

Kevin's Review - 35 NCLEX Practice Questions

1. A nurse is caring for a client with a hiatal hernia. The client complains of abdominal and sternal pain after eating. The pain makes it difficult for the client to sleep. Which instructions should the nurse recommend when teaching this client? Select all that apply.

- A. Avoid constrictive clothing.
- B. Lie down for 30 minutes after eating.
- C. Decrease the intake of caffeine and spicy foods.
- D. Eat three meals per day.
- E. Sleep with the upper body elevated.
- F. Maintain a normal body weight.

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

A hiatal hernia occurs when a portion of the stomach pushes through the diaphragm. A hiatal hernia may cause abdominal and sternal pain after eating. The discomfort is associated with reflux of gastric contents.

- **Option A:** To reduce gastric reflux, the nurse should instruct the client to avoid constrictive clothing. Instruct the client to avoid bending over, coughing, straining at defecations, and other activities that increase reflux.
- **Option B:** To reduce gastric reflux, the nurse should instruct the client to remain upright for 2 hours after eating. Instruct to remain in an upright position at least 2 hours after meals; avoiding eating 3 hours before bedtime. This helps control reflux and causes less irritation from reflux action into the esophagus.
- **Option C:** To reduce gastric reflux, the nurse should instruct the client to avoid caffeine and spicy foods. Avoid foods and liquids, such as coffee and alcohol, that stimulate the secretion of stomach acids. Instruct the client to avoid highly seasoned food, acidic juices, alcoholic drinks, bedtime snacks, and foods high in fat.
- **Option D:** To reduce gastric reflux, the nurse should instruct the client to eat small, frequent meals. Encourage small frequent meals of high calories and high protein foods. Small and frequent meals are easier to digest.
- **Option E:** To reduce gastric reflux, the nurse should instruct the client to sleep with the upper body elevated. Elevating the head of the bed six inches to prevent the reflux of stomach contents into the esophagus.
- **Option F:** To reduce gastric reflux, the nurse should instruct the client to lose weight, if obese. Accurately measure the client's weight and height for baseline data. Identify the amount of weight loss needed for optimal body size and frame. This provides a basis for dietary planning.

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

- A. Subcutaneous injection

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

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

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

3. Which of the following blood tests is most indicative of cardiac damage?

- A. Lactate dehydrogenase
- B. Complete blood count (CBC)
- C. Troponin I
- D. Creatine kinase (CK)

Correct Answer: C. Troponin I

Troponin I levels rise rapidly and are detectable within 1 hour of myocardial injury. Troponin I levels aren't detectable in people without cardiac injury. Anything that causes damage to cardiac muscle can cause troponin to spill into the circulation. The most common cause of injury is oxygen supply and demand mismatch, which is seen in acute myocardial infarction.

- **Option A:** Lactate dehydrogenase (LDH) is present in almost all body tissues and not specific to the heart muscle. LDH isoenzymes are useful in diagnosing a cardiac injury. Lactate dehydrogenase is an enzyme that is present in almost all body tissues. Conditions that can cause increased LDH in the blood may include liver disease, anemia, heart attack, bone fractures, muscle trauma, cancers, and infections such as encephalitis, meningitis, encephalitis, and HIV. LDH is also a non-specific marker of tissue turnover, which is a normal metabolic process.
- **Option B:** CBC is obtained to review blood counts, and complete chemistry is obtained to review electrolytes. The complete blood count (CBC) is a group of tests that evaluate the cells that circulate in the blood, including red blood cells (RBCs), white blood cells (WBCs), and platelets (PLTs). The CBC can evaluate your overall health and detect a variety of diseases and conditions, such as infections, anemia and leukemia.
- **Option D:** Because CK levels may rise with a skeletal muscle injury, CK isoenzymes are required to detect cardiac injury. Creatine phosphokinase (CPK), also known by the name creatine kinase (CK) is the enzyme that catalyzes the reaction of creatine and adenosine triphosphate (ATP) to phosphocreatine and adenosine diphosphate (ADP). Many conditions can cause derangement in CPK levels, including rhabdomyolysis, heart disease, kidney disease, or even certain medications.

4. The nurse writes an expected outcome statement in measurable terms. An example is:

- A. Client will have less pain.
- B. Client will be pain-free.
- C. Client will report pain acuity less than 4 on a scale of 0-10.

D. Client will take pain medication every 4 hours around the clock.

Correct Answer: C. Client will report pain acuity less than 4 on a scale of 0-10.

When developing goals for patients, the nurse needs to look at several factors. Think back to the SMART goal criteria. In order to be specific, nurses focus on questions like 'What is the problem? What is the response desired?' To make it measurable, 'How will the client look or behave if the healthy response is achieved? What can I see, hear, measure, observe?'

- **Option A:** One way to help nurses remember how to write goals is to make sure they are SMART. SMART goals are Specific, Measurable, Action-Oriented, Realistic, and Timely. 'Specific' refers to who, what, when, where, and why. 'Measurable' means that you can actually measure and evaluate the progress of that goal in a concrete way. 'Action-oriented' means there are actions that can be taken to reach the goal. 'Realistic' includes the ability to work on the goal, having the resources, attitudes, abilities, and skills to reach this goal, and how realistic it is to come to fruition. Finally, 'Timely' means that there is an end time frame or date at which the goal is going to be evaluated.
- **Option B:** Goal setting occurs in the third phase of the process, planning. Is the goal for nursing care to heal patients? To help them get better? To help them get well? While these are certainly at the forefront of nurses' minds, how do you evaluate these statements? What if the definition of wellness is different from one person to another? This is why nursing goal statements that are patient-centered and measurable are so important.
- **Option D:** Considering action-oriented, 'Are there steps and nursing interventions needed to reach that goal? Is this a realistic outcome for the patient? Have we considered all of the factors involved, including the client's capabilities and limitations? Does the patient have what he or she needs to reach that goal?' And finally, 'Is it timely? When do we expect the goal to be reached?'

5. A client's blood gases reflect diabetic acidosis. The nurse should expect:

- A. Increased pH
- B. Decreased PO₂
- C. Increased PCO₂
- D. Decreased HCO₃

Correct Answer: D. Decreased HCO₃

The bicarbonate-carbonic acid buffer system helps maintain the pH of the body fluids; in metabolic acidosis, there is a decrease in bicarbonate because of an increase of metabolic acids. Acidosis in DKA is due to the overproduction of β -hydroxybutyric acid and acetoacetic acid. At physiological pH, these 2 keto acids dissociate completely, and the excess hydrogen ions bind the bicarbonate, resulting in decreased serum bicarbonate levels.

- **Option A:** Due to carbon dioxide forming carbonic acid in the body when combining with water, the amount of carbon dioxide expired can cause pH to increase or decrease. If bicarbonate is reabsorbed and/or acid is secreted into the urine, the pH becomes more alkaline (increases).
- **Option B:** If a PaO₂ level is lower than 80 mmHg, it means that a person is not getting enough oxygen. A low PaO₂ level can point to an underlying health condition, such as emphysema, chronic obstructive pulmonary disease, or COPD, pulmonary fibrosis.
- **Option C:** PaCO₂ level determines respiratory contribution; a high level means the respiratory system is lowering the pH and vice versa. Due to carbon dioxide forming carbonic acid in the body

when combining with water, the amount of carbon dioxide expired can cause pH to increase or decrease.

6. Which patient should not be prescribed alendronate (Fosamax) for osteoporosis?

- A. A female patient being treated for high blood pressure with an ACE inhibitor.
- B. A patient who is allergic to iodine/shellfish.
- C. A patient on a calorie restricted diet.
- D. A patient on bed rest who must maintain a supine position.

Correct Answer: D. A patient on bed rest who must maintain a supine position.

Alendronate can cause significant gastrointestinal side effects, such as esophageal irritation, so it should not be taken if a patient must stay in supine position. It should be taken upon rising in the morning with 8 ounces of water on an empty stomach to increase absorption. The patient should not eat or drink for 30 minutes after administration and should not lie down.

- **Option A:** Contraindications to alendronate include patients with known hypersensitivity, esophageal abnormalities, delayed esophageal emptying, or achalasia. Severe risk of esophageal morbidity indicates avoidance in patients who are unable to sit or stand upright for at least 30 minutes. Avoid alendronate in patients with hypocalcemia.
- **Option B:** ACE inhibitors are not contraindicated with alendronate and there is no iodine allergy relationship. Baseline concentrations of calcium and bone mineral density should be established before therapy begins, with follow-up testing at 6 to 12 months post-therapy. Calcium at baseline and continual monitoring is needed if hypocalcemia risk is recurring.
- **Option C:** There is no restriction for alendronate on a patient taking a calorie restricted diet. The accumulation of alendronate in the kidney allows for persistent anti-fracture benefits even after cessation of treatment. Current recommendations suggest tailoring the drug holiday length to the individual patients. The average drug-holiday in low-risk patients is 3 to 5 years.

7. How does the nurse appropriately administer Mycostatin suspension in an infant?

- A. Have the infant drink water, and then administer myostatin in a syringe
- B. Place Mycostatin on the nipple of the feeding bottle and have the infant suck it
- C. Mix Mycostatin with formula
- D. Swab Mycostatin on the affected areas

Correct Answer: D. Swab Mycostatin on the affected areas.

Mycostatin suspension is given as a swab. Mycostatin is given for an infection caused by Candida, which is called thrush. These spots come together and form “cheesy” white patches that may cover the tongue, the gums or sides, and roof of the mouth.

- **Option A:** Give the Nystatin by mouth. Give it right after feeding the baby, so the medicine stays in the mouth for a while. It will not hurt the child to swallow the medicine. Be sure the child drinks plenty of formula or other liquids so that he does not get dehydrated.

- **Option B:** Gently open the child's mouth and drop half of the medicine onto the white patches inside the cheek. Turn the child's head to the other side and drop the other half of the medicine on the inside of that cheek. Using a cotton-tipped swab, "paint" the medicine onto the child's tongue and gums.
- **Option C:** Never mix medications with food and formula. For an older child, have him or her swish the medicine in the mouth for 30 seconds, then swallow. Wait 30 minutes before giving the child anything to eat or drink.

8. When assessing a newborn whose mother consumed alcohol during the pregnancy, the nurse would assess for which of these clinical manifestations?

- A. Wide-spaced eyes, smooth philtrum, flattened nose
- B. Strong tongue thrust, short palpebral fissures, simian crease
- C. Negative Babinski sign, hyperreflexia, deafness
- D. Shortened limbs, increased jitteriness, constant sucking

Correct Answer: A. Wide-spaced eyes, smooth philtrum, flattened nose

The nurse should anticipate that the infant may have fetal alcohol syndrome and should assess for signs and symptoms of it. These include the characteristics listed in choice A. Fetal alcohol syndrome is a condition in a child that results from alcohol exposure during the mother's pregnancy. Fetal alcohol syndrome causes brain damage and growth problems. The problems caused by fetal alcohol syndrome vary from child to child, but defects caused by fetal alcohol syndrome are not reversible.

- **Option B:** A single palmar crease is a single line that runs across the palm of the hand. People most often have 3 creases in their palms. A single palmar crease appears in about 1 out of 30 people. Males are twice as likely as females to have this condition. Some single palmar creases may indicate problems with development and be linked with certain disorders.
- **Option C:** Hyperreflexia is a sign of upper motor neuron damage and is associated with spasticity and a positive Babinski sign. In infants with at CST which is not fully myelinated the presence of a Babinski sign in the absence of other neurological deficits is considered normal up to 24 months of age.
- **Option D:** Achondroplasia is the most common form of short-limb dwarfism. It is an autosomal dominant disorder caused by a mutation in the gene that creates the cells (fibroblasts) which convert cartilage to bone. This means, if the gene is passed on by one parent, the child will have achondroplasia.

9. An elderly man is admitted to the hospital. He was alert and oriented during the admission interview. However, his family states that he becomes disruptive and disoriented around dinnertime. One night he was shouting furiously and didn't know where he was. He was sedated and the next morning he was fine. At dinnertime, the disruptive behavior returned. The client is diagnosed as having sundown syndrome. The client's son asks the nurse what causes sundown syndrome. The nurse's best response is that it is attributed to

- A. An underlying depression
- B. Inadequate cerebral flow

- C. Changes in the sensory environment
- D. Fluctuating levels of oxygen exchange

Correct Answer: C. Changes in the sensory environment

Because the confusion occurs at sundown, the cause probably changes in the sensory environment. Sundown syndrome is related to environmental and sensory abnormalities that lead to acute confusion. The evaluation and management of altered mental status are broad and require careful history and physical examination to eliminate life-threatening situations. Changes in consciousness can be categorized into changes of arousal, the content of consciousness, or a combination of both. Arousal includes wakefulness and/or alertness and can be described as hypoactivity or hyperactivity, while changes in the content of consciousness can lead to changes in self-awareness, expression, language, and emotions

- **Option A:** An underlying depression does not cause sundown syndrome. Depression is characterized by personal withdrawal, slowed speech, or poor results of a cognitive test. Patients rarely have a rapid fluctuation of symptoms and are usually oriented and able to follow commands. When eliciting a history from a patient who presents for altered mental status, it is important to obtain information both from the patient and from collateral sources (e.g., parents, children, friends, emergency management services, bystanders, the patient's primary physician). This information can provide more insight regarding the chronicity of the change, precipitating factors, exacerbating or relieving factors, and recent as well as chronic medical history.
- **Option B:** There is not sufficient evidence to suggest he has inadequate cerebral blood flow. Delirium is typically an acute confusional state, defined by impairment of attention or cognition that usually develops over hours to days. Some patients may experience rapid fluctuations between hypoactive and hyperactive states, that may be interjected with periods of intermittent lucidity. A nearly pathognomonic characteristic of delirium is sleep-wake cycle disruption, which leads to "sundowning," a phenomenon in which delirium becomes worse or more persistent at night
- **Option D:** Fluctuating levels of oxygen exchange do not cause sundown syndrome. The ascending reticular activating system is the anatomic structure that mediates arousal. Neurons of the ascending reticular activating system are located in the midbrain, pons, and medulla, and control arousal from sleep. Metabolic conditions, likely hypoglycemia or hypoxia, can decrease acetylcholine synthesis in the central nervous system, which correlates with the severity of delirium.

10. Which of the following is the most important nursing order in a client with major head trauma who is about to receive bolus enteral feeding?

- A. Measure intake and output
- B. Check albumin level
- C. Monitor glucose levels
- D. Increase enteral feeding

Correct Answer: A. Measure intake and output

It is important to measure intake and output, which should be equal. Water given before feeding will present a hyperosmotic diuresis. I and O measures assess fluid balance. A urinary catheter is inserted to assess the adequacy of renal perfusion. The kidney requires 20% to 25% of cardiac output; commonly, it's the first organ to show the effects of impaired perfusion or intravascular volume.

- **Option B:** Osmotherapy aims to increase the osmolality of the intravascular space, which in turn helps mobilize excess fluid from brain tissue. If ICP increases, mannitol (an osmotic diuretic) may

be given to decrease cerebral edema, transiently increase intravascular volume, and improve cerebral blood flow.

- **Option C:** Low peripheral oxygen saturation values or low arterial blood oxygen values (as shown by arterial blood gas testing) should be avoided. Maintaining adequate brain tissue oxygenation seems to improve patient outcomes.
- **Option D:** Enteral feedings are hyperosmotic agents pulling fluid from cells into the vascular bed. Initially, a nasogastric or orogastric tube is inserted to decompress the stomach and reduce the aspiration risk. (Typically, the nasal route is avoided as it can obstruct sinus drainage, leading to sinusitis or VAP).

11. Mickey, a 6-year-old child with a congenital heart disorder is admitted with congestive heart failure. Digoxin (lanoxin) 0.12 mg is ordered for the child. The bottle of Lanoxin contains .05 mg of Lanoxin in 1 ml of solution. What amount should the nurse administer to the child?

- A. 1.2 ml
- B. 2.4 ml
- C. 3.5 ml
- D. 4.2 ml

Correct Answer: B. 2.4 ml

$.05 \text{ mg} / 1 \text{ ml} = .12 \text{ mg} / x \text{ ml}$, $.05x = .12$, $x = 2.4 \text{ ml}$.

- **Option A:** 1.2 ml is less than the correct dosage and may not produce the desired effects of the drug.
- **Option C:** 3.5 ml is more than the correct dosage as calculated and may produce adverse effects.
- **Option D:** 4.2 ml is an incorrect dosage according to the formula used.

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

- A. Platelet count of 30,000/mm³.
- B. Hemoglobin level of 7.5 g/dL.
- C. Reticulocyte count of 6.5%.
- D. Eosinophil count of 700 cells/mm³.

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

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

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

13. An 18-year-old client is admitted with a closed head injury sustained in a MVA. His intracranial pressure (ICP) shows an upward trend. Which intervention should the nurse perform first?

- A. Reposition the client to avoid neck flexion.
- B. Administer 1 g Mannitol IV as ordered.
- C. Increase the ventilator's respiratory rate to 20 breaths/minute.
- D. Administer 100 mg of pentobarbital IV as ordered.

Correct Answer: A. Reposition the client to avoid neck flexion.

The nurse should first attempt nursing interventions, such as repositioning the client to avoid neck flexion, which increases venous return and lowers ICP. Elevate the head of the bed to greater than 30 degrees. Keep the neck midline to facilitate venous drainage from the head. 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 B:** Osmotic agents can be used to create an osmotic gradient across blood thereby drawing fluid intravascularly and decreasing cerebral edema. Mannitol was the primary agent used at doses of 0.25 to 1 g/kg body weight and is thought to exert its greatest benefit by decreasing blood viscosity and to a lesser extent by decreasing blood volume. Side effects of mannitol use are eventual osmotic diuresis and dehydration as well as renal injury if serum osmolality exceeds 320 mOsm.
- **Option C:** Hypercarbia lowers serum pH and can increase cerebral blood flow contributing to rising ICP, hence hyperventilation to lower pCO₂ to around 30 mm Hg can be transiently used.
- **Option D:** If nursing measures prove ineffective notify the physician, who may prescribe pentobarbital. Pentobarbital is a drug within the barbiturate class that works primarily on the central nervous system. Common off-label uses are for control of intracranial pressure in patients with severe brain injuries, cerebral ischemia, and those receiving treatment for Reye syndrome.

14. Breast self-examination is best done by the woman on herself every month during

- A. The middle of her cycle to ensure that she is ovulating.
- B. During the menstrual period.
- C. Right after the menstrual period so that the breast is not being affected by the increase in hormones particularly estrogen.
- D. Just before the menstrual period to determine if ovulation has occurred.

Correct Answer: C. Right after the menstrual period so that the breast is not being affected by the increase in hormones particularly estrogen.

The best time to do self-breast examination is right after the menstrual period is over so that the hormonal level is low thus the breasts are not tender.

- **Option A:** The best time to examine the breasts is usually 1 week after the menstrual period starts, when the breasts are least likely to be swollen or tender. Examining the breasts at other times in the menstrual cycle may make it hard to compare results of one exam with another.
- **Option B:** The hormone levels fluctuate each month during the menstrual cycle, which causes changes in breast tissue. Swelling begins to decrease when the woman's period starts. The best time to perform a self-exam for breast awareness is usually the week after the period ends.
- **Option D:** The best time to do a monthly self-breast exam is about 3 to 5 days after the woman's period starts. Do it at the same time every month. The breasts are not as tender or lumpy at this time in the monthly cycle. If the woman has gone through menopause, she should do the exam on the same day every month.

15. A male client with chronic obstructive pulmonary disease (COPD) is recovering from a myocardial infarction. Because the client is extremely weak and can't produce an effective cough, the nurse should monitor closely for:

- A. Pleural effusion
- B. Pulmonary edema
- C. Atelectasis
- D. Oxygen toxicity

Correct Answer: C. Atelectasis

In a client with COPD, an ineffective cough impedes secretion removal. This, in turn, causes mucus plugging, which leads to localized airway obstruction — a known cause of atelectasis. Adults with COPD have extensive collateral ventilation secondary to airway destruction and thus are less likely to develop resorption atelectasis in the presence of an obstructing lesion (i.e., intrathoracic tumor). The use of high inspiratory oxygen concentration (high FiO₂) during induction and maintenance of general anesthesia also contributes to atelectasis via absorption atelectasis.

- **Option A:** An ineffective cough doesn't cause pleural effusion (fluid accumulation in the pleural space). Common causes of transudates include conditions that alter the hydrostatic or oncotic pressures in the pleural space like congestive left heart failure, nephrotic syndrome, liver cirrhosis, hypoalbuminemia leading to malnutrition and the initiation of peritoneal dialysis.
- **Option B:** Pulmonary edema usually results from left-sided heart failure, not an ineffective cough. Although many noncardiac conditions may cause pulmonary edema, an ineffective cough isn't one of them. Noncardiogenic pulmonary edema is caused by lung injury with a resultant increase in

pulmonary vascular permeability leading to the movement of fluid, rich in proteins, to the alveolar and interstitial compartments.

- **Option D:** Oxygen toxicity results from prolonged administration of high oxygen concentrations, not an ineffective cough. Extended exposure to above-normal oxygen partial pressures, or shorter exposures to very high partial pressures, can cause oxidative damage to cell membranes leading to the collapse of the alveoli in the lungs. Pulmonary effects can present as early as within 24 hours of breathing pure oxygen.

16. During a prenatal examination, the nurse draws blood from a young Rh-negative client and explain that an indirect Coombs test will be performed to predict whether the fetus is at risk for:

- A. Acute hemolytic disease
- B. Respiratory distress syndrome
- C. Protein metabolic deficiency
- D. Physiologic hyperbilirubinemia

Correct Answer: A. Acute hemolytic disease.

When an Rh-negative mother carries an Rh-positive fetus there is a risk for maternal antibodies against Rh-positive blood; antibodies cross the placenta and destroy the fetal RBCs.

- **Option B:** Respiratory distress syndrome, also known as hyaline membrane disease, occurs almost exclusively in premature infants. In premature infants, respiratory distress syndrome develops because of impaired surfactant synthesis and secretion leading to atelectasis, ventilation-perfusion (V/Q) inequality, and hypoventilation with resultant hypoxemia and hypercarbia.
- **Option C:** Infants with protein metabolism disorders are unable to metabolize certain amino acids and require specialized formulas without the offending amino acid, allowing the baby to receive essential nutrients for growth.
- **Option D:** Physiologic jaundice is also referred to as non-pathologic jaundice, and it is mild and transient. This occurs because of differences in the metabolism of bilirubin in the neonatal period leading to an increased bilirubin load.

17. A client begins clozapine (Clozaril) therapy after several other antipsychotic agents fail to relieve her psychotic symptoms. The nurse instructs her to return for weekly white blood cell (WBC) counts to assess for which adverse reaction?

- A. Hepatitis
- B. Infection
- C. Granulocytopenia
- D. Systemic dermatitis

Correct Answer: C. Granulocytopenia

Clozapine can cause life-threatening neutropenia or granulocytopenia. To detect this adverse reaction, a WBC count should be performed weekly. Weekly complete blood count (CBC) to measure ANC

levels. ANC levels less than 1500 indicate neutropenia. Levels less than 500 indicate agranulocytosis. A complete blood count should be taken weekly for the first six months, then every other week for the next six months. A national registry is in place to monitor for safe use.

- **Option A:** Hepatitis is not an adverse effect of clozapine. Clozapine is associated with significant weight gain, diabetes type 2, diabetic ketoacidosis, and increased lipid levels—all due to increased insulin resistance. Both clozapine and olanzapine have higher metabolic side effects than the other atypical and typical antipsychotics due to their high affinity for serotonin 5-HT_{2C} receptors.
- **Option B:** Infection does not occur with clozapine. Clozapine-induced myocarditis is a rare complication, affecting less than 3% of patients. This lethal dose-independent side effect appears more frequently during the first four weeks of treatment. In these patients, signs and symptoms of myocarditis may vary from having a flu-like illness to respiratory and cardiovascular symptoms.
- **Option D:** Systemic dermatitis isn't an adverse reaction of clozapine therapy. Clozapine, due to its many lethal adverse reactions, has become a drug that many clinicians are afraid to prescribe due to fear of patient safety. One of the greatest concerns for clozapine is the side effect of agranulocytosis. The FDA has required a registry to be in place to monitor weekly white blood cell count levels for anyone prescribed with clozapine.

18. The nurse is instructing a client with hyperkalemia on the importance of choosing foods low in potassium. The nurse should teach the client to limit which of the following foods?

- A. Grapes
- B. Carrot
- C. Green beans
- D. Lettuce

Correct Answer: B. Carrot

Carrots have 320 mg of potassium per 100 mg serving; green beans give 209 mg of potassium, 194 mg for lettuce, and 191 mg for grapes all in 100 mg serving. Other foods that are low in potassium include applesauce, blueberries, pineapple, and cabbage. To minimize potassium buildup, a person with chronic kidney disease should stick to a low-potassium diet of between 1,500 and 2,000 milligrams (mg) per day. Limiting phosphorus, sodium, and fluids may also be important for people with kidney dysfunction.

- **Option A:** Grapes are also rich in potassium, but not as much as in carrots. They're also a good source of vitamin C, an essential nutrient and powerful antioxidant necessary for connective tissue health. Grapes are high in a number of powerful antioxidant compounds. In fact, over 1,600 beneficial plant compounds have been identified in this fruit.
- **Option C:** Half a cup of freshly cooked green beans has only 90 milligrams of potassium and 18 milligrams of phosphorus, making them a great vegetable choice for the kidney diet.
- **Option D:** Lettuce is a popular vegetable and is usually eaten raw in salads. Because CKD patients with hyperkalemia need to limit potassium intake from meals, they are not able to eat large quantities of raw vegetables such as lettuce.

19. A client had oral surgery following a motor vehicle accident. The nurse assessing the client finds the skin flushed and warm. Which of the following

would be the best method to take the client's body temperature?

- A. Oral
- B. Axillary
- C. Arterial line
- D. Rectal

Correct Answer: B. Axillary

Taking the temperature via the axilla is the most appropriate route. Body temperature is a numerical expression of the body's heat and metabolic activity balance and can be a major indicator of a person's health status. Assessing a patient's body temperature is a common procedure nurses perform to monitor for signs of infection, environmental exposure, shock, ovulation, or therapeutic response to medications or medical procedures. A normal body temperature can be a potentially positive sign that the patient isn't experiencing a disease process, infection, or trauma and that the body's cells, tissues, and organs aren't under metabolic distress.

- **Option A:** Taking the temperature via the oral route is incorrect since the client had oral surgery. The esophageal temperature probe (ETP) is an 18-in (45.7 cm) long, thin, flexible catheter that has a rounded tip that should be lubricated with water-soluble lubricant before being placed through the nares or mouth, extending into the esophagus at least 2 to 3 in (5 to 7.6 cm). The external end portion of the catheter has a small, coated wire with a plug that can be attached to a telemetry monitor for continuous temperature monitoring.
- **Option C:** A PiCCO thermodilution catheter (Pulsion Medical Systems) containing a temperature thermistor was inserted into the brachial artery at the antecubital fossa and doubled as the arterial pressure monitoring line and arterial blood sampling portal. This measured brachial artery temperature from the time of insertion to the time the patient left the operating room.
- **Option D:** This is unnecessary. The ETP and RTP (rectal temperature probe) are the same device but can be used in either orifice depending on the patient's medical condition. Again, the tip should be lubricated with water-soluble lubricant, and then placed approximately 3 in (7.6 cm) inside the rectal vault. The RTP can also be attached to a telemetry monitor cable for continuous temperature monitoring.

20. A client's ABG results are as follows: pH: 7.16; PaCO₂ 80 mm Hg; PaO₂ 46 mm Hg; HCO₃⁻ 24 mEq/L; SaO₂ 81%. This ABG result represents which of the following conditions?

- A. Metabolic acidosis
- B. Metabolic alkalosis
- C. Respiratory acidosis
- D. Respiratory alkalosis

Correct Answer: C. Respiratory acidosis

PaCO₂ > 40 with a pH < 7.4 indicates a respiratory acidosis. If the pH is in the normal range (7.35-7.45), use a pH of 7.40 as a cutoff point. In other words, a pH of 7.37 would be categorized as acidosis. Arterial blood gas interpretation is best approached systematically. Interpretation leads to an understanding of the degree or severity of abnormalities, whether the abnormalities are acute or chronic, and if the primary disorder is metabolic or respiratory in origin.

- **Option A:** Evaluate the respiratory and metabolic components of the ABG results, the PaCO₂ and HCO₃, respectively. The PaCO₂ indicates whether the acidosis or alkalemia is primarily from a respiratory or metabolic acidosis/alkalosis.
- **Option B:** The acid-base that is inconsistent with the pH is the HCO₃, as it is elevated, indicating a metabolic alkalosis, so there is compensation signifying a non-acute primary disorder because it takes days for metabolic compensation to be effective.
- **Option D:** PaCO₂ < 40 and pH < 7.4 indicates a respiratory alkalosis (but is often from hyperventilation from anxiety or compensation for a metabolic acidosis). Assess for evidence of compensation for the primary acidosis or alkalosis by looking for the value (PaCO₂ or HCO₃) that is not consistent with the pH.

21. Nurse John is aware that most crisis situations should resolve in about:

- A. 1 to 2 weeks
- B. 4 to 6 weeks
- C. 4 to 6 months
- D. 6 to 12 months

Correct Answer: B. 4 to 6 weeks

Crisis is self-limiting and lasts from 4 to 6 weeks. In mental health terms, a crisis refers not necessarily to a traumatic situation or event, but to a person's reaction to an event. One person might be deeply affected by an event while another individual suffers little or no ill effects. The Chinese word for crisis presents an excellent depiction of the components of a crisis. The word "crisis" in Chinese is formed with the characters for danger and opportunity.

- **Option A:** "People are in a state of crisis when they face an obstacle to important life goals—and obstacle that is, for a time, insurmountable by the use of customary methods of problem-solving." (Caplan, 1961). A crisis can sometimes be quite obvious, such as a person losing his or her job, getting divorced, or being involved in some type of accident. In other cases, a personal crisis might be less apparent but can still lead to dramatic changes in behavior and mood.
Option C: "Crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms." (James and Gilliland, 2001). It's important to lean on friends, family, and loved ones during a crisis, but you should also seek professional help if you need it. Consider talking to your doctor about what you are dealing with.
- **Option D:** If you are coping with a crisis, whether it's emotional or situational, there are things that you can do to help ensure your psychological and physical well-being during this difficult time of your life. Focus on what's important at the moment. This can mean getting yourself out of an unsafe situation or it can mean just focusing on the basics so that you can get through each day. Avoid taking on too much and conserve your energy so you can deal with the problem you are facing.

22. In caring for a young child with pain, which assessment tool is the most useful?

- A. Simple descriptive pain intensity scale
- B. 0-10 numeric pain scale
- C. Faces pain-rating scale

D. McGill-Melzack pain questionnaire

Correct Answer: C. Faces pain-rating scale

The Faces pain rating scale (depicting smiling, neutral, frowning, crying, etc.) is appropriate for young children who may have difficulty describing pain or understanding the correlation of pain to numerical or verbal descriptors. The Faces Pain Scale-Revised (FPS-R) is a self-report measure of pain intensity developed for children. It was adapted from the Faces Pain Scale to make it possible to score the sensation of pain on the widely accepted 0-to-10 metric. The scale shows a close linear relationship with visual analog pain scales across the age range of 4-16 years. It is easy to administer and requires no equipment except for the photocopied faces. The other tools require abstract reasoning abilities to make analogies and use of advanced vocabulary.

- **Option A:** The Simple Descriptive Scale exhibits degrees of pain intensity (no pain, mild pain, moderate pain, and severe pain). Risk factors for the development of chronic pain have been a major topic in pain research in the past two decades. Now, it has been realized that psychological and psychosocial factors may substantially influence pain perception in patients with chronic pain and thus may influence the surgical outcome.
- **Option B:** This pain scale is most commonly used. A person rates their pain on a scale of 0 to 10 or 0 to 5. Zero means “no pain,” and 5 or 10 means “the worst possible pain.” These pain intensity levels may be assessed upon initial treatment, or periodically after treatment.
- **Option D:** The McGill pain questionnaire, or MPQ, is one of the most widely used multidimensional pain scales in the world. In the MPQ, the evaluation of pain is divided into three categories: sensory, affective, and evaluative. The questionnaire is self-reported and allows individuals to describe the quality and intensity of their pain by using 78 adjectives in 20 different sections.

23. The outcome that is unrelated to a crisis state is:

- A. Learning more constructive coping skills.
- B. Decompensation to a lower level of functioning.
- C. Adaptation and a return to a prior level of functioning.
- D. A higher level of anxiety continuing for more than 3 months.

Correct Answer: D. A higher level of anxiety continuing for more than 3 months.

This is not an expected outcome of a crisis because by definition a crisis would be resolved in 6 weeks. A crisis is defined as an overwhelming event, which can include divorce, violence, the passing of a loved one, or the discovery of a serious illness. A successful intervention involves obtaining background information on the patient, establishing a positive relationship, discussing the events, and providing emotional support.

- **Option A:** Crisis intervention is a short-term management technique designed to reduce potential permanent damage to an individual affected by a crisis. SAFER-R is a common intervention model used, which consists of stabilization, acknowledgment, facilitate understanding, encouragement, recovery, and referral. SAFER-R helps patients return to their mental baseline following a crisis. The use of humor, emotional support, planning, and acceptance also correlate with superior mental health outcomes compared to substance abuse and denial. Positive coping mechanisms, such as the ones listed above, are reported to be effective in crisis management, and with crisis intervention services in place, people will be better equipped to handle unexpected events.
- **Option B:** SAFER-R can be used in conjunction with the Assessment Crisis Intervention Trauma Treatment (ACT), which is a seven-stage crisis intervention model. It consists of assessing the

affected person, establishing a relationship, understanding the problem, confronting emotions, exploring coping strategies, implementing a plan, and following up. If left unmanaged, a person with a severe crisis can undergo a significant amount of psychological stress, which carries links to major depressive disorder and other mental health conditions. Not only is crisis intervention effective in preventing the development of mental illness, but it can also be used in a clinical setting to treat patients currently suffering from one.

- **Option C:** Psychological crisis intervention is necessary to prevent traumatized victims from developing illnesses. It also alleviates stress upon healthcare workers so that they can continue helping others. Another major concern is what coping strategies are most effective. Social support and problem-solving planning are effective coping mechanisms that are frequently used by school staff following a crisis.

24. Toxicity from which of the following medications may cause a client to see a green-yellow halo around lights?

- A. digoxin (Lanoxin)
- B. furosemide (Lasix)
- C. metoprolol (Lopressor)
- D. enalapril (Vasotec)

Correct Answer: A. digoxin (Lanoxin)

One of the most common signs of digoxin toxicity is the visual disturbance known as the “green-yellow halo sign.” Digoxin’s therapeutic half-life is between 30 to 40 hours, but this may change in overdose. Digoxin excretion is primarily renal, and for this reason, patients with poor or worsening renal function, such as patients who are elderly or have CKD, are more likely to develop toxicity. The other medications aren’t associated with such an effect.

- **Option B:** Toxicity with furosemide manifests as extensions of its diuretic activity. Signs and symptoms of overdose or toxicity include dehydration, reduced blood volume, and electrolyte imbalances. Risk of hypokalemia increases with the use of a high dose of furosemide, decreased oral intake of potassium, in patients with hyperaldosteronism states (liver abnormalities or licorice ingestion) or concomitant use of corticosteroid, ACTH, and laxatives.
- **Option C:** The primary adverse effects of metoprolol include heart failure exacerbation, fatigue, depression, bradycardia or heart block, hypotension, bronchospasm, cold extremities, dizziness, decreased libido, diarrhea, tinnitus, decreased exercise tolerance, glucose intolerance, and may mask hypoglycemia.
- **Option D:** The side effect most commonly encountered with the use of ACE inhibitors is cough. The cough is characteristically non-productive and stops with the discontinuation of the drug. Other adverse effects of enalapril are hypotension, hyperkalemia, angioedema, cholestatic jaundice, and hypersensitivity reaction. Vasodilation caused by enalapril to reduce the afterload of heart and decrease the total peripheral resistance is also responsible for hypotension.

25. A nurse is giving discharge instructions to a client who will be taking phenobarbital (Luminal). The nurse would educate the client in which of the following directly correlates with the safety of the client?

- A. Take the medication at the same time each day.

- B. Take the medication with meals only.
- C. Avoid using sleep aids while taking the medication.
- D. Decrease the dosage once with symptoms of dizziness and lightheadedness.

Correct Answer: C. Avoid using sleep aids while taking the medication.

Phenobarbital (Luminal) is an anticonvulsant and hypnotic drug. The client should avoid drinking alcohol or use medicines that may cause drowsiness (eg, sleep aids, muscle relaxers).

- **Option A:** Taking the medication at the same time daily improves compliance and maintains more stable blood levels of the medication.
- **Option B:** The medication is taken without regard to meals.
- **Option D:** Decreasing the dosage is not done without the approval of the physician.

26. Which of the following interventions is important for a Cely experiencing a paranoid personality disorder taking olanzapine (Zyprexa)?

- A. Explain effects of serotonin syndrome.
- B. Teach the client to watch for extrapyramidal adverse reactions.
- C. Explain that the drug is less effective if the client smokes.
- D. Discuss the need to report paradoxical effects such as euphoria.

Correct Answer: C. Explain that the drug is less effective if the client smokes.

Olanzapine (Zyprexa) is less effective for clients who smoke cigarettes. Olanzapine is a second-generation (atypical) antipsychotic medication. Olanzapine also has approval for use with fluoxetine, a selective serotonin reuptake inhibitor (SSRI), in patients with episodes of depression associated with bipolar disorder type 1 and treatment-resistant depression.

- **Option A:** Serotonin syndrome occurs with clients who take a combination of antidepressant medications. Serotonin syndrome is a potentially life-threatening condition precipitated by the use of serotonergic drugs. It may be a consequence of therapeutic medication use, accidental interactions between medications or recreational drugs, or intentional overdose. Symptoms can range from mild to fatal and classically include altered mental status, autonomic dysfunction, and neuromuscular excitation.
- **Option B:** Extrapyramidal adverse reactions aren't a problem. However, the client should be aware of adverse effects such as tardive dyskinesia. Olanzapine's mechanism of action also lends itself to directly causing adverse reactions associated with the dopaminergic blockade. Patients taking olanzapine have a risk of developing akathisia, extrapyramidal symptoms, tardive dyskinesia, and neuroleptic malignant syndrome. However, the risk of developing these side effects is lesser than first-generation antipsychotics due to the loose association and quick dissociation of olanzapine with the D2 receptors.
- **Option D:** Olanzapine doesn't cause euphoria. One of the most common adverse effects of olanzapine is the potential for gaining weight. Olanzapine causes an increase in appetite leading to hyperphagia with a consequence of weight gain. Therefore, it should be used cautiously in patients who are obese, have little control over their food intake, and do not exercise regularly to combat weight gain.

27. The nurse is completing an assessment history of a client with pernicious anemia. Which complaint differentiates pernicious anemia from other types of anemia?

- A. Difficulty in breathing after exertion
- B. Numbness and tingling in the extremities
- C. A faster-than-usual heart rate
- D. Feelings of lightheadedness

Correct Answer: B. Numbness and tingling in the extremities

- Option B: Pernicious anemia is a condition where there is a vitamin B12 deficiency. A deficiency may lead to nerve damage. This can cause numbness and tingling sensation in the extremities.
- Options A, C, and D: These are common symptoms of all types of anemia.

28. At Hope Pediatric Center, Nurse Jordan is reviewing the case of 8-year-old Lily, who is currently being treated for leukemia. Lily's medical journey has been filled with frequent hospital visits, intensive chemotherapy sessions, and consistent monitoring. Lily's mother, Mrs. Williams, rushes into the clinic looking panicked and informs Nurse Jordan that Lily's cousin, who visited their home two days ago, has just been diagnosed with chickenpox. Given Lily's compromised immunity due to leukemia and chemotherapy, Mrs. Williams is gravely concerned about the potential repercussions of this exposure. Nurse Jordan recalls the center's protocol for such situations and assesses the appropriate treatment measures for Lily. Given the circumstances, which treatment measure is most appropriate for Lily, who has leukemia and has been exposed to chickenpox?

- A. No treatment is indicated.
- B. Acyclovir (Zovirax) should be started on exposure.
- C. Varicella-zoster immunoglobulin (VZIG) should be given with the evidence of disease.
- D. VZIG should be given within 72 hours of exposure.
- E. Administer a booster dose of the varicella vaccine.
- F. Start prophylactic antibiotics to prevent secondary infections.

Correct Answer: D. VZIG should be given within 72 hours of exposure.

VZIG provides passive immunity to chickenpox and is recommended for high-risk individuals like Lily, who are immunocompromised. It should be given as soon as possible after exposure to be effective.

- **Option A:** Given Lily's compromised immune system, doing nothing could lead to severe complications if she contracts the disease.
- **Option B:** While antiviral medications such as acyclovir can be useful in treating chickenpox, the priority for someone with leukemia and without prior immunity to chickenpox would be passive immunization through VZIG.

- **Option C:** Waiting for evidence of disease is risky, especially in an immunocompromised child. It's better to administer VZIG soon after exposure.
- **Option E:** The vaccine is live-attenuated and isn't typically given to severely immunocompromised patients due to the potential risk.
- **Option F:** Chickenpox is a viral infection, and antibiotics won't prevent its onset. They might be considered if there's a concern for secondary bacterial infections, but it's not the primary measure following exposure.

29. A depressed client is ready for discharge. The nurse feels comfortable that the client has a good understanding of the disease process when the client states:

- A. "I'll never let this happen to me again. I won't let my boss or my job or my family get to me!"
- B. "It's important for me to eat well, exercise, and to take my medication. If I begin to lose my appetite or not sleep well, I've got to get in to see my doctor."
- C. "I've learned that I'm a good person and that I am worthy of giving and receiving love. I don't need anyone; I have myself to rely on!"
- D. "I don't know what happened to me. I've always been able to make decisions for myself and for my business. I don't ever want to feel so weak or vulnerable again!"

Correct Answer: B. "It's important for me to eat well, exercise, and to take my medication. If I begin to lose my appetite or not sleep well, I've got to get in to see my doctor."

The exact cause of depression is not known but is believed to be related to the biochemical disruption of neurotransmitters in the brain. Diet, exercise, and medication are recognized treatments for the disease process. Nursing care plan goals for patients with major depression include determining a degree of impairment, assessing the client's coping abilities, assisting the client to deal with the current situation, providing for meeting psychological needs, and promoting health and wellness.

- **Option A:** The patient should be able to identify two unrealistic self-expectations and reformulate more realistic life goals with a nurse by the end of the day. The patient will demonstrate a zest for life and ability to enjoy the present, and identify one or two strengths by the end of the day.
- **Option C:** The patient will be able to verbalize that he/she enjoys interacting with others in activities and one-on-one interactions to the extent they did before becoming depressed. The patient will state and demonstrate progress in the resumption of sustaining relationships with friends and family members within one month.
- **Option D:** The patient will be able to identify negative thoughts and rationally counter them and/or reframe them in a positive manner within 2 weeks. He will remember to keep appointments, attend activities, and attend to grooming with minimal reminders from others within 1 to 3 weeks.

30. A 75-year-old client has dementia of the Alzheimer's type and confabulates. The nurse understands that this client:

- A. Denies confusion by being jovial
- B. Pretends to be someone else
- C. Rationalizes various behaviors

D. Fills in memory gaps with fantasy

Correct Answer: D. Fills in memory gaps with fantasy

Confabulation is a communication device used by patients with dementia to compensate for memory gaps. Confabulation is a type of memory error in which gaps in a person's memory are unconsciously filled with fabricated, misinterpreted, or distorted information. When someone confabulates, they are confusing things they have imagined with real memories. A person who is confabulating is not lying. They are not making a conscious or intentional attempt to deceive. Rather, they are confident in the truth of their memories even when confronted with contradictory evidence. The remaining answer choices are incorrect.

- **Option A:** Dementia is a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal aging. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. Consciousness is not affected. The impairment in cognitive function is commonly accompanied and occasionally preceded, by deterioration in emotional control, social behavior, or motivation.
- **Option B:** Dementia results from a variety of diseases and injuries that primarily or secondarily affect the brain, such as Alzheimer's disease or stroke. Dementia is one of the major causes of disability and dependency among older people worldwide. It can be overwhelming, not only for the people who have it, but also for their carers and families. There is often a lack of awareness and understanding of dementia, resulting in stigmatization and barriers to diagnosis and care. The impact of dementia on carers, family, and society at large can be physical, psychological, social, and economic.
- **Option C:** Although age is the strongest known risk factor for dementia, it is not an inevitable consequence of aging. Further, dementia does not exclusively affect older people – young onset dementia (defined as the onset of symptoms before the age of 65 years) accounts for up to 9% of cases. Studies show that people can reduce their risk of dementia by getting regular exercise, not smoking, avoiding harmful use of alcohol, controlling their weight, eating a healthy diet, and maintaining healthy blood pressure, cholesterol, and blood sugar levels. Additional risk factors include depression, low educational attainment, social isolation, and cognitive inactivity.

31. A client with a diagnosis of major depression, recurrent with psychotic features is admitted to the mental health unit. To create a safe environment for the client, the nurse most importantly devises a plan of care that deals specifically with the client's:

- A. Disturbed thought processes
- B. Imbalanced nutrition
- C. Self-care deficit
- D. Deficient knowledge

Correct Answer: A. Disturbed thought processes

Major depression, recurrent, with psychotic features alerts the nurse that in addition to the criteria that designate the diagnosis of major depression, one also must deal with the client's psychosis. Psychosis is defined as a state in which a person's mental capacity to recognize reality and to communicate and relate to others is impaired, thus interfering with the person's capacity to deal with the demands of life. Altered thought processes generally indicate a state of increased anxiety in which hallucinations and

delusions prevail. Although all of the nursing diagnoses may be appropriate because the client is experiencing psychosis, option A is correct.

- **Option B:** In Imbalanced nutrition, the patient will regain a more normal elimination pattern with aid of foods high in roughage, increased fluid intake, and exercise daily (also with the aid of medications). Encourage small, high-calorie, and high-protein snacks and fluids frequently throughout the day and evening if weight loss is noted; minimizes weight loss, constipation, and dehydration.
- **Option C:** In Self-care deficit, the patient will demonstrate progress in the maintenance of adequate hygiene and be appropriately groomed and dressed (shave/makeup, clothes clean and neat). Encourage the use of soap, washcloth, toothbrush, shaving equipment, make-up etc. Give step-by-step reminders such as “Brush the teeth “Clean the outer surfaces of your upper teeth, then your lower teeth. . .” Slowed thinking and difficulty concentrating make organizing simple tasks difficult.
- **Option D:** In Deficient Knowledge, the patient and significant other will verbalize accurate information about at least two of the possible causes of depression, three-four of the signs and symptoms of depression, and use of medications, psychotherapy, and electroconvulsive therapy as treatment.

32. One morning, nurse Diane finds a disturbed client curled up in the fetal position in the corner of the dayroom. The most accurate initial evaluation of the behavior would be that the client is:

- A. Physically ill and experiencing abdominal discomfort.
- B. Tired and probably did not sleep well last night.
- C. Attempting to hide from the nurse.
- D. Feeling more anxious today.

Correct Answer: D. Feeling more anxious today

The fetal position represents regressed behavior. Regression is a way of responding to overwhelming anxiety. Validate observations by asking the patient, “Are you feeling anxious now?” Anxiety is a highly individualized, normal physical and psychological response to internal or external life events.

- **Option A:** Assess physical reactions to anxiety. Anxiety also plays a role in somatoform disorders, which are characterized by physical symptoms such as pain, nausea, weakness, or dizziness that have no apparent physical cause. Recognize awareness of the patient’s anxiety. Since a cause of anxiety cannot always be identified, the patient may feel as though the feelings being experienced are counterfeit. Acknowledgment of the patient’s feelings validates the feelings and communicates acceptance of those feelings.
- **Option B:** Use presence, touch (with permission), verbalization, and demeanor to remind patients that they are not alone and to encourage expression or clarification of needs, concerns, unknowns, and questions. Being supportive and approachable promotes communication. Consider the patient’s use of coping strategies that the patient has found effective in the past. This enhances the patient’s sense of personal mastery and confidence.
- **Option C:** Observe how the patient uses coping techniques and defense mechanisms to cope with anxiety. Asking questions requiring informative answers helps identify the effectiveness of coping strategies currently used by the patient. This approach may help the patient feel like he or she is contributing to patient care. Coping strategies may include reading, journaling, or physical activity

such as taking a walk. Defense mechanisms are used by people to preserve the ego and manage anxiety. Some defense mechanisms are highly adaptive in managing anxiety, such as humor, sublimation, or suppression. Other defense mechanisms may lead to less adaptive behavior, especially with long-term use. These defense mechanisms include displacement, repression, denial, projection, and self-image splitting.

33. A male client with primary diabetes insipidus is ready for discharge on desmopressin (DDAVP). Which instruction should nurse Lina provide?

- A. "Administer desmopressin while the suspension is cold."
- B. "Your condition isn't chronic, so you won't need to wear a medical identification bracelet."
- C. "You may not be able to use desmopressin nasally if you have nasal discharge or blockage."
- D. "You won't need to monitor your fluid intake and output after you start taking desmopressin."

Correct Answer: C. "You may not be able to use desmopressin nasally if you have nasal discharge or blockage."

Desmopressin may not be absorbed if the intranasal route is compromised. Desmopressin administration can be utilized to distinguish between central vs. nephrogenic diabetes insipidus, with a positive response noted in central diabetes insipidus, meaning the kidneys respond appropriately to desmopressin with the expected concentration of the urine and increased reabsorption of fluids, resulting in eutonic urine.

- **Option A:** The intranasal form of vasopressin is frequently a choice when administration occurs at home. Each spray typically dispenses 150 micrograms. The intranasal dosage is directly proportional to the weight of the patient, with patients weighing less than 50 kg prescribed one spray, or 150 micrograms, and patients over 50 kg prescribed 2 sprays, or 300 micrograms, every 12 to 24 hours. This form of the drug reaches peak levels in 60 to 90 minutes.
- **Option B:** Although diabetes insipidus is treatable, the client should wear medical identification and carry medication at all times to alert medical personnel in an emergency and ensure proper treatment. As patients age, they should also be continually monitored for declining renal function, as the therapeutic index and clearance of the drug will change according to the renal function.
- **Option D:** The client must continue to monitor fluid intake and output and receive adequate fluid replacement. Desmopressin is generally well-tolerated in most patients. There are a few instances where patients require monitoring for adverse effects of the drug. Patients receiving desmopressin need monitoring for the occurrence of hyponatremia.

34. After a subtotal gastrectomy, the nurse should anticipate that nasogastric tube drainage will be what color for about 12 to 24 hours after surgery?

- A. Dark brown
- B. Bile green
- C. Bright red
- D. Cloudy white

Correct Answer: A. Dark brown

About 12 to 24 hours after a subtotal gastrectomy, gastric drainage is normally brown, which indicates digested blood. The aims of prophylactic drainage are to prevent repeated infection (for example by discharging remnant blood and preventing abscess formation), control possible leakage from the surgical seam (by drainage of the digestive closure, for example, a colonic anastomosis), and to provide a warning of potential complications.

- **Option B:** Bile green is not expected during the first 12 to 24 hours after subtotal gastrectomy. Bile-colored (greenish) drainage is characteristic when the tube is in the duodenum. Measure and record the amount of drainage. Dispose of measured drainage by flushing into the hopper or toilet.
- **Option C:** Drainage during the first 6 to 12 hours contains some bright red blood, but large amounts of blood or excessively bloody drainage should be reported to the physician promptly. In gastrointestinal drainage, blood varies in color—it may be dark red when fresh, dark brownish-red, or in brown particles (“coffee ground drainage”) if it has been partially digested.
- **Option D:** Cloudy, pale-yellowish drainage is characteristic when the tube is in the stomach. However, this is not expected within 12 to 24 hours. Measure the contents and empty the drainage bottle at the hours ordered by the physician, when the drainage bottle is two-thirds full or when suction is discontinued.

35. A maternity nurse is providing instruction to a new mother regarding the psychosocial development of the newborn infant. Using Erikson’s psychosocial development theory, the nurse would instruct the mother to

- A. Allow the newborn infant to signal a need
- B. Anticipate all of the needs of the newborn infant
- C. Avoid the newborn infant during the first 10 minutes of crying
- D. Allow the infant to cry, once lessen, then attend to the infant

Correct Answer: A. Allow the newborn infant to signal a need.

If a newborn is not allowed to signal a need, the newborn will not learn how to control the environment. The primary way the caregiver can build trust with the baby is to respond when they try to communicate. Because babies can’t use words to express themselves, they use nonverbal strategies to communicate what they’re thinking and feeling at all times.

- **Option B:** According to Erikson, the caregiver should not try to anticipate the newborn infant's needs at all times but must allow the newborn infant to signal needs. Crying is one of the most common strategies babies use to communicate with their caregivers, and it carries different meanings.
- **Option C:** It is important for caregivers to provide comfort to an infant by holding them closely and securely. This provides both warmth and physical contact. Feeding, bathing, and comforting your child helps them learn to trust that their needs will be met.
- **Option D:** Erikson believed that a delayed or prolonged response to a newborn’s signal would inhibit the development of trust and lead to mistrust of others. By responding quickly and appropriately to the infant’s cries, the caregiver is building a foundation of trust.