Option A:** The client does not need to avoid showering.
- **Option B:** Application of a warm, damp washcloth intermittently to the site will provide relief from any discomfort.

- **Option C:** Alcohol-soaked dressings will cause irritation.

26. The nurse is caring for the client with a 5-year-old diagnosis of plumbism. Which information in the health history is most likely related to the development of plumbism?

- A. The client has traveled out of the country in the last 6 months.
- B. The client's parents are skilled stained-glass artists.
- C. The client lives in a house built in one.
- D. The client has several brothers and sisters.

Correct Answer: B. The client's parents are skilled stained-glass artists.

Plumbism is lead poisoning. One factor associated with the consumption of lead is eating from pottery made in Central America or Mexico that is unfired. The child lives in a house built after 1976 (this is when lead was taken out of paint), and the parents make stained glass as a hobby. Stained glass is put together with lead, which can drop on the work area, where the child can consume the lead beads.

- **Option A:** Traveling out of the country does not increase the risk of plumbism. Because lead is not biodegradable, it demonstrates remarkable environmental persistence. Despite the fact that the amount of lead in paint intended for use in or on residential buildings, furniture, or children's toys in the United States has been restricted to 0.06% since 1978 and was further reduced to 0.009% in 2008, lead-based paint continues to be a major source of lead exposure in young children.
- **Option C:** The house was built after the lead was removed with the paint. Several million young children in the United States live in older homes in which lead-based paint was previously used, and as this old paint ages, it peels, flakes, and crumbles into dust that settles on the interior surfaces of homes and in the soil surrounding the exterior of the home. The dust and soil containing these tiny paint particles inevitably make their way into children's mouths as a result of normal childhood exploratory hand-to-mouth behavior.
- **Option D:** Having several siblings is unrelated to the stem. A variety of occupations and hobbies may expose adults to lead, and working parents may inadvertently bring lead home where they can expose their children second-hand. Some of the highest risk occupations and hobbies include metal welding, battery manufacturing, and recycling, shipbuilding and shipbreaking, firing range use or instruction as well as bullet salvaging, lead smelting and refining, painting and construction work, and pipefitting and plumbing.

27. A mother calls the clinic to report that her son has recently started medication to treat attention-deficit/hyperactivity disorder (ADHD). The mother fears her son is experiencing side effects of the medicine. Which of the following side effects are typically related to medications used for ADHD? Select all that apply.

- A. Poor appetite
- B. Insomnia
- C. Sleepiness
- D. Agitation

E. Decreased attention span

Correct Answer: A, B, D & E

ADHD in children is frequently treated with CNS stimulant medications, which increase focus and improve concentration. Children often experience insomnia, agitation, and decreased appetite. ADHD treatment commonly uses a combination of dextroamphetamine and levoamphetamine, as well as pure dextroamphetamine and lisdexamfetamine.

- **Option A:** Loss of appetite is among the most common side effects of stimulants for ADHD. Across studies, approximately 20% of patients with ADHD who were treated with stimulants reported a loss of appetite. Weight loss is also quite common, as are digestive problems.
- **Option B:** Insomnia or delayed SOL greater than 30 minutes is one of the most common adverse events associated with stimulant medications. This should be distinguished from bedtime resistance, which is when the child refuses to go to bed. Insomnia is a frequent side effect of all stimulant medications, based on parent report or side effects scales completed side effects scales by parents.
- **Option C:** Sleepiness is not a side effect of stimulants. Efron et al. compared twice-daily, immediate-release MPH and dextroamphetamine in 125 ADHD youth in a crossover study. Using the parent-completed, Barkley Side Effect Scale, dextroamphetamine, but not MPH, was associated with higher ratings of severe insomnia relative to baseline.
- **Option D:** The immediate psychological effects of stimulant administration include a heightened sense of well-being, euphoria, excitement, heightened alertness, and increases in motor activity. Stimulants also reduce food intake, reduce sleep time, and may increase socialization activities. Stimulants may also enhance performance of certain types of psychomotor tasks. High doses may result in restlessness and agitation, and excessive doses may produce stereotypic behaviors (repetitive and automatic acts).
- **Option E:** In people with ADHD, stimulants produce a paradoxical calming effect. This results in a reduction in hyperactivity and an improvement in attention span in many patients.

28. 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.

29. The nurse is providing teachings to a client receiving cyclophosphamide (Cytosan). The nurse tells the client to which of the following?

- A. Eat foods rich in potassium.
- B. Increase fluid intake to 2-3 liters per day.
- C. Take the medication with food.
- D. Eat foods rich in purine.

Correct Answer: B. Increase fluid intake to 2-3 liters per day.

Cyclophosphamide can cause hemorrhagic cystitis. Encourage the client to increase their fluid intake to 2- 3 liters per day, unless contraindicated.

- **Option A:** This medication can cause hyperkalemia.
- **Option C:** The medication is taken without food.
- **Option D:** Client must follow a low purine diet to alkalinize the urine and lowers the uric acid level.

30. A nursing instructor asks a nursing student who is preparing to assist with the assessment of a pregnant client to describe the process of quickening. Which of the following statements if made by the student indicates an understanding of this term?

- A. "It is the irregular, painless contractions that occur throughout pregnancy."
- B. "It is the soft blowing sound that can be heard when the uterus is auscultated."
- C. "It is the fetal movement that is felt by the mother."
- D. "It is the thinning of the lower uterine segment."

Correct Answer: C. "It is the fetal movement that is felt by the mother."

Quickening is fetal movement and may occur as early as the 16th and 18th week of gestation, and the mother first notices subtle fetal movements that gradually increase in intensity. A thinning of the lower uterine segment occurs about the 6th week of pregnancy and is called Hegar's sign.

- **Option A:** Braxton Hicks contractions are irregular, painless contractions that may occur throughout the pregnancy.

- **Option B:** Uterine souffle or placental souffle is a soft, blowing sound heard using a stethoscope, usually in the second trimester of pregnancy (13–28 weeks). This sound is heard most clearly in the lower part of the uterus and is synchronous with the pulse of the mother.
- **Option D:** The lower uterine segment, therefore, is defined as the portion of the uterine musculature which must undergo circumferential dilatation during labor, its extent being dependent upon the size of the presenting part and its level in the uterine cavity. The available evidence suggests that brachystasis, with retraction, occurs in this segment just as it does in the upper, and that thinning in the first stage of labor is due not to passive elongation, but rather to active shortening of the cup-shaped lower pole with dilatation as it is pulled up about the presenting part.

31. Amid an ongoing economic recession, a small town has seen a significant uptick in community stress levels, manifesting in increased cases of anxiety and depression among its residents. In response, the local healthcare department has coordinated a community outreach program focused on stress management and coping mechanisms. A group of volunteer nurses have been tasked to lead interactive sessions with the community members. During a breakout session, a perplexed participant named Mary, who recently lost her job and is struggling to support her family, seeks guidance on effectively coping with stress. The nurses prepare to explain different beliefs and methods that can help individuals cope with stressful life events. They developed a questionnaire to gauge the participants' understanding of stress management principles post-session. Which belief, as a method of coping with stressful life events, would the nurses most likely advocate for during the session?

- A. Avoidance of stress is an important goal for living.
- B. Control over one's response to stress is possible.
- C. Most people have no control over their level of stress.
- D. Significant others are important to provide care and concern.
- E. Meditative practices and relaxation techniques can help manage stress responses.
- F. Finding a support group to share and discuss stressful events can be beneficial.

Correct Answer: B. Control over one's response to stress is possible.

This is the correct answer. It empowers individuals to manage their reactions to stressors, encouraging the development of coping mechanisms and resilience. By selecting option B, the nurses aim to instill a sense of self-efficacy and control in Mary and other participants, fostering a proactive approach towards managing their stress in these challenging times.

- **Options A:** This option may promote an unrealistic expectation as stress is a natural part of life, and avoidance might not be possible or healthy.
- **Options C:** This option could foster a sense of helplessness and may discourage individuals from attempting to manage their stress.
- **Options D:** While social support is crucial, it doesn't equip individuals with personal coping skills. Relying solely on others might not be a long-term solution.
- **Option E:** While this is a useful approach, it's more of an actionable strategy rather than a belief about coping with stress.

- **Option F:** Similar to option D, while helpful, it does not promote individual control over one's response to stress.

32. Continuous positive airway pressure (CPAP) can be provided through an oxygen mask to improve oxygenation in hypoxic patients by which of the following methods? A. The mask provides 100% oxygen to the client.

- A. The mask provides 100% oxygen to the client.
- B. The mask provides continuous air that the client can breathe.
- C. The mask pressurizes at the end of expiration to open collapsed alveoli.
- D. The mask provides pressurized oxygen so the client can breathe more easily.

Correct Answer: D. The mask provides pressurized oxygen so the client can breathe more easily.

The mask provides pressurized oxygen continuously through both inspiration and expiration. Continuous positive airway pressure (CPAP) is a type of positive airway pressure that is used to deliver a set pressure to the airways that is maintained throughout the respiratory cycle, during both inspiration and expiration.

- **Option A:** The mask can be set to deliver any amount of oxygen needed. CPAP therapy utilizes machines specifically designed to deliver a flow of constant pressure. Some CPAP machines have other features as well, such as heated humidifiers. Components of a CPAP machine include an interface for delivering CPAP.
- **Option B:** By providing the client with pressurized oxygen, the client has less resistance to overcome in taking his next breath, making it easier to breathe. Continuous positive airway pressure (CPAP) is a type of positive airway pressure, where the air flow is introduced into the airways to maintain a continuous pressure to constantly stent the airways open, in people who are breathing spontaneously.
- **Option C:** Pressurized oxygen delivered at the end of expiration is positive end-expiratory pressure (PEEP), not continuous positive airway pressure. Positive end-expiratory pressure (PEEP) is the pressure in the alveoli above atmospheric pressure at the end of expiration. CPAP is a way of delivering PEEP but also maintains the set pressure throughout the respiratory cycle, during both inspiration and expiration.

33. The scope of Nursing Practice, the established educational requirements for nurses, and the distinction between nursing and medical practice is defined by:

- A. Statutory law
- B. Common law
- C. Civil law
- D. Nurse Practice Acts

Correct Answer: D. Nurse Practice Acts

The NPA is then interpreted into regulations by each state and territorial nursing board with the authority to regulate the practice of nursing care and the power to enforce the laws. Fifty states, the District of Columbia and 4 United States (US) territories, have state boards of nursing (BON) that are

responsible for regulating their individual NPA.

- **Option A:** Statutory Law is the term used to define written laws, usually enacted by a legislative body. Statutory laws vary from regulatory or administrative laws that are passed by executive agencies, and common law, or the law created by prior court decisions.
- **Option B:** Common law results from judicial decisions made in courts when individual legal cases are decided. Examples of common law include informed consent, the patient's right to refuse treatment, negligence, and malpractice.
- **Option C:** Civil laws protect the rights of individuals within our society and provide for fair and equitable treatment when civil wrongs or violations occur (Garner, 2006). The consequences of civil law violations are damages in the form of fines or specific performance of good works such as public service. An example of a civil law violation for a nurse is negligence or malpractice.

34. Nurse Trixie is preparing to perform tracheostomy care. Prior to the beginning of the procedure, the nurse performs which action?

- A. Tells the client to raise two fingers to indicate pain or distress.
- B. Changes twill tape holding the tracheostomy and place.
- C. Cleans the incision site.
- D. Check the tightness of the ties and knot.

Correct Answer: A. Tells the client to raise two fingers to indicate pain or distress.

Prior to starting the procedure, it is important to develop a means of communication by which the client can express pain or discomfort. Tracheostomy is a procedure where an artificial airway is established surgically or percutaneously in the cervical trachea. The term "tracheostomy" has evolved to refer to both the procedure as well as the clinical condition of having a tracheostomy tube. With the increasing number of patients with tracheostomy, safe caring requires knowledge and competencies in dealing with routine care, weaning, decannulation, as well as tracheostomy-related emergencies.

- **Option B:** The twill tape is not changed until after performing tracheostomy care. Remove any sutures or ties attached to the tracheostomy tube and patient. When doing this, the assistant must stabilize the flange at all times to prevent premature removal.
- **Option C:** Cleaning the incision should be done after cleaning the inner cannula. Inspect the stoma for signs of infection, presence of granulation tissue, bleeding, wound breakdown, and adequacy of a tract. Clean the area with moist gauze (with normal saline or hydrogen peroxide) followed by dry gauze while ensuring no foreign body enters the airway. Stay sutures, if present, may be used gently to pull up the trachea to provide exposure.
- **Option D:** Checking the tightness of the ties and knot is done after applying new twill tape. Make sure the trach ties are not too tight and should be able to pass an index finger in between the trach ties and neck.

35. The following are considered steps in the qualitative research process, A. Literature review?

- A. Literature review
- B. Hypothesis

C. Sample

D. Data collection

Correct Answer: B. Hypothesis

A hypothesis is the tool of quantitative studies and is only found in such studies. A hypothesis states the predictions about what the research will find. It is a tentative answer to a research question that has not yet been tested. A hypothesis is not just a guess — it should be based on existing theories and knowledge. It also has to be testable, which means the researcher can support or refute it through scientific research methods (such as experiments, observations, and statistical analysis of data).

- **Option A:** A literature review is a comprehensive summary of previous research on a topic. The literature review surveys scholarly articles, books, and other sources relevant to a particular area of research. The review should enumerate, describe, summarize, objectively evaluate and clarify this previous research.
- **Option C:** In research terms, a sample is a group of people, objects, or items that are taken from a larger population for measurement. The sample should be representative of the population to ensure that we can generalize the findings from the research sample to the population as a whole.
- **Option D:** This step revolves around obtaining the information that the researcher will need to solve the issue or problem identified. Data collection involves a field force or staff that operates either in the field, as in the case of personal interviewing (in-home, mall intercept, or computer-assisted personal interviewing), from an office by telephone (telephone or computer-assisted telephone interviewing), or through the mail (traditional mail and mail panel surveys with recruited households).