

Kevin's Review - 35 NCLEX Practice Questions

1. The client has burns on both legs. These areas appear white and leather-like. No blisters or bleeding are present, and there is just a "small amount of pain." How will the nurse categorize this injury?

- A. Full-thickness
- B. Partial-thickness superficial
- C. Partial-thickness deep
- D. Superficial

Correct Answer: A. Full-thickness

The characteristics of the wounds meet the criteria for a full-thickness injury: color that is black, brown, yellow, white, or red; no blisters; pain minimal; outer layer firm and inelastic. The burn is leathery and dry. There is minimal to no pain because of decreased sensation. Full-thickness burns heal by contracture and take greater than 8 weeks. Full-thickness burns require skin grafting.

- **Option B:** Superficial partial-thickness (second-degree) involves the superficial dermis. It appears red with blisters and is wet. The erythema blanches with pressure. The pain associated with superficial partial-thickness is severe. Healing typically occurs within 3 weeks with minimal scarring.
- **Option C:** Deep partial-thickness (second-degree) involves the deeper dermis. It appears yellow or white, is dry, and does not blanch with pressure. There is minimal pain due to a decreased sensation. Healing occurs in 3 to 8 weeks with scarring present.
- **Option D:** Superficial (first-degree) involves the epidermis of the skin only. It appears pink to red, there are no blisters, and it is dry. It is moderately painful. Superficial burns heal without scarring within 5 to 10 days.

2. Nurse Dorothy is evaluating care of a client with schizophrenia; the nurse should keep which point in mind?

- A. Frequent reassessment is needed and is based on the client's response to treatment.
- B. The family does not need to be included in the care because the client is an adult.
- C. The client is too ill to learn about his illness.
- D. Relapse is not an issue for a client with schizophrenia.

Correct Answer: A. Frequent reassessment is needed and is based on the client's response to treatment.

Because the client responds to treatment in different ways, the nurse must constantly evaluate the client and his potential. A premorbid adjustment must also be considered. Assess if incoherence in speech is chronic or if it is more sudden, as in an exacerbation of symptoms. Establishing a baseline facilitates the establishment of realistic goals, the foundation for planning effective care.

- **Option B:** Most clients with such conditions go home, so the family should be involved. Inform the client's family in clear, simple terms about psychopharmacologic therapy: dose, duration, indication, side effects, and toxic effects. Written information should be given to the client and family members as well. Understanding of the disease and the treatment of the disease encourages greater family support and client adherence.
- **Option C:** The client can learn about the illness if the information is provided gradually. Use simple, concrete, and literal explanations. Minimizes misunderstanding and/or incorporating those

misunderstandings into delusional systems. Use therapeutic techniques (clarifying feelings when speech and thoughts are disorganized) to try to understand the client's concerns. Even if the words are hard to understand, try getting to the feelings behind them.

- **Option D:** Relapse is common in schizophrenia. Educating patients on the importance of modifying risk factors such as increasing exercise, healthier diets, and smoking cessation will decrease their risk of cardiovascular problems and reduce the mortality rate. Moreover, cognitive behavioral therapy has been shown to improve patient compliance and decrease future hospital admissions.

3. The physician has ordered Basaljel (aluminum carbonate gel) for a client with recurrent indigestion. The nurse should teach the client common side effects of the medication, which include:

- A. Constipation
- B. Diarrhea
- C. Urinary retention
- D. Confusion

Correct Answer: A. Constipation

- Option A: Antacids containing aluminum and calcium tend to cause constipation. Aluminum causes the relaxation of the gastrointestinal smooth muscle which delays gastric emptying causing constipation.
- Option B: Diarrhea is a side effect of antacids containing magnesium.
- Option C: Urinary retention is a side effect of anticholinergic medications used to treat ulcers.
- Option D: Confusion is a side effect of dopamine antagonists that are used to treat ulcers.

4. Newly hired nurse Liza is excited to perform her very first physical assessment with a 19-year-old client. Which assessment examination requires Liza to wear gloves?

- A. Breast
- B. Integumentary
- C. Ophthalmic
- D. Oral

Correct Answer: D. Oral

Gloves should be worn anytime there is a risk of exposure to the client's blood or body fluids. Oral, rectal, and genital examinations require gloves because they involve contact with body fluids. Ophthalmic, breast, or integumentary examinations normally do not involve contact with the client's body fluids and do not require the nurse to wear gloves for protection.

- **Option A:** After completing the visual inspection, the patient should be instructed to lay supine. If a site-specific breast complaint is being evaluated, the examiner should begin his/her exam on the opposite, or "normal" side. As one breast is examined, the other is covered for the patient's comfort. The patient should place the ipsilateral hand above and/or behind their head to flatten the breast tissue as much as possible. The breast tissue itself is evaluated using a sequence of palpation that

allows serial progression from superficial to deeper tissues.

- **Option B:** A general assessment of the skin begins at the initial contact with the patient and continues throughout the examination. Specific areas of the skin are assessed during the examination of other body systems unless the chief complaint is a dermatologic problem. However, if there are areas of skin breakdown or drainage, gloves should be used.
- **Option C:** The Royal College of Ophthalmologists have updated their advice on PPE to ophthalmologists and are now recommending that clinicians should wear standard surgical masks when examining or treating patients at the slit lamp. Gowns and gloves are not recommended. They also recommend that plastic breath shields attached to slit lamps provide some protection, but must be disinfected between patients as studies show that the COVID-19 virus is viable for up to 72 hours on plastic surfaces.

5. When planning care for a client who has ingested phencyclidine (PCP), nurse Wayne is aware that the following is the highest priority?

- A. Client's physical needs
- B. Client's safety needs
- C. Client's psychosocial needs
- D. Client's medical needs

Correct Answer: B. Client's safety needs

The highest priority for a client who has ingested PCP is meeting safety needs of the client as well as the staff. Drug effects are unpredictable and prolonged, and the client may lose control easily. Phencyclidine (PCP) is a dissociative anesthetic that is a commonly used recreational drug. PCP is a crystalline powder that can be ingested orally, injected intravenously, inhaled, or smoked. PCP is available as a powder, crystal, liquid, and tablet. It produces both stimulation and depression of the CNS. PCP is a non-competitive antagonist to the NMDA receptor, which causes analgesia, anesthesia, cognitive defects, and psychosis.

- **Option A:** Depending on the dose and route of administration, PCP can have a wide range of central nervous system (CNS) manifestations. Emergency department providers should become familiar with how to manage patients with PCP toxicity since rhabdomyolysis, hypoglycemia, seizures, hypertensive crisis, coma, and trauma are several of the complications that can arise with PCP use
- **Option C:** PCP blocks the uptake of dopamine and norepinephrine, leading to sympathomimetic effects such as hypertension, tachycardia, bronchodilation, and agitation. PCP can also cause sedation, muscarinic, and nicotinic signs by binding to acetylcholine receptors and GABA receptors. Sigma receptor stimulation by PCP causes lethargy and coma.
- **Option D:** Most patients survive PCP intoxication with supportive care. Airway, breathing, circulation, and hemodynamic monitoring are essential to the care of patients with PCP toxicity. Intubation with ventilatory support may be required for airway protection. Gastrointestinal decontamination is generally unnecessary in PCP ingestions; however, activated charcoal may be beneficial with a massive ingestion of PCP or a dangerous coingestion. Activated charcoal therapy should only be started within one hour from the time of ingestion. The activated charcoal dose is 1 g/kg, with a maximum dose of 50 g.

6. A preoperative patient receives atropine before induction of anesthesia. The nurse caring for this patient understands that this agent is used to prevent:

- A. Anxiety.
- B. Bradycardia.
- C. Dry mouth.
- D. Hypertension.

Correct Answer: B. Bradycardia.

Atropine, an anticholinergic drug, is used as an adjunct to anesthesia to counter the effects of vagal stimulation, which is caused by surgical manipulations that trigger parasympathetic reflexes, resulting in bradycardia. Atropine is the first-line therapy (Class IIa) for symptomatic bradycardia in the absence of reversible causes. Treatments for bradydysrhythmias are indicated when there is a structural disease of the infra-nodal system or if the heart rate is less than 50 beats/min with unstable vital signs.

- **Option A:** Atropine is not anxiolytic. Acetylcholine works on three different receptors that merit attention in nerve agent poisonings. Atropine is only useful to counter muscarinic effects (pralidoxime and benzodiazepines act on the others). If there are local symptoms to the eyes or respiratory tract, atropine is not indicated. Intravenous (IV) atropine indications include patients with hypersalivation, bronchial secretions, or bradycardia.
- **Option C:** Atropine causes dry mouth and sometimes is used to minimize bronchial secretions. While atropine can be used independently for anti-salivation effects, it most commonly is secondary to anticholinergic or antimuscarinic poisoning, as discussed below. It is not formally recommended for routine use in controlled airways, though it can be used off-label for minimizing secretions in the intubated patient.
- **Option D:** Approximately 20% of bradydysrhythmias are due to endogenous cardiac electrical systems. The structural disease may or may not require resuscitation and should be closely monitored with medication and pacing readily available. If there is no improvement in the clinical state after repeat doses of atropine, additional treatments with atropine are unlikely to be effective. However, transient improvements with repeat dosing are an indication to continue treatment with atropine (which may exceed standard cumulative dosing maximums).

7. The nurse in charge is caring for a patient who is in the first stage of labor. What is the shortest but most difficult part of this stage?

- A. Active phase
- B. Complete phase
- C. Latent phase
- D. Transitional phase

Correct Answer: D. Transitional phase

The transitional phase, which lasts 1 to 3 hours, is the shortest but most difficult part of the first stage of labor. This phase is characterized by intense uterine contractions that occur every 1 ½ to 2 minutes and last 45 to 90 seconds.

- **Option A:** The active phase lasts 4 ½ to 6 hours; it is characterized by contractions that start out moderately intense, grow stronger, and last about 60 seconds.

- **Option B:** The complete phase occurs during the second, not first, stage of labor.
- **Option C:** The latent phase lasts 5 to 8 hours and is marked by mild, short, irregular contractions.

8. The nurse is preparing to discharge a patient with chronic low back pain. Which statement by the patient indicates that additional teaching is necessary?

- A. "I will avoid exercise because the pain gets worse."
- B. "I will use heat or ice to help control the pain."
- C. "I will not wear high-heeled shoes at home or work."
- D. "I will purchase a firm mattress to replace my old one."

Correct Answer: A. "I will avoid exercise because the pain gets worse."

Exercises are used to strengthen the back, relieve pressure on compressed nerves and protect the back from re-injury. Doing exercises to strengthen the lower back can help alleviate and prevent lower back pain. It can also strengthen the core, leg, and arm muscles. According to researchers, exercise also increases blood flow to the lower back area, which may reduce stiffness and speed up the healing process.

- **Option B:** Ice and heat application are appropriate interventions for back pain. Applying ice or a reusable gel pack constricts blood vessels and reduces swelling around the injury. This is particularly useful for conditions, like a sprained ankle, that cause significant swelling. Heat has the opposite effect, increasing blood flow to the area. This relaxes muscle fibers, which can help when the client experiences spasms or stiffness.
- **Option C:** People with chronic back pain should avoid wearing high-heeled shoes at all times. The normal s-curve of the spine acts as a cushion or spring, reducing stress on the vertebrae. When wearing high heels, the shape of the spine is altered and the client doesn't get that same shock absorption as she walks, which, over time, can lead to uneven wear on the cartilage discs, joints and ligaments of the back.
- **Option D:** A firm mattress prevents lower back pain. Sleeping on a mattress that is too firm can cause aches and pains on pressure points. A medium-firm mattress may be more comfortable because it allows the shoulder and hips to sink in slightly. Patients who want a firmer mattress for back support can get one with thicker padding for greater comfort.

9. Which of the following groups of clients are most at risk for GI bleeding from the use of NSAIDs?

- A. Clients with dysmenorrhea.
- B. Clients with headaches.
- C. Clients with arthritis.
- D. Clients with renal failure.

Correct Answer: C. Clients with arthritis.

Clients with arthritis are taking the drugs for prolonged periods of time and may take higher doses. Nonsteroidal anti-inflammatory drugs (NSAIDs) are a drug class FDA-approved for use as antipyretic, anti-inflammatory, and analgesic agents. These effects make NSAIDs useful for the treatment of muscle pain, dysmenorrhea, arthritic conditions, pyrexia, gout, migraines, and used as opioid-sparing

agents in certain acute trauma cases. Choices A and B are incorrect because the use of NSAIDs with these clients is intermittent.

- **Option A:** Gastric adverse effects are likely due to the inhibition of COX-1, preventing the creation of prostaglandins that protect the gastric mucosa. The damage is more likely in a patient that has a prior history of peptic ulcers. Since it is COX-1 specific, the use of COX-2 selective NSAIDs is a lower risk alternative.
- **Option B:** The main mechanism of action of NSAIDs is the inhibition of the enzyme cyclooxygenase (COX). Cyclooxygenase is required to convert arachidonic acid into thromboxanes, prostaglandins, and prostacyclins. The therapeutic effects of NSAIDs are attributed to the lack of these eicosanoids. Specifically, thromboxanes play a role in platelet adhesion, prostaglandins cause vasodilation, increase the temperature set-point in the hypothalamus, and play a role in anti-nociception.
- **Option D:** Renal failure is a contraindication for NSAIDs because most of the drug is excreted through the kidneys. Renal adverse effects are because COX-1 and COX-2 facilitate the production of prostaglandins that play a role in renal hemodynamics. In a patient with normal renal function, inhibition of prostaglandin synthesis does not pose a large problem; however, in a patient with renal dysfunction, these prostaglandins play a greater role and can be the source of problems when reduced via NSAIDs. Complications that can occur due to this are acute renal dysfunction, fluid and electrolyte disorders, renal papillary necrosis, and nephrotic syndrome/ interstitial nephritis.

10. Kitty, a 9-year-old child has a very limited vocabulary and interaction skills. She has an I.Q. of 45. She is diagnosed to have Mental retardation of this classification:

- A. Profound
- B. Mild
- C. Moderate
- D. Severe

Correct Answer: C. Moderate

The child with moderate mental retardation has an I.Q. of 35- 50. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the diagnosis of intellectual disability requires deficits in intellectual function, deficits in adaptive function, and onset before the age of 18. The IQ test is widely used to assess the intellectual function of individuals. IQ test derives from Stanford-Binet Intelligence Scales, used for school placement in France.

- **Option A:** Profound Mental retardation has an I.Q. of below 20. Lewis Terman adapted the test to measure general intelligence. Scores were reported as “mental age” divided by chronological age, multiplied by 100. The current version of the IQ test is standardized, and two standard deviations below the test taker’s group are calculated as IQ of 70. An IQ of 70 or below suggests an intellectual disability diagnosis.
- **Option B:** Mild mental retardation has an I.Q. of 50-70. However, it is no longer a standard to classify intellectual disability by IQ score alone. For instance, if an individual has IQ below 70, but has a good adaptive function, the subject does not have an intellectual disability. On the other side, individuals with a normal, or even higher than normal IQ, may manifest severe deficits in adaptive functions and are, therefore, classified as having an intellectual disability.

- **Option D:** Severe mental retardation has an I.Q. of 20-35. In turn, the current diagnosis of intellectual disability also considers a person's adaptive function. The Adaptive Behaviour Assessment System can measure adaptive function. It encompasses the social and practical domain. Adaptive function measures ability in communication, social participation, and independent living.

11. The nurse is caring for a client hospitalized with bipolar disorder, manic phase. Which of the following meals would be best for the client with mania?

- A. Canned beans
- B. Grapefruit juice
- C. Coffee
- D. Cold-water fish

Correct Answer: D. Cold-water fish

- **Option D:** High levels of omega-3 fats can improve conditions such as bipolar disorder, depression, mania, and other mental health diseases. Cold-water fish such as salmon and mackerel are rich in omega-3 fats which can benefit the client
- **Option A:** Canned beans are high in sodium, which causes the client to excrete the lithium (a medication that helps decrease manic symptoms).
- **Option B:** Grapefruit juice may interact with medications that treat bipolar disorder.
- **Option C:** Caffeine can trigger symptoms of mania. It impairs sleep, increases anxiety, and irritability.

12. When deciding on what time of day to give medications, the nurse pays the closest attention to the client's habits regarding:

- A. Eating
- B. Sleeping
- C. Elimination
- D. Activity

Correct Answer: A. Eating

Eating is the most important of these because food in the stomach must be a consideration. When a medicine is prescribed on an empty stomach, it is done to ensure the most effective absorption. The changes in the gut with food restrict and therefore affect the effectiveness of these particular medicines. In some cases, elements of food like iron or calcium might bind to chemical structures in medicine.

- **Option B:** Acute exposure to drugs of abuse disrupts sleep by affecting sleep latency, duration, and quality [1]. With chronic administration, sleep disruption becomes more severe, and during abstinence, insomnia with a negative effect prevails, which drives drug craving and contributes to impulsivity and relapse.
- **Option C:** All drugs are eventually eliminated from the body. They may be eliminated after being chemically altered (metabolized), or they may be eliminated intact. Most drugs, particularly water-soluble drugs and their metabolites, are eliminated largely by the kidneys in urine. Therefore,

drug dosing depends largely on kidney function. Some drugs are eliminated by excretion in the bile (a greenish-yellow fluid secreted by the liver and stored in the gallbladder)

- **Option D:** One important area that has been understudied to date is the relationship between medication use and both the rehabilitation process and habitual physical activity in people. Most people have more than one disease (referred to as multimorbidity) and hence take multiple medications. Just as some diseases may interfere with the ability to undertake physical activity (eg, arthritis, heart failure, or lung disease), it is plausible that some medications may either enhance or interfere with the ability to undertake physical activity or rehabilitation.

13. You're caring for a patient with a sigmoid colostomy. The stool from this colostomy is:

- A. Formed
- B. Semisolid
- C. Semiliquid
- D. Watery

Correct Answer: A. Formed

A colostomy in the sigmoid colon produces a solid, formed stool. This is the most common type. It is located in the bottom part of the large intestine. The sigmoid colon moves waste to the rectum. Sigmoid colostomies produce stool that is more solid and regular than other colostomies.

- **Option B:** The transverse colon crosses the top of the abdomen. Stool in this area is usually soft. This is because only a small portion of the colon has absorbed water from the indigestible material. This common type of colostomy has 3 versions.
- **Option C:** A double-barrel colostomy divides the colon into 2 ends that form separate stomas. Stool exits from 1 of the stomas. Mucus made by the colon exits from the other. This type of transverse colostomy is the least common. A loop colostomy creates a stoma through which stool exits. In this type, the colon stays connected to the rectum. As a result, people will sometimes pass stool or gas through the rectum.
- **Option D:** The ascending colon runs from the beginning of the large intestine to the right side of the abdomen. In this procedure, only part of the colon still works. As a result, little water is absorbed from the waste. This means the stool is usually liquid. This type of colostomy is rare. An ileostomy is more appropriate for this portion of the colon.

14. To differentiate as a female, the hormonal stimulation of the embryo that must occur involves which of the following?

- A. Increase in maternal estrogen secretion
- B. Decrease in maternal androgen secretion.
- C. Secretion of androgen by the fetal gonad.
- D. Secretion of estrogen by the fetal gonad.

Correct Answer: D. Secretion of estrogen by the fetal gonad.

The fetal gonad must secrete estrogen for the embryo to differentiate as a female.

- **Option A:** An increase in maternal estrogen secretion does not affect differentiation of the embryo, and maternal estrogen secretion occurs in every pregnancy.
- **Option B:** Maternal androgen secretion remains the same as before pregnancy and does not affect differentiation.
- **Option C:** Secretion of androgen by the fetal gonad would produce a male fetus.

15. Which of the following best describes pleural effusion?

- A. The collapse of alveoli.
- B. The collapse of bronchiole.
- C. The fluid in the alveolar space.
- D. The accumulation of fluid between the linings of the pleural space.

Correct Answer: D. The accumulation of fluid between the linings of the pleural space.

The pleural fluid normally seeps continually into the pleural space from the capillaries lining the parietal pleura and is reabsorbed by the visceral pleural capillaries and lymphatics. Any condition that interferes with either the secretion or drainage of this fluid will lead to a pleural effusion.

- **Option A:** The word “atelectasis” is Greek in origin; It is a combination of the Greek words atelez (ateles) and ektasiz (ektasis) meaning “imperfect” and “expansion” respectively. It results from the partial or complete, reversible collapse of the small airways leading to an impaired exchange of CO₂ and O₂ – i.e., intrapulmonary shunt.
- **Option B:** Bronchomalacia is a term for weak cartilage in the walls of the bronchial tubes, often occurring in children under a day. Bronchomalacia means ‘floppiness’ of some part of the bronchi. Patients present with noisy breathing and/or wheezing. There is collapse of a main stem bronchus on exhalation.
- **Option C:** The fluid within the alveoli, often referred to as alveolar fluid, is part of the alveolar surface network (Scarpelli, 2003). This network within the alveoli can be envisaged as a foam made of surfactant and water. The foam forms a network within the alveoli and has a gas: fluid volume ratio of 900:1 (Scarpelli, 2003).

16. Gio, a community health nurse, is instructing a group of female clients about breast self-examination. The nurse instructs the client to perform the examination:

- A. At the onset of menstruation
- B. Every month during ovulation
- C. Weekly at the same time of day
- D. 1 week after menstruation begins

Correct Answer: D. 1 week after menstruation begins

- **Option D:** The breast self-examination should be performed monthly 7 days after the onset of the menstrual period when the breasts are less tender and lumpy.
- **Options A and B:** At the onset of menstruation and during ovulation, hormonal changes occur that may alter breast tissue.

- **Option C:** Performing the examination weekly is not recommended.

17. A nurse is caring for a 46-year-old patient admitted with a diagnosis of Chronic Lymphocytic Leukemia (CLL). As part of the treatment regimen, the patient is scheduled for a bone marrow transplantation. The nurse is reviewing the patient's education plan concerning the procedure. Which of the following statements about bone marrow transplantation is NOT correct?

- A. The patient will be under local anesthesia during the procedure.
- B. The harvested bone marrow will be treated with heparin to prevent clotting.
- C. The bone marrow is typically aspirated from the posterior or anterior iliac crest.
- D. The patient will receive cyclophosphamide (Cytosan) for 4 consecutive days prior to the procedure.
- E. A series of chemotherapy and/or radiation therapy may be administered before the transplantation.
- F. The patient will be placed in protective isolation following the transplant to reduce the risk of infection.

Correct Answer: A. The patient will be under local anesthesia during the procedure.

Before the procedure, the patient is administered with drugs that would help to prevent infection and rejection of the transplanted cells such as antibiotics, cytotoxic, and corticosteroids. During the transplant, the patient is placed under general anesthesia.

18. A client with diabetes mellitus has a prescription for Glucotrol XL (glipizide). The client should be instructed to take the medication:

- A. With breakfast
- B. Before lunch
- C. After dinner
- D. At bedtime

Correct Answer: A. With breakfast

- Option A: Glucotrol XL is a medication that helps to treat type 2 diabetes. It is combined with diet and exercise and is given once a day with breakfast.
- Options B and C: The client would develop hypoglycemia later in the day or evening.
- Option D: The client would develop hypoglycemia while sleeping.

19. Which of the following foods should the nurse teach a client with heart failure to avoid or limit when following a 2-gram sodium diet?

- A. Apples
- B. Tomato juice
- C. Whole wheat bread

D. Beef tenderloin

Correct Answer: B. Tomato juice

Canned foods and juices, such as tomato juice, are typically high in sodium and should be avoided on a sodium-restricted diet. Canned and processed foods, such as gravies, instant cereal, packaged noodles, and potato mixes, olives, pickles, soups, and vegetables are high in salt. Choose the frozen item instead; or better yet, choose fresh foods when you can. Cheeses, cured meats (such as bacon, bologna, hot dogs, and sausages), fast foods, and frozen foods also may contain a lot of sodium.

- **Option A:** Choose plenty of fresh fruits and vegetables. They contain only small amounts of salt. Check the nutrition facts on the label for sodium content per serving. Find out the number of servings in the package. How does the sodium in each serving compare to the total sodium you can eat each day? Try to pick packaged foods with a sodium content of less than 350 milligrams for each serving.
- **Option C:** Be careful with condiments. High-sodium condiments include various flavored salts, lemon pepper, garlic salt, onion salt, meat tenderizers, flavor enhancers, bouillon cubes, catsup, mustard, steak sauce and soy sauce.
- **Option D:** Choose foods that are low in salt, such as fresh meats, poultry, fish, dry and fresh legumes, eggs, milk, and yogurt. Plain rice, pasta, and oatmeal are good low-sodium choices. However, the sodium content can increase if salt or other high-sodium ingredients are added during their preparation.

20. During the initial care of rape victims, the following are to be considered except:

- A. Assure privacy.
- B. Touch the client to show acceptance and empathy.
- C. Accompany the client to the examination room.
- D. Maintain a non-judgmental approach.

Correct Answer: B. Touch the client to show acceptance and empathy.

The client finds touch intrusive and therefore should be avoided. Establish trust and rapport. Since the victim may misinterpret any statements unrelated to her immediate situation as blaming or rejecting, the nurse should delay asking questions until the therapeutic nature is established.

- **Option A:** Privacy is one of the rights of a victim of rape. Provide strict confidentiality. The client's situation is not to be talked over with anyone other than medical staff involved unless the client gives consent to it.
- **Option C:** The client is anxious. Accompanying the client in a quiet room ensures the safety and offers emotional support. Have someone stay with the client (friend, neighbor, or staff member) while he or she waits to be treated. People with high levels of anxiety need to feel physical safety by providing someone by his/her side until the anxiety level is down to moderate.
- **Option D:** Guilt feeling is common among rape victims. They should not be blamed. Stress that they did the right thing to save their life. Rape victims might feel guilt and shame. Reinforcing that they did what they had to do to stay alive can reduce guilt and maintain self-esteem.

21. Nausea and vomiting are common adverse effects of radiation and chemotherapy. When should a nurse administer antiemetics?

- A. When therapy is completed
- B. Immediately after nausea begins
- C. With the administration of therapy
- D. 30 minutes before the initiation of therapy

Correct Answer: D. 30 minutes before the initiation of therapy

- **Option D:** Antiemetics are most beneficial when given before the onset of nausea and vomiting. To calculate the optimum time for administration, the first dose is given 30 minutes to 1 hour before nausea is expected, and then every 2, 4, or 6 hours for approximately 24 hours after chemotherapy.
- **Options A, B, and C:** If the antiemetic was given with the medication or after the medication, it could lose its maximum effectiveness when needed.

22. Following myocardial infarction, a hospitalized patient is encouraged to practice frequent leg exercises and ambulate in the hallway as directed by his physician. Which of the following choices reflects the purpose of exercise for this patient?

- A. Increases fitness and prevents future heart attacks
- B. Prevents bedsores
- C. Prevents DVT (deep vein thrombosis)
- D. Prevent constipations

Correct Answer: C. Prevents DVT (deep vein thrombosis)

Exercise is important for all hospitalized patients to prevent deep vein thrombosis. Muscular contraction promotes venous return and prevents hemostasis in the lower extremities.

- **Options A, B, and D:** This exercise is not sufficiently vigorous to increase physical fitness, nor is it intended to prevent bedsores or constipation.

23. When the nurse checks the fundus of a client on the first postpartum day, she notes that the fundus is firm, is at the level of the umbilicus, and is displaced to the right. The next action the nurse should take is to:

- A. Check the client for bladder distention
- B. Assess the blood pressure for hypotension
- C. Determine whether an oxytocic drug was given
- D. Check for the expulsion of small clots

Correct Answer: A. Check the client for bladder distention

If the fundus of the client is displaced to the side, this might indicate a full bladder. The next action by the nurse should be to check for bladder distention and catheterize, if necessary. The uterus continues to contract after delivery, and its size decreases rapidly as estrogen and progesterone levels diminish. Immediately after delivery, the upper portion of the uterus, known as the fundus, is midline and palpable halfway between the symphysis pubis and the umbilicus.

- **Option B:** Primary responsibilities of nurses in postpartum settings are to assess postpartum patients, provide care and teaching, and if necessary, report any significant findings. It is imperative for nurses to distinguish between normal and abnormal findings and to have a clear understanding of the nursing care necessary to promote patients' health and well-being.
- **Option C:** By approximately one-hour post-delivery, the fundus is firm and at the level of the umbilicus. The fundus continues to descend into the pelvis at the rate of approximately one centimeter (finger-breadth) per day and should be nonpalpable by two weeks postpartum.
- **Option D:** These are actions that relate to postpartum hemorrhage. After delivery, the endometrial surface of the uterus is shed via the vagina. The shedding endometrium is known as lochia. Menstruation does not typically return until 12 weeks or later. However ovulation can return prior to menses, and it is important for healthcare providers to discuss family planning with patients during the early postpartum period in order to prevent undesired pregnancies.

24. A pregnant woman is advised to alter her diet during pregnancy by increasing her protein and Vitamin C to meet the needs of the growing fetus. Which diet best meets the client's needs?

- A. Scrambled egg, hash browned potatoes, half-glass of buttermilk, small nectarine
- B. 3oz. Chicken, ½ cup corn, lettuce salad, small banana
- C. 1 C. macaroni, ¾ cup peas, whole glass milk, medium pear
- D. Beef, ½ cup Lima beans, glass of skim milk, ¾ cup strawberries

Correct Answer: D. Beef, ½ C. Lima beans, a glass of skim milk, ¾ cup strawberries

Increasing vitamin C intake helps the pregnant woman in the absorption of iron while protein aids in building the baby's bones, muscles, and other tissues during the second and third trimester. Beef and beans are an excellent source of protein as is skim milk. Strawberries are a good source of Vitamin C.

- **Option A:** Hash browns, quick-cook oats, bacon, and even eggs (prepared in restaurants) can be loaded with sodium. Sodium causes the woman to retain water, which leaves her bloated from the start of the day.
- **Option B:** Oranges have a perfect score of 100, earning more credit than apples (96) and bananas (91) due to high concentrations of vitamin C, fiber, calcium, folate, bioflavonoids, and carotenoids.
- **Option C:** They contain the least amount of protein and vitamins needed for the growing fetus. A pregnant woman can have around three glasses of milk, preferably the low-fat or non-fat variety, every day to benefit from it.

25. A 50-year-old patient, who is blind and deaf and has recently undergone a major abdominal surgery, has been admitted to your post-operative floor. The patient has a history of anxiety and has been on medication for the same. As the charge nurse, considering the patient's sensory deficits, recent surgery, and psychological background, what should be your primary responsibility for

this patient?

- A. Let others know about the patient's deficits.
- B. Communicate with your supervisor your patient safety concerns.
- C. Continuously update the patient on the social environment.
- D. Provide a secure environment for the patient.
- E. Arrange for specialized communication tools or interpreters to facilitate patient interaction.
- F. Monitor the patient's anxiety levels and liaise with the psychiatrist for potential medication adjustments.

Correct Answer: D. Provide a secure environment for the patient.

This patient's safety is your primary concern. Patient safety protocols can help reduce medical mistakes and prevent adverse patient outcomes. When the goal is to help people, it seems obvious that it's important to work to protect them from unintended or unexpected harm. Given the patient's sensory deficits, recent surgery, and history of anxiety, creating a safe environment becomes paramount. This encompasses both physical safety (preventing falls, ensuring surgical recovery) and emotional safety (addressing anxiety, ensuring the patient feels secure).

26. The client is to undergo kidney transplantation with a living donor. Which of the following preoperative assessments is important?

- A. Urine output
- B. Signs of graft rejection
- C. Signs and symptoms of infection
- D. Client's support system and understanding of lifestyle changes.

Correct Answer: D. Client's support system and understanding of lifestyle changes.

The client undergoing renal transplantation will need vigilant follow-up care and must adhere to the medical regimen. For many people, getting a kidney transplant can feel like getting another chance at life. There are many great things that come with getting a kidney transplant, like having more time in the day and more freedom. There are also many things the client should consider in the life after transplant that involve taking care of the new kidney.

- **Option A:** The client is most likely anuric or oliguric preoperatively but postoperatively will require close monitoring of urine output to make sure the transplanted kidney is functioning optimally. Those patients who were followed for 6 months post-transplant were observed to have a mean urine volume of 3.20 +/- 1.24 L at the end of this period. This trend showed that urine volume steadily decreased from 24 and 48 hours to 1 month after renal transplantation
- **Option B:** Rejection can occur postoperatively. Though kidney transplants are often successful, there are some cases when they are not. It is possible that the body may refuse to accept the donated kidney shortly after it is placed in the body. It is also possible the new kidney may stop working overtime.
- **Option C:** While the client will always need to be monitored for signs and symptoms of infection, it's most important postoperatively due to the immunosuppressant therapy. One risk of a kidney transplant is that the body will reject (fight) the new kidney. This can happen if the body's immune system realizes that the kidney is from someone else. To prevent this from happening, the client

must take medicines to weaken the immune system. These medicines are called immunosuppressants, or anti-rejection medicines.

27. The nurse is giving instructions to a client receiving phenytoin (Dilantin). The nurse concludes that the client has a sufficient knowledge if the client states that:

- A. "Wearing a medical alert tag is not required".
- B. "Alcohol is permitted while taking this medication".
- C. "I can take the medicine with milk".
- D. "Have the serum phenytoin level taken before giving the medication".

Correct Answer: D. "Have the serum phenytoin level taken before giving the medication".

Taking the prescribed daily dosage to keep the blood level of the drug constant and having a sample drawn for serum drug level before taking the morning dose.

- **Option A:** Wearing a medical tag allows any medical care provider to know that the client is on seizure medication.
- **Option B:** Alcohol use can increase the blood levels of phenytoin and may increase side effects.
- **Option C:** Taking it with milk will impair the absorption.

28. Which of the following would the nurse identify as the initial priority for a child with acute lymphocytic leukemia?

- A. Instituting infection control precautions.
- B. Encouraging adequate intake of iron-rich foods.
- C. Assisting with coping with chronic illness.
- D. Administering medications via IM injections.

Correct Answer: A. Instituting infection control precautions

Acute lymphocytic leukemia (ALL) causes leukopenia, resulting in immunosuppression and increasing the risk of infection, a leading cause of death in children with ALL. Therefore, the initial priority nursing intervention would be to institute infection control precautions to decrease the risk of infection.

- **Option B:** Iron-rich foods help with anemia, but dietary iron is not an initial intervention. For the treatment of iron deficiency anemia in adults, 100 to 200 mg of elemental iron per day has been recommended. The best way to take the supplement so that it can be absorbed in the greatest amount of iron is to take it in two or more doses during the day.
- **Option C:** The prognosis of ALL usually is good. However, later on, the nurse may need to assist the child and family with coping since death and dying may still be an issue in need of discussion.
- **Option D:** Injections should be discouraged, owing to increased risk of bleeding due to thrombocytopenia.

29. A nurse assesses a client who has episodes of autonomic dysreflexia. Which of the following conditions can cause autonomic dysreflexia?

- A. Headache
- B. Lumbar spinal cord injury
- C. Neurogenic shock
- D. Noxious stimuli

Correct Answer: D. Noxious stimuli

Noxious stimuli, such as a full bladder, fecal impaction, or a decubitus ulcer, may cause autonomic dysreflexia. Dysregulation of the autonomic nervous system leads to an uncoordinated autonomic response that may result in a potentially life-threatening hypertensive episode when there is a noxious stimulus below the level of the spinal cord injury. In about 85% of cases, this stimulus is from a urological source such as a UTI, a distended bladder, or a clogged Foley catheter.

- **Option A:** A headache is a symptom of autonomic dysreflexia, not a cause. Autonomic dysreflexia should be strongly suspected in any spinal cord injured patient with a lesion above T6 who complains of a headache. A blood pressure reading should be taken immediately, and corrective treatment starts if the patient's blood pressure is significantly elevated as most spinal cord injured patients have low blood pressure.
- **Option B:** Autonomic dysreflexia is most commonly seen with injuries at T10 or above. Spinal cord injuries below T10 rarely result in autonomic dysreflexia because the splanchnic innervation remains intact and allows for compensatory parasympathetic dilation of the splanchnic vascular bed. The etiology is a spinal cord injury, usually above the T6 level. It is unlikely to occur if the level is below T10. The higher the injury level, the greater the severity of the cardiovascular dysfunction.
- **Option C:** Neurogenic shock isn't a cause of dysreflexia. The severity and frequency of autonomic dysreflexia episodes are also associated with the completeness of the spinal cord injury. Patients usually develop autonomic dysreflexia one month to one year after their injury. However, it has also been described in the first days or weeks after the original trauma. Objectively, an episode is defined as an increase in systolic blood pressure of 25 mm Hg.

30. The home health nurse is visiting a client with autoimmune thrombocytopenic purpura (ATP). The client's platelet count currently is 80, it will be most important to teach the client and family about:

- A. Bleeding precautions
- B. Prevention of falls
- C. Oxygen therapy
- D. Conservation of energy

Correct Answer: A. Bleeding precautions

The normal platelet count is 120,000–400, Bleeding occurs in clients with low platelets. The priority is to prevent and minimize bleeding. Review laboratory results for coagulation status as appropriate: platelet count, prothrombin time/international normalized ratio (PT/INR), activated partial thromboplastin time (aPTT), fibrinogen, bleeding time, fibrin degradation products, vitamin K, activated coagulation time (ACT); and educate the at-risk patient and caregivers about precautionary measures to prevent tissue trauma or disruption of the normal clotting mechanisms.

- **Option B:** Thoroughly conform patient to surroundings; put call light within reach and teach how to call for assistance; respond to call light immediately; avoid use of restraints; obtain a physician's order if restraints are needed; and eliminate or drop all possible hazards in the room such as razors, medications, and matches.
- **Option C:** Option C is important, but platelets do not carry oxygen. Wash hands and teach patient and SO to wash hands before contact with patients and between procedures with the patient; encourage fluid intake of 2,000 to 3,000 mL of water per day, unless contraindicated.
- **Option D:** Option D is of lesser priority and is incorrect in this instance. Recommend the use of soft-bristled toothbrushes and stool softeners to protect mucous membranes; and if infection occurs, teach the patient to take antibiotics as prescribed; instruct the patient to take the full course of antibiotics even if symptoms improve or disappear.

31. Findings during an endoscopic exam include a cobblestone appearance of the colon in your patient. The findings are characteristic of which disorder?

- A. Ulcer
- B. Crohn's disease
- C. Chronic gastritis
- D. Ulcerative colitis

Correct Answer: B. Crohn's disease

Crohn's disease penetrates the mucosa of the colon through all layers and destroys the colon in patches, which creates a cobblestone appearance. As the inflammation progresses, non-caseating granulomas form involving all layers of the intestinal wall. It can develop into the classic cobblestone mucosal appearances and skip lesions along the length of the intestine sparing areas with normal mucosa.

- **Option A:** In a gastric ulcer, on histopathology, one will see an ulcer base with clear margins that penetrate the muscularis propria and into the submucosa. Inflammatory debris on the epithelial surface is often present. In the submucosa, one will see fibrosis and thickened blood vessels.
- **Option C:** H. pylori infection's first appearance of gastritis tends to be antral. The inflammation, composing mainly of mononuclear inflammatory cells and plasma cells are superficial and mostly in the upper layers of the mucosa of the corpus (body of the stomach). The chronic inflammation of gastric mucosa is associated with neutrophilic inflammation; the effects are dependent on the cytotoxicity of the H. pylori strain.
- **Option D:** Histologically, the mucosal layer of the colon in a patient with ulcerative colitis includes infiltrates of varying density and composition, depending on the stage of the disease. These infiltrates primarily consist of lymphocytes, plasma cells, and granulocytes, with the latter being more prominent during acute flares of the disease.

32. A nurse educator is preparing a seminar for a group of new graduate nurses who will be starting their careers in the pediatric intensive care unit. Given the vulnerability of the pediatric population to certain infections, the educator wants to emphasize the importance of understanding meningitis and its causative agents. When discussing the microorganisms responsible for meningitis in humans, which of the following should the nurse educator

highlight as NOT being linked to meningitis?

- A. S. pneumoniae
- B. H. influenzae
- C. N. meningitidis
- D. Cl. difficile

Correct Answer: D. Cl. difficile

Cl. difficile has not been linked to meningitis. Clostridium difficile (C. diff) is a germ (bacteria) that causes life-threatening diarrhea. It is usually a side-effect of taking antibiotics.

- **Option A:** Pneumococcal meningitis is caused by Streptococcus pneumoniae. The most common route of infection starts by nasopharyngeal colonization by Streptococcus pneumoniae, which must avoid mucosal entrapment and evade the host immune system after local activation.
- **Option B:** H influenzae meningitis is caused by Haemophilus influenzae type B bacteria. It is the leading cause of bacterial meningitis in children under age 5. Haemophilus species are small oxidase-positive pleomorphic gram-negative aerobic or facultative anaerobic coccobacilli. Humans are the only known host for Haemophilus influenza.
- **Option C:** Bacteria called Neisseria meningitidis cause meningococcal disease. About 1 in 10 people have these bacteria in the back of their nose and throat without being ill.

33. The nurse is preparing to teach a client about the prescribed spironolactone (Aldactone) to monitor for adverse effects of the drug. The nurse should instruct the client about which adverse effects? Select all that apply.

- A. Confusion.
- B. Fatigue.
- C. Hypertension.
- D. Leg cramps.
- E. Weakness.
- F. Urinary retention.

Correct Answer: A, B, & E.

Spironolactone (Aldactone) is used to treat hypertension and edema by removing excess fluid. Aldactone is known as a potassium-sparing diuretic. Confusion, fatigue, and weakness are signs of hyperkalemia, an adverse effect of spironolactone.

- **Option A:** One study mentions the following additional adverse effects in order from more to less common: dehydration, hyponatremia, gastrointestinal problems (nausea, vomiting, diarrhea or anorexia), neurological abnormalities (headache, drowsiness, asterixis, confusion, or coma), and skin rashes.
- **Option B:** Spironolactone blocks the hormone aldosterone, which can lead to fatigue. In addition, it can lower the blood pressure, and if this drop is sudden, the client may feel tired.
- **Option C:** Spironolactone is used to treat hypertension, so it would not produce this effect. Spironolactone is recommended in patients with resistant hypertension which is defined as

uncontrolled blood pressure despite three antihypertensive drug combinations including a diuretic. Spironolactone is a mineralocorticoid receptor antagonist and causes anti-androgenic side effects.

- **Option D:** Leg cramps are an adverse effect of hypokalemia. Hyperkalemia is an adverse effect of spironolactone. This drug is contraindicated in patients with hyperkalemia and in those at increased risk of developing hyperkalemia.
- **Option E:** Symptoms of hypokalemia may include attacks of severe muscle weakness, eventually leading to paralysis and possibly respiratory failure. Muscular malfunction may result in paralysis of the bowel, low blood pressure, muscle twitches and mineral deficiencies (tetany).
- **Option F:** Urinary retention is a side effect of anticholinergics. Medications with anticholinergic properties, such as tricyclic antidepressants, cause urinary retention by decreasing bladder detrusor muscle contraction.

34. Which organization's standards require that all patients be assessed specifically for pain?

- A. American Nurses Association (ANA)
- B. State nurse practice acts
- C. National Council of State Boards of Nursing (NCSBN)
- D. The Joint Commission

Correct Answer: D. The Joint Commission

The Joint Commission has developed assessment standards, including that all clients be assessed for pain.

- **Option A:** The ANA has developed standards for clinical practice, including those for assessment, but not specifically for pain. The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 4 million registered nurses. ANA is at the forefront of improving the quality of health care for all. Founded in 1896, and with members in all 50 states and U.S. territories, ANA is the strongest voice for the profession.
- **Option B:** State nurse practice acts regulate nursing practice in individual states. An NPA is enacted by state legislation and its purpose is to govern and guide nursing practice within that state. An NPA is actually a law and must be adhered to as law. Each state has a Board of Nursing (BON) that interprets and enforces the rules of the NPA.
- **Option C:** The NCSBN asserts that the scope of nursing includes a comprehensive assessment but does not specifically include pain. National Council of State Boards of Nursing (NCSBN) is an independent, not-for-profit organization through which nursing regulatory bodies act and counsel together on matters of common interest and concern affecting public health, safety, and welfare, including the development of nursing licensure examinations.

35. What is the appropriate infusion time for the dialysate in your 38 y.o. patient with chronic renal failure undergoing peritoneal dialysis?

- A. 15 minutes
- B. 30 minutes
- C. 1 hour

D. 2 to 3 hours

Correct Answer: A. 15 minutes

Dialysate should be infused quickly. The dialysate should be infused over 15 minutes or less when performing peritoneal dialysis. The fluid exchange takes place over a period ranging from 30 minutes to several hours. Each exchange takes about 30 to 40 minutes. During an exchange, the client can read, talk, watch television, or sleep. With CAPD, the client can keep the solution in the belly for 4 to 6 hours or more. The time that the dialysis solution is in the belly is called the dwell time. Usually, the client changes the solution at least four times a day and sleep with solution in the belly at night

- **Option B:** The client's schedule will change as he works his dialysis exchanges into his routine. If he does CAPD during the day, he has some control over when he does the exchanges. However, he'll still need to stop his normal activities and take about 30 minutes to perform an exchange. If he does automated peritoneal dialysis, he'll have to set up his cyclor every night.
- **Option C:** Between exchanges, the client keeps his catheter and transfer set hidden inside his clothing. At the beginning of an exchange, he'll remove the disposable cap from the transfer set and connect the set to a tube that branches like the letter Y. One branch of the Y-tube connects to the drain bag, while the other connects to the bag of fresh dialysis solution.
- **Option D:** With automated peritoneal dialysis, a machine called a cyclor fills and empties the belly three to five times during the night. In the morning, the client begins the day with a fresh solution in his belly. He may leave this solution in his belly all day or do one exchange in the middle of the afternoon without the machine. People sometimes call this treatment continuous cyclor-assisted peritoneal dialysis or CCPD.