

Kevin's Review - 35 NCLEX Practice Questions

1. Which of the following characteristics is expected for a client with paranoid personality disorder who receives bad news?

- A. The client is overly dramatic after hearing the facts.
- B. The client focuses on self to not become over-anxious.
- C. The client responds from a rational, objective point of view.
- D. The client doesn't spend time thinking about the information.

Correct Answer: C. The client responds from a rational, objective point of view.

Clients with paranoid personality disorder are affectively restricted, appear unemotional, and appear rational and objective. People with PPD are always on guard, believing that others are constantly trying to demean, harm, or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, interfere with their ability to form close or even workable relationships.

- **Option A:** Histrionic personality disorder, or dramatic personality disorder, is a psychiatric disorder distinguished by a pattern of exaggerated emotionality and attention-seeking behaviors. Histrionic personality disorder falls within the "Cluster B" of personality disorders.
- **Option B:** Narcissistic personality disorder (NPD) is an enduring pattern of inner experience and behavior characterized by self-centeredness, lack of empathy, and an exaggerated sense of self-importance. People with narcissistic personality disorder are typically described as arrogant, conceited, self-centered, and haughty. Because they imagine themselves as superior to others, they often insist on possessing items that reflect a successful lifestyle.
- **Option D:** Avoidant personality disorder (AVPD) is an enduring pattern of behavior related to social inhibition, feelings of inadequacy, and sensitivity to rejection that causes problems in work situations and relationships. The disorder is characterized by extreme shyness and sensitivity to criticism from others and is known as a Cluster C personality disorder or one that involves anxious and fearful personality disorders.

2. Chloride helps maintain acid-base balance by performing which of the following roles?

- A. Participating in the chloride shift.
- B. Following sodium to maintain serum osmolarity.
- C. Maintaining the balance of cations in the ICF and ECF.
- D. Separating carbonic acid.

Correct Answer: A. Participating in the chloride shift.

To maintain acid-base balance, chloride shifts into and out of red blood cells in exchange for bicarbonate. In the presence of an acid-base imbalance, chloride levels change independently of sodium. Because of its inverse relationship with bicarbonate, chloride losses result in an increase in bicarbonate, and chloride gains result in a decrease in bicarbonate.

- **Option B:** Sodium ions are reabsorbed at the membrane, and hydrogen ions are expelled into the filtrate. The hydrogen ions combine with bicarbonate, forming carbonic acid, which dissociates into CO₂ gas and water.
- **Option C:** The kidneys help maintain the acid-base balance by excreting hydrogen ions into the urine and reabsorbing bicarbonate from the urine. Acid-base homeostasis concerns the proper

balance between acids and bases; it is also called body pH. The body is very sensitive to its pH level, so strong mechanisms exist to maintain it.

- **Option D:** This reaction can and does occur without an enzyme; however, carbonic anhydrase is an enzyme that assists with this process. It catalyzes the first reaction above to form carbonic acid which can then freely dissociate into bicarbonate and a hydrogen ion. Carbonic anhydrase is located in red blood cells, renal tubules, gastric mucosa, and pancreatic cells.

3. The following are interventions to make the fundus contract postpartally, except:

- A. Make the baby suck the breast regularly.
- B. Apply ice cap on fundus.
- C. Massage the fundus vigorously for 15 minutes until contracted.
- D. Give oxytocin as ordered.

Correct Answer: C. Massage the fundus vigorously for 15 minutes until contracted.

Massaging the fundus of the uterus should not be vigorous and should only be done until the uterus feels firm and contracted. If the massage is vigorous and prolonged, the uterus will relax due to overstimulation.

- **Option A:** If the woman breastfeeds, the hormone oxytocin is released, which causes the uterus to contract.
- **Option B:** Cooling the uterus by placing an icepack on the lower abdomen is one of the standard non-pharmacological prophylactic strategies to prevent PPH in Japan; the reasoning is that cold compresses may help to contract the myometrium and decrease blood loss. Cold therapy causes blood vessels within the smooth muscles to constrict, which subsequently decreases blood flow. Furthermore, blood vessels in the skin are affected by cold, resulting in somatovisceral reflex and subsequent vasoconstriction of relevant internal organs
- **Option D:** Prophylactic administration of oxytocin (Pitocin) reduces rates of postpartum hemorrhage by 40 percent; this reduction also occurs if oxytocin is given after placental delivery. Oxytocin is the drug of choice for preventing postpartum hemorrhage because it is at least as effective as ergot alkaloids or prostaglandins and has fewer side effects. Misoprostol (Cytotec) has a role in the prevention of postpartum hemorrhage; this agent has more side effects but is inexpensive, heat- and light-stable, and requires no syringes.

4. Barbara with bipolar disorder is being treated with lithium for the first time. Nurse Clint should observe the client for which common adverse effect of lithium?

- A. Polyuria
- B. Seizures
- C. Constipation
- D. Sexual dysfunction

Correct Answer: A. Polyuria

Polyuria commonly occurs early in the treatment with lithium and could result in fluid volume deficit. Before starting treatment with lithium, it is essential to get kidney function tests and thyroid function tests. Lithium is not recommended in patients with renal impairment. It is also not recommended in patients with cardiovascular disease. Avoid all diuretics. If the patient has severe renal dysfunction or failure, or severely altered mental status, then start with hemodialysis.

- **Option B:** Rarely, toxicity can cause pseudotumor cerebri and seizures. Lithium toxicity has no antidote. Treatment for lithium toxicity is primarily hydration and to stop the drug. Give hydration with normal saline, which will also enhance lithium excretion. 20 to 30 mg of propranolol given 2 to 3 times per day may help reduce tremors.
- **Option C:** It is also important to monitor patients for dehydration and lower the dose when there are signs of infection, excessive sweating, or diarrhea. Toxic levels are when the drug level is more than 2 mEq/L. Monitoring should be done every 1 to 2 weeks until reaching the desired therapeutic levels. Then, check lithium levels every 2 to 3 months for six months.
- **Option D:** Lithium has a very narrow therapeutic index, and toxic levels are when the drug is above 2 mEq/L, which is very close to its therapeutic range. Lithium toxicity can cause interstitial nephritis, arrhythmia, sick sinus syndrome, hypotension, T wave abnormalities, and bradycardia.

5. Mr. and Mrs. Andrews' child was diagnosed with Duchenne's muscular dystrophy; which of the following usually is the first indication of the condition?

- A. Inability to suck in the newborn
- B. Lateness in walking in the toddler
- C. Difficulty running in the preschooler
- D. Decreasing coordination in the school-age child

Correct Answer: C. Difficulty running in the preschooler

Usually, signs and symptoms of Duchenne's muscular dystrophy are not noticed until ages 3 to 5 years. Typically weakness starts with the pelvic girdle, evidenced as difficulty running in the preschooler. Duchenne's muscular dystrophy usually is not diagnosed in the infant or toddler period.

- **Option A:** Sucking is not the first sign of Duchenne's muscular dystrophy. In ambulatory patients, an increased incidence of fractures is noted as a consequence of the frequent falls. Enlargement of the calves with wasting of the thigh muscles results in pseudohypertrophy of the calves, which is a classical feature. Aside from the calves, hypertrophy of the tongue and muscles of the forearm may be seen but are less classical.
- **Option B:** Signs and symptoms of muscular dystrophy are not noticed until ages 3 to 5 years. Weakness and difficulty in ambulation is typically first noted between 2 and three years of life. This manifests as toe walking, difficulty running, climbing up stairs, and frequently falling.
- **Option D:** Mild hypotonia in an infant may be present, and poor head control in an infant may be an initial sign. Patients do not have atypical facies, but with the onset of facial muscle weakness, a transverse or horizontal sign may be seen in later childhood. Weakness is more pronounced in proximal than distal muscles and the lower limb more than the upper limb.

6. A patient is brought to the emergency department after a bee sting. The family reports a history of severe allergic reaction, and the patient appears to have some oral swelling. Which of the following is the most urgent nursing

action?

- A. Consult a physician.
- B. Maintain a patent airway.
- C. Administer epinephrine subcutaneously.
- D. Administer diphenhydramine (Benadryl) orally.

Correct Answer: B. Maintain a patent airway.

The patient may be experiencing an anaphylactic reaction. Airway management is paramount. Thoroughly examine the patient for airway patency or any indications of an impending loss of airway. Perioral edema, stridor, and angioedema are very high risk, and obtaining a definitive airway is imperative. Delay may reduce the chances of successful intubation as continued swelling occurs, increasing the risk for a surgical airway.

- **Option A:** The physician will see the patient as soon as possible with the above actions underway. Often when anaphylaxis is diagnosed co-treatment is initiated with steroids, antihistamines, inhaled bronchodilators, and vasopressors. Glucagon can also be used if indicated. These agents can assist in refractory initial anaphylaxis or aid in the prevention of recurrence and biphasic reactions.
- **Option C:** The most urgent action is to maintain an airway, particularly with visible oral swelling, followed by the administration of epinephrine by subcutaneous injection. Epinephrine is given through intramuscular injection and at a dose of 0.3 to 0.5 mL of 1:1,000 concentration of epinephrine. Pediatric dosing is 0.01 mg/kg or 0.15 mg intramuscularly (IM) (epinephrine injection for pediatric dosage). Intramuscular delivery has proven to provide more rapid delivery and produce better outcomes than subcutaneous or intravascular.
- **Option D:** Oral diphenhydramine is indicated for mild allergic reactions and is not appropriate for anaphylaxis. Antihistamines are often routinely used; most commonly is Hblocker administration of diphenhydramine 25 to 50 mg IV/IM. While the clinical benefit is unproven in anaphylaxis, its utility is evident in more minor allergic processes.

7. A female client with anorexia nervosa describes herself as “a whale.” However, the nurse’s assessment reveals that the client is 5’ 8” (1.7 m) tall and weighs only 90 lb (40.8 kg). Considering the client’s unrealistic body image, which intervention should nurse Angel be included in the plan of care?

- A. Asking the client to compare her figure with magazine photographs of women her age.
- B. Assigning the client to group therapy in which participants provide realistic feedback about her weight.
- C. Confronting the client about her actual appearance during one-on-one sessions, scheduled during each shift.
- D. Telling the client of the nurse’s concern for her health and desire to help her make decisions to keep her healthy.

Correct Answer: D. Telling the client of the nurse’s concern for her health and desire to help her make decisions to keep her healthy

A client with anorexia nervosa has an unrealistic body image that causes consumption of little or no food. Therefore, the client needs assistance with making decisions about health. Respond (confront) with reality when a patient makes unrealistic statements. The patient may be denying the psychological

aspects of their own situation and is often expressing a sense of inadequacy and depression.

- **Option A:** Instead of protecting the client's health, option A may serve to make the client defensive and more entrenched in her unrealistic body image. Allow the patient to draw a picture of self. It provides an opportunity to discuss the patient's perception of self and body image and realities of an individual situation.
- **Option B:** Encourage personal development program, preferably in a group setting. Provide information about the proper application of makeup and grooming. Learning about methods to enhance personal appearance may be helpful to a long-range sense of self-esteem and image. Feedback from others can promote feelings of self-worth.
- **Option C:** Establish a therapeutic nurse-patient relationship. Within a helping relationship, the patient can begin to trust and try out new thinking and behaviors. Assist the patient to assume control in areas other than dieting and weight loss such as management of their own daily activities, work, and leisure choices. Feelings of personal ineffectiveness, low self-esteem, and perfectionism are often part of the problem. The patient feels helpless to change and requires assistance to problem-solve methods of control in life situations.

8. The most important pathophysiological factor contributing to the formation of esophageal varices is:

- A. Decreased prothrombin formation.
- B. Decreased albumin formation by the liver.
- C. Portal hypertension.
- D. Increased central venous pressure.

Correct Answer: C. Portal hypertension

As the liver cells become fatty and degenerate, they are no longer able to accommodate a large amount of blood necessary for homeostasis. The pressure in the liver increases and causes increased pressure in the venous system. As the portal pressure increases, fluid exudes into the abdominal cavity. This is called ascites.

- **Option A:** Esophageal varices are dilated submucosal distal esophageal veins connecting the portal and systemic circulations. They form due to portal hypertension, which commonly is a result of cirrhosis, resistance to portal blood flow, and increased portal venous blood inflow. Variceal rupture is the most common fatal complication of cirrhosis. The severity of liver disease correlates with the presence of varices and the risk of bleeding.
- **Option B:** Increased resistance to portal flow at the level of hepatic sinusoids is caused by intrahepatic vasoconstriction due to decreased nitric oxide production, and increased release of endothelin-1 (ET-1), angiotensinogen, and eicosanoids; sinusoidal remodeling disrupting blood flow' and increased portal flow is caused by hyperdynamic circulation due to splanchnic arterial vasodilation through mediators such as nitric oxide, prostacyclin, and TNF.
- **Option D:** Portal hypertension causes portocaval anastomosis to develop to decompress portal circulation. Normal portal pressure is between 5-10 mmHg but in the presence of portal obstruction, the pressure may be as high as 15-20 mmHg. Since the portal venous system has no valves, resistance at any level between the splanchnic vessels and the right side of the heart results in retrograde flow and elevated pressure.

9. Kevin is remanded by the courts for psychiatric treatment. His police record, which dates to his early teenage years, includes delinquency, running away, auto theft, and vandalism. He dropped out of school at age 16 and has been living on his own since then. His history suggests maladaptive coping, which is associated with:

- A. Antisocial personality disorder
- B. Borderline personality disorder
- C. Obsessive-compulsive personality disorder
- D. Narcissistic personality disorder

Correct Answer: A. Antisocial personality disorder

The client's history of delinquency, running away from home, vandalism, and dropping out of school are characteristic of antisocial personality disorder. This maladaptive coping pattern is manifested by a disregard for societal norms of behavior and an inability to relate meaningfully to others. Antisocial personality disorder (ASPD) is a deeply ingrained and rigid dysfunctional thought process that focuses on social irresponsibility with exploitive, delinquent, and criminal behavior with no remorse. Disregard for and the violation of others' rights are common manifestations of this personality disorder, which displays symptoms that include failure to conform to the law, inability to sustain consistent employment, deception, manipulation for personal gain, and incapacity to form stable relationships.

- **Option B:** In borderline personality disorder, the client exhibits mood instability, poor self-image, identity disturbance, and labile affect. Borderline personality disorder (BPD) is 1 of 4 Cluster-B disorders that include borderline, antisocial, narcissistic, and histrionic. Borderline personality disorder (BPD) is characterized by hypersensitivity to rejection and resulting instability of interpersonal relationships, self-image, affect, and behavior.
- **Option C:** Obsessive-compulsive personality disorder is characterized by a preoccupation with impulses and thoughts that the client realizes are senseless but can't control. Obsessive-compulsive disorder (OCD) is often a disabling condition consisting of bothersome intrusive thoughts that elicit a feeling of discomfort. To reduce the anxiety and distress associated with these thoughts, the patient may employ compulsions or rituals. These rituals may be personal and private, or they may involve others to participate; the rituals are to compensate for the ego-dystonic feelings of the obsessional thoughts and can cause a significant decline in function.
- **Option D:** Narcissistic personality disorder is marked by a pattern of self-involvement, grandiosity, and demand for constant attention. Narcissistic personality disorder (NPD) is a pattern of grandiosity, need for admiration, and lack of empathy per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The disorder is classified in the dimensional model of "Personality Disorders." NPD is highly comorbid with other disorders in mental health.

10. When auscultating the apical pulse of a client who has atrial fibrillation, the nurse would expect to hear a rhythm that is characterized by:

- A. The presence of occasional coupled beats.
- B. Long pauses in an otherwise regular rhythm.
- C. A continuous and totally unpredictable irregularity.
- D. Slow but strong and regular beats.

Correct Answer: C. A continuous and totally unpredictable irregularity.

In atrial fibrillation, multiple ectopic foci stimulate the atria to contract. The AV node is unable to transmit all of these impulses to the ventricles, resulting in a pattern of highly irregular ventricular contractions. Due to its rhythm irregularity, blood flow through the heart becomes turbulent and has a high chance of forming a thrombus (blood clot), which can ultimately dislodge and cause a stroke. Atrial fibrillation is the leading cardiac cause of stroke.

- **Option A:** The most common sensation associated with PVCs is that of a skipped heartbeat followed by a fluttering sensation. Patients commonly present complaining of heart palpitations. The vast majority of patients are entirely asymptomatic as there are no associated symptoms with the palpitations.
- **Option B:** In the presence of a pause, one should exclude premature complexes with compensatory pause. If the ectopic beat failed to reset the sinus node, the premature complex would be followed by a compensatory pause, i.e. the R-R interval after the premature complex is longer than the R-R interval between normal sinus beats.
- **Option D:** Having bradycardia means that the heart beats very slowly. For most people, a heart rate of 60 to 100 beats a minute while at rest is considered normal. If the heart beats less than 60 times a minute, it is slower than normal. For some people, a slow heart rate does not cause any problems. It can be a sign of being very fit. Healthy young adults and athletes often have heart rates of less than 60 beats a minute.

11. Nurse Berta is facilitating a monthly mothers' class at a small village. As a knowledgeable nurse, she must know that a mother who breastfeeds her child passes on which antibody through breast milk?

- A. IgA
- B. IgE
- C. IgG
- D. IgM

Correct Answer: A. IgA

Antibodies, which are also called immunoglobulins, take five basic forms, indicated as IgG, IgA, IgM, IgD and IgE. All have been detected in human milk, but by far the most abundant type is IgA, particularly the form known as secretory IgA, which is found in great amounts throughout the gut and respiratory system of adults. The secretory IgA molecules passed to the suckling child are helpful in ways that go beyond their ability to bind to microorganisms and keep them away from the body's tissues.

- **Option B:** IgE is a monomer. It has a molecular weight of 188 Kd and a serum concentration of 0.00005 mg/mL. It protects against parasites and also binds to high-affinity receptors on mast cells and basophils causing allergic reactions. IgE is regarded as the most important host defense against different parasitic infections which include *Strongyloides stercoralis*, *Trichinella spiralis*, *Ascaris lumbricoides*, and the hookworms *Necator americanus* and *Ancylostoma duodenal*.
- **Option C:** IgG2 forms an important host defense against bacteria that are encapsulated. IgG is the only immunoglobulin that crosses the placenta as its Fc portion binds to the receptors present on the surface of the placenta, protecting the neonate from infectious diseases. IgG is thus the most abundant antibody present in newborns.

- **Option D:** IgM has a molecular weight of 970 Kd and an average serum concentration of 1.5 mg/ml. It is mainly produced in the primary immune response to infectious agents or antigens. It is a pentamer and activates the classical pathway of the complement system. IgM is regarded as a potent agglutinin (e.g., anti-A and anti-B isoagglutinin present in type B and type A blood respectively) and a monomer of IgM is used as a B cell receptor (BCR).

12. For a client who is taking aspirin, which laboratory value should be reported to the physician?

- A. Potassium 3.6 mEq/L
- B. Hematocrit 41%
- C. PT 14 seconds
- D. BUN 20 mg/dL

Correct Answer: C. PT 14 seconds

When a client takes aspirin, monitor for increases in PT (normal range 11.0-12.5 seconds in 85%-100%). Also, monitor for possible decreases in potassium (normal range 3.5-5.0 mEq/L). If bleeding signs are noted, hematocrit should be monitored (normal range male 42%-52%, female 37%-47%). An elevated BUN could be seen if the client is having chronic gastrointestinal bleeding (normal range 10-20 mg/dL).

- **Option A:** Severity is categorized as mild when the serum potassium level is 3 to 3.4 mmol/L, moderate when the serum potassium level is 2.5 to 3 mmol/L, and severe when the serum potassium level is less than 2.5 mmol/L. Values obtained from plasma and serum may differ.
- **Option B:** HCT calculation is by dividing the lengths of the packed RBC layer by the length of total cells and plasma. As it is a ratio, it doesn't have any unit. Multiplying the ratio by 100 gives the accurate value, which is the accepted reporting style for HCT. A normal adult male shows an HCT of 40% to 54% and female shows 36% to 48%.
- **Option D:** BUN and creatinine levels that are within the ranges established by the laboratory performing the test suggest that the kidneys are functioning as they should. Increased BUN and creatinine levels may mean that the kidneys are not working as they should. This healthcare practitioner will consider other factors, such as the medical history and physical exam, to determine what condition, if any, may be affecting the kidneys.

13. The physician has ordered aspirin therapy for a client with severe rheumatoid arthritis. A sign of acute aspirin toxicity is:

- A. Confusion
- B. Lactic acidosis
- C. Tinnitus
- D. Hypoxia

Correct Answer: C. Tinnitus

- **Option C:** Salicylates such as aspirin are neurotoxic. Acute aspirin toxicity can lead to temporary hearing loss and tinnitus.
- **Options A, B, and D:** Confusion, lactic acidosis, and hypoxia are signs of chronic aspirin overdose.

14. Calcium is absorbed in the GI tract under the influence of:

- A. Vitamin D
- B. Glucose
- C. HCl
- D. Vitamin C

Correct Answer: A. Vitamin D

Calcium is absorbed in the GI tract under the influence of vitamin D in its biologically active form. Vitamin D also increases the intestinal absorption of calcium, as well as bone resorption and the tubular reabsorption of calcium. The effects on intestinal reabsorption of calcium and bone resorption seem to be due primarily to the active metabolite 1,25-DHCC, but other metabolites may contribute to some of the other effects on serum calcium.

- **Option B:** Abnormal calcium regulation may contribute to reduced β -cells function, thereby promoting altered glucose homeostasis. In vitro studies have also found that high cytosolic calcium may contribute to insulin resistance within adipocytes and skeletal muscle.
- **Option C:** Oral calcium carbonate (0-5 g, pH 9-4) increased serum gastrin and gastric acid output with slight but insignificant change in serum calcium. A similar rise in serum calcium during an intravenous infusion of calcium gluconate failed to increase serum gastrin and gastric acid output.
- **Option D:** Vitamin C blocks cells that break down our bones and helps us make more cells responsible for bone formation. It also regulates important bone-building minerals, like calcium, in our bodies. Most people can get enough vitamin C through diet alone.

15. Following a generalized seizure, the nurse can expect the client to:

- A. Be unable to move the extremities
- B. Be drowsy and prone to sleep
- C. Remember events before the seizure
- D. Have a drop in blood pressure

Correct Answer: B. Be drowsy and prone to sleep

- **Option B:** When a generalized seizure ends, the client is experiencing the postictal phase, which is the recovery period following the seizure. The client in this phase shows symptoms of drowsiness, confusion, and sleepiness.
- **Option A:** The client is able to move the extremities.
- **Option C:** The client cannot remember events before the seizure.
- **Option D:** Blood pressure is elevated.

16. When discussing normal infant growth and development with parents, which of the following toys would the nurse suggest as most appropriate for an 8-month-old?

- A. Push-pull toys
- B. Rattle
- C. Large blocks
- D. Mobile

Correct Answer: C. Large blocks

Because the 8-month-old is refining his gross motor skills, being able to sit unsupported, and also improving his fine motor skills, probably capable of making hand-to-hand transfers, large blocks would be the most appropriate toy selection.

- **Option A:** Push-pull toys would be more appropriate for the 10 to 12-month-old as he or she begins to cruise the environment. Push toys provide support for babies who aren't quite ready to stand or walk on their own. Teetering behind a push toy helps build strength, balance, and confidence — three essential ingredients to becoming a champion walker. Like push toys, pull toys and ride-ons also boost balance and coordination.
- **Option B:** Rattles are more appropriate for infants in the 1 to 3 month age range. The sounds rattles make can also alert babies to noise. If they hear the sound of a rattle, babies will eventually turn their heads towards the sound. Many rattles also have moving parts that can be twisted, turned, and spun, which can help further develop a baby's attention span and fine motor skills.
- **Option D:** Mobiles pose a danger to older infants because of possible strangulation.

17. Jenny with an advanced breast cancer is prescribed Nolvadex (tamoxifen). When teaching the client about this drug, the nurse should emphasize the importance of reporting which adverse reaction immediately?

- A. Anorexia
- B. Headache
- C. Hearing loss
- D. Vision changes

Correct Answer: D. Vision changes

- **Option D:** Tamoxifen, a selective estrogen receptor modulator (SERM) causes ocular side effects such as dryness, irritation, and cataracts. The client must report changes in visual acuity immediately because this adverse effect may be irreversible.
- **Options A and B:** Although the drug may cause anorexia, headache, and hot flashes, the client need not report these adverse effects immediately because they don't warrant a change in therapy.
- **Option C:** Tamoxifen isn't associated with hearing loss.

18. You are a nurse on a pediatric unit, and are assigned to care for Tommy, an 8-year-old boy with a severe bacterial lung infection. Tommy has been receiving intravenous antibiotics for the past 10 days. During the morning assessment, Tommy mentions that he has been having frequent watery stools since the previous evening. You recall that antibiotic-associated diarrhea, particularly caused by Clostridium difficile, is a common problem in hospitalized patients.

Keeping Tommy's comfort and the safety of other patients in mind, you need to decide the appropriate initial action to manage this new symptom.

- A. Place the client on contact precaution.
- B. Instruct the client about correct handwashing.
- C. Obtain stool specimens for culture.
- D. Notify the physician about the loose stools.
- E. Administer antidiarrheal medication as a standing order.
- F. Educate the family about the importance of notifying the healthcare team regarding changes in bowel habits.

Correct Answer: A. Place the client on contact precaution.

Given the scenario, the first action should be to implement contact precautions to prevent the potential spread of a *Clostridium difficile* infection (or other infectious causes of diarrhea) to other vulnerable patients on the unit. It's crucial to follow infection control practices while the exact cause of diarrhea is being determined. In summary, in a clinical setting, ensuring the safety of all patients by preventing the spread of infection is paramount. Therefore, placing Tommy on contact precaution is the most appropriate initial action to take in response to his new symptom of frequent watery stools following a prolonged antibiotic treatment.

- **Option B:** While important, this action does not address the immediate need to prevent potential transmission of an infectious agent.
- **Option C:** This action is necessary to identify the causative agent of the diarrhea, but it does not take precedence over preventing the potential spread of infection.
- **Option D:** While it is important to notify the physician, the first action should be to prevent the potential spread of infection to other patients or staff on the unit.
- **Option E:** Administration of antidiarrheal medication without a specific order and before identifying the cause of diarrhea could potentially worsen the condition, especially if *Clostridium difficile* is the culprit.
- **Option F:** Although education is important, the priority should be to prevent potential transmission of an infectious agent to other patients.

19. A client is admitted to the labor and delivery unit. The nurse performs a vaginal exam and determines that the client's cervix is 5 cm dilated with 75% effacement. Based on the nurse's assessment the client is in which phase of labor?

- A. Active
- B. Latent
- C. Transition
- D. Early

Correct Answer: A. Active

The active phase of labor occurs when the client is dilated 4–7cm. Active labor with more rapid cervical dilation generally starts around 6 centimeters of dilation. During the active phase, the cervix typically

dilates at a rate of 1.2 to 1.5 centimeters per hour. Multiparas, or women with a history of prior vaginal delivery, tend to demonstrate more rapid cervical dilation. The absence of cervical change for greater than 4 hours in the presence of adequate contractions or six hours with inadequate contractions is considered the arrest of labor and may warrant clinical intervention.

- **Option B:** The latent phase is commonly defined as the 0 to 6 cm, while the active phase commences from 6 cm to full cervical dilation. The presenting fetal part also begins the process of engagement into the pelvis during the first stage. Throughout the first stage of labor, serial cervical exams are done to determine the position of the fetus, cervical dilation, and cervical effacement.
- **Option C:** The transition phase of labor is 8–10cm in dilation. The second stage of labor commences with complete cervical dilation to 10 centimeters and ends with the delivery of the neonate. This was also defined as the pelvic division phase by Friedman. After cervical dilation is complete, the fetus descends into the vaginal canal with or without maternal pushing efforts.
- **Option D:** The latent or early phase of labor is from 1cm to 3cm in dilation. During the latent phase, the cervix dilates slowly to approximately 6 centimeters. The latent phase is generally considerably longer and less predictable with regard to the rate of cervical change than is observed in the active phase. A normal latent phase can last up to 20 hours and 14 hours in nulliparous and multiparous women respectively, without being considered prolonged.

20. The following statements appear on a nursing care plan for a client after a mastectomy: Incision site approximated; absence of drainage or prolonged erythema at the incision site; and the client remains afebrile. These statements are examples of:

- A. Nursing interventions
- B. Short-term goals
- C. Long-term goals
- D. Expected outcomes

Correct Answer: D. Expected outcomes

Goals or desired outcomes describe what the nurse hopes to achieve by implementing the nursing interventions and are derived from the client's nursing diagnoses. One overall goal is determined for each nursing diagnosis. The terms goal, outcome, and expected outcome are oftentimes used interchangeably.

- **Option A:** Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis.
- **Option B:** Short-term goals can act as stepping stones to achieving longer-term targets. For example, a client may have the long-term goal of being able to groom herself, including cleaning her teeth, washing her face, combing her hair, and applying her make-up on her own. A short-term goal for this client might be to be able to clean her teeth.
- **Option C:** Long-term goals are often used for clients who have chronic health problems or who live at home, in nursing homes, or extended-care facilities. Long-term goal indicates an objective to be completed over a longer period, usually over weeks or months.

21. A client is admitted to the unit with the diagnosis of Deficient Fluid Volume related to excessive fluid loss. Which action related to fluid management should be charged to a nursing assistant?

- A. Administer intravenous (IV) fluids as prescribed by the physician.
- B. Develop a plan for added fluid intake over 24 hours.
- C. Provide straws and offer fluids between meals.
- D. Educate family members to assist the client with fluid intake.

Correct Answer: C. Provide straws and offer fluids between meals.

Additional fluid intake can be reinforced by the nursing assistance once it is part of the care plan. A CNA's main role is to provide patients with basic care and assist them in their everyday activities, particularly when patients have a hard time doing a few activities on their own, such as bathing.

- **Option A:** In some hospitals, a CNA will administer a patient's medication. Usually, however, this depends on the CNA's level of experience and training, as well as the regulations of the state.
- **Option B:** Among the tasks that CANNOT be legally and appropriately delegated to nursing assistants include assessments, nursing diagnosis, establishing expected outcomes, evaluating care and any and all other tasks and aspects of care.
- **Option D:** Educating families demand further education and skills that are within the field of practice of an RN. Based on the basic entry educational preparation differences among these members of the nursing team, care should be assigned according to the level of education of the particular team member.

22. A 25-year-old male is admitted in sickle cell crisis. Which of the following interventions would be of the highest priority for this client?

- A. Taking hourly blood pressures with mechanical cuff
- B. Encouraging fluid intake of at least 200mL per hour
- C. Position in high Fowler's with knee gatch raised
- D. Administering Tylenol as ordered

Correct Answer: B. Encouraging fluid intake of at least 200mL per hour

It is important to keep the client in sickle cell crisis hydrated to prevent further sickling of the blood.

- **Option A:** Taking hourly blood pressures with mechanical cuff is incorrect because a mechanical cuff places too much pressure on the arm.
- **Option C:** Position in high Fowler's with knee gatch raised is inappropriate because it impedes circulation.
- **Option D:** Administering Tylenol is too mild an analgesic for the client in crisis.

23. Which of the following route should the nurse expect the pain medication to be given to a client who was admitted with extensive burns?

- A. Oral

- B. Intramuscular
- C. Subcutaneous
- D. Intravenous

Correct Answer: D. Intravenous

For clients with major burns, the intravascular route is the preferred choice of medication administration. Patient-controlled analgesia (PCA) with IV opioids is a safe and efficient method of achieving flexible analgesia in burn-injured patients. Studies comparing PCA with other routes of administration have shown mixed results as to benefit and patient satisfaction.

- **Option A:** Oral NSAIDs and acetaminophen are mild analgesics that exhibit a ceiling effect in their dose-response relationship. Such limitations render these agents unsuitable for the treatment of typical, severe burn pain. Oral NSAIDs and acetaminophen are of benefit in treating minor burns, usually in the outpatient setting.
- **Option B:** In intramuscular drug administration, the absorption of the drug is determined by the bulk of the muscle and its vascularity. The onset and duration of the action of the drug is not adjustable. In case of inadvertent scenarios such as anaphylaxis, burns, or neurovascular injuries, intravenous (IV) access needs to be secured
- **Option C:** Subcutaneous injections are another form of the parenteral route of medication and are administered to the layer of skin referred to as cutis, just below the dermis and epidermis layers. Subcutaneous tissue has few blood vessels; therefore, the medications injected undergo absorption at a slow, sustained rate.

24. The principal goals of therapy for older patients who have poor glycemic control are:

- A. Enhancing the quality of life.
- B. Decreasing the chance of complications.
- C. Improving self-care through education.
- D. All of the above.

Correct Answer: D. All of the above.

Older adults with diabetes are at substantial risk for both acute and chronic microvascular and cardiovascular complications of the disease. More than 25% of the U.S. population aged ≥65 years has diabetes, and the aging of the overall population is a significant driver of the diabetes epidemic.

- **Option A:** One of the principal goals of therapy for older persons with diabetes mellitus and poor glycemic control is enhancing the quality of life due to the decline in physical performance and an increased risk of poor health outcomes due to physiologic vulnerability to clinical, functional, or psychosocial stressors.
- **Option B:** Decreasing the chance of complications is another goal of therapy for older persons with diabetes because diabetes complications can lead to serious illness and even death, which is why prevention is so important.
- **Option C:** As with all patients with diabetes, diabetes self-management education and ongoing diabetes self-management support are vital components of diabetes care for older adults and their caregivers. Through good self-management, people with diabetes can better their quality of life and diminish the risk of developing complications. It can also help lower the number of hospital

admissions, or make those times when they do need to go into hospital, for whatever reason, a better experience, with a reduced length of stay.

25. Which of the following conditions most commonly results in CAD?

- A. Atherosclerosis
- B. DM
- C. MI
- D. Renal failure

Correct Answer: A. Atherosclerosis

Atherosclerosis, or plaque formation, is the leading cause of CAD.

- **Option B:** DM is a risk factor for CAD but isn't the most common cause. Near-normal glycemic control for a median of 3.5 to 5 years does not reduce cardiovascular events. Thus, the general goal of HbA1c <7% appears reasonable for the majority of patients. Iatrogenic hypoglycemia is the limiting factor in the glycemic management of diabetes and is an independent cause of excess morbidity and mortality.
- **Option D:** Renal failure doesn't cause CAD, but the two conditions are related. Chronic kidney disease (CKD) accelerates the course of coronary artery disease, independent of conventional cardiac risk factors. In addition, CKD has been shown to confer inferior clinical outcomes following successful coronary revascularisation, which may be offset by arterial grafting.
- **Option C:** Myocardial infarction is commonly a result of CAD. Myocardial infarction occurs when a coronary artery is so severely blocked that there is a significant reduction or break in the blood supply, causing damage or death to a portion of the myocardium (heart muscle).

26. Mrs. Santos is on her 5th pregnancy and has a history of abortion in the 4th pregnancy, and the first pregnancy was a twin. She is considered to be:

- A. G 4 P 3
- B. G 5 P 3
- C. G 5 P 4
- D. G 4 P 4

Correct Answer: B. G 5 P 3

Gravida refers to the total number of pregnancies including the current one. Para refers to the number of pregnancies that have reached viability. Thus, if the woman has had one abortion, she would be considered Para 3. Twin pregnancy is counted only as 1.

- **Option A:** Gravida should be 5 since the woman is on her 5th pregnancy.
- **Option C:** Para should be 3 because twin pregnancies are counted as one and the woman has one abortion.
- **Option D:** Gravida should be 5 since the woman is on her 5th pregnancy.

27. Corinne is experiencing diarrhea after consuming her prescribed antibiotics for the whole week. This is because:

- A. The drugs render food indigestible.
- B. Gastric flora is disturbed.
- C. Fluid is added into the intestine.
- D. Normal intestinal bacteria are destroyed.

Correct Answer: D. Normal intestinal bacteria are destroyed.

The destruction of normal intestinal flora causes diarrhea. Bacteria in the gut, for example, help break down food. Antibiotics kill these “good” microbes along with bacteria that are causing an infection. This upsets the balance of the normal flora in the intestines. The result is often loose, watery stools known as antibiotic-associated diarrhea.

- **Option A:** A drug that rendered food indigestible could not be given because it would cause severe malnutrition. Thousands of species of bacteria, yeast, and other microorganisms live on our skin, in our intestines, and on other body surfaces. They’re known as our “normal flora.” When it is in balance, these microbes stay put and many of them contribute to good health. Bacteria in the gut, for example, help break down food.
- **Option B:** This is incorrect because there is no gastric flora. About one in three people who take antibiotics develop diarrhea. The symptoms usually start on the last day or two of antibiotic therapy, or a day or so after it has ended. The diarrhea is usually mild, with two to four loose stools lasting for a couple days. In most cases, it gets better quickly without treatment. That said, antibiotic-associated diarrhea makes some people very sick. The most severe form, called *C. difficile* colitis, can be life-threatening.
- **Option C:** There is no way to add fluid into the intestine. Almost all antibiotics, particularly those that act on anaerobes, can cause diarrhea, but the risk is higher with aminopenicillins, a combination of aminopenicillins and clavulanate, cephalosporins, and clindamycin.^{1,4,5} Host factors for antibiotic-associated diarrhea include age over 65, immunosuppression, being in an intensive care unit, and prolonged hospitalization.

28. A client with chronic renal failure has asked to be evaluated for a home continuous ambulatory peritoneal dialysis (CAPD) program. The nurse should explain that the major advantage of this approach is that it:

- A. Is relatively low in cost.
- B. Allows the client to be more independent.
- C. Is faster and more efficient than standard peritoneal dialysis.
- D. Has fewer potential complications than standard peritoneal dialysis.

Correct Answer: B. Allows the client to be more independent.

The major benefit of CAPD is that it frees the client from daily dependence on dialysis centers, home health care personnel, and machines for life-sustaining treatment. Independence is a valuable outcome for some people. Continuous ambulatory peritoneal dialysis (CAPD) represents a new method for the treatment of end-stage renal disease. It offers the advantages of greater clearance of higher molecular-weight substances than during haemodialysis, good control of blood pressure, marked improvement of anemia, and unrestricted diet.

- **Option A:** CAPD is costly and must be done daily. In many developing countries, the annual cost of continuous ambulatory peritoneal dialysis (CAPD) is greater than the per-capita gross national income (GNI). The median cost of a 2-L bag of peritoneal dialysis (PD) fluid is around US\$5. The absolute cost of PD fluid among countries with significant differences in per-capita GNI actually varies very little. Thus, most renal failure patients can be expected to have problems accessing PD therapy in developing countries in Asia.
- **Option C:** Furthermore, CAPD is a time-consuming procedure. In spite of the need for technical improvements, CAPD is even now, for selected patients, a valuable alternative treatment to intermittent dialysis methods.
- **Option D:** Side effects and complications are similar to those of standard peritoneal dialysis. In contrast, the risks of peritonitis, hypoproteinemia, and hypertriglyceridemia are major disadvantages.

29. Which of the following illnesses is the leading cause of death in the US?

- A. Cancer
- B. Coronary artery disease
- C. Liver failure
- D. Renal failure

Correct Answer: B. Coronary artery disease

Coronary artery disease accounts for over 50% of all deaths in the US.

- **Option A:** Cancer accounts for approximately 20%.
- **Option C:** Liver failure accounts for less than 10% of all deaths in the US.
- **Option D:** Less than 10% of all deaths in the US can be attributed to renal failure.

30. On a follow-up visit after having a vaginal hysterectomy, a 32-year-old patient has a decreased hematocrit level. Which of the following complications does this suggest?

- A. Hematoma
- B. Hypovolemia
- C. Infection
- D. Pulmonary embolus (PE)

Correct Answer: A. Hematoma

A decreased hematocrit level is a sign of hematoma, a delayed complication of abdominal and vaginal hysterectomy.

- **Option B:** Symptoms of hypovolemia include increased hematocrit and hemoglobin values.
- **Option C:** Infection manifests with fever and high WBC count.
- **Option D:** Symptoms of a PE include dyspnea, chest pain, cough, hemoptysis, restlessness, and signs of shock.

31. The neonate of a mother with diabetes mellitus is prone to developing hypoglycemia because:

- A. The pancreas is immature and unable to secrete the needed insulin.
- B. There is rapid diminution of glucose level in the baby's circulating blood and his pancreas is normally secreting insulin.
- C. The baby is reacting to the insulin given to the mother.
- D. His kidneys are immature leading to a high tolerance for glucose.

Correct Answer: B. There is rapid diminution of glucose level in the baby's circulating blood and his pancreas is normally secreting insulin.

If the mother is diabetic, the fetus while in utero has a high supply of glucose. When the baby is born and is now separate from the mother, it no longer receives a high dose of glucose from the mother. In the first few hours after delivery, the neonate usually does not feed yet thus this can lead to hypoglycemia.

- **Option A:** The primary function of β -cells is to store and secrete insulin in response to glucose load. When β -cells lose the ability to adequately sense blood glucose concentration, or to release sufficient insulin in response, this is classified as β -cell dysfunction. β -cell dysfunction is thought to be the result of prolonged, excessive insulin production in response to chronic fuel excess
- **Option C:** β -cell dysfunction is exacerbated by insulin resistance. Reduced insulin-stimulated glucose uptake further contributes to hyperglycemia, overburdening the β -cells, which have to produce additional insulin in response. The direct contribution of glucose to β -cell failure is described as glucotoxicity. Thus, once β -cell dysfunction begins, a vicious cycle of hyperglycemia, insulin resistance, and further β -cell dysfunction is set in motion.
- **Option D:** Insulin resistance occurs when cells no longer adequately respond to insulin. At the molecular level, insulin resistance is usually a failure of insulin signaling, resulting in inadequate plasma membrane translocation of glucose transporter 4 (GLUT4)—the primary transporter that is responsible for bringing glucose into the cell to use as energy.

32. A nurse prepares to administer a 3ml injection via intramuscular injection to a 5-year-old child. The nurse selects which site to administer the medication?

- A. Rectus femoris
- B. Deltoid
- C. Ventrogluteal
- D. Vastus lateralis

Correct Answer: C. Ventrogluteal

Intramuscular injection sites are chosen based on the child's age and muscle development. The ventrogluteal muscle is the ideal choice to administer 0.5ml-3ml amount of injection on a 3-12-year-old child. A study found that the muscle in the ventrogluteal site is adequately developed, even in infants between the ages of 1-12 months and that in particular, in children 12-36 months old, the ventrogluteal site is even thicker than the anterolateral.

- **Option A:** This site only allows 2ml of injection. Do not use the inner thigh or back of the thigh. Divide the thigh into thirds; the injection site is in the middle third section. To inject into the thigh,

the needle size must be at least 16 mm long but may need to be longer depending on the child's size.

- **Option B:** This allows 0.5-1ml amount of injection. This is the top, upper part of the arm. Only inject on this site if the health-care provider instructs that this is an appropriate injection site for the child. To inject into the deltoid, the needle size must be 16 mm.
- **Option D:** For most infants, the vastus lateralis muscle in the anterolateral thigh is the recommended site for injection because it provides a large muscle mass. The deltoid muscle is preferred for children aged 3 through 18 years. The vastus lateralis muscle in the anterolateral thigh is an alternative site if the deltoid sites cannot be used.

33. Which of the following conditions is likely to coexist in clients with a diagnosis of borderline personality disorder?

- A. Depression
- B. Delirium
- C. Avoidance
- D. Disorientation

Correct Answer: A. Depression

Chronic feelings of emptiness and sadness predispose a client to depression. About 40% of the clients with borderline struggle with depression. Individuals with BPD have difficulties related to the stability of their sense of self. They report many ups and downs in how they feel about themselves. One moment they may feel good about themselves, but the next they may feel they are bad or even evil.

- **Option B:** Delirium is characterized by an acute change in cognition and a disturbance of consciousness, usually resulting from an underlying medical condition or from medication or drug withdrawal. Delirium affects 10 to 30 percent of hospitalized patients with medical illness; more than 50 percent of persons in certain high-risk populations are affected.
- **Option C:** Avoidant personality disorder (AVPD) is an enduring pattern of behavior related to social inhibition, feelings of inadequacy, and sensitivity to rejection that causes problems in work situations and relationships. The disorder is characterized by extreme shyness and sensitivity to criticism from others and is known as a Cluster C personality disorder or one that involves anxious and fearful personality disorders.
- **Option D:** Disorientation is a state of mental confusion that includes losing track of direction and time. A version of disorientation typical for people with mid- to late-stage Alzheimer's disease, or related dementia, is sundowning. Sundowning is also known as sundown syndrome and late-day confusion.

34. The following are signs and symptoms of fetal distress EXCEPT:

- A. Fetal heart rate (FHR) decreases during a contraction and persists even after the uterine contraction ends.
- B. The FHR is less than 120 bpm or over 160 bpm.
- C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm, and FHR after uterine contraction is 126 bpm.

D. FHR is 160 bpm, weak and irregular.

Correct Answer: C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm, and FHR after uterine contraction is 126 bpm.

The normal range of FHR is 120-160 bpm, strong and regular. During a contraction, the FHR usually goes down but must return to its pre-contraction rate after the contraction ends.

- **Option A:** Usually, doctors identify fetal distress based on an abnormal heart rate pattern in the fetus. Throughout labor, the fetus's heart rate is monitored. It is usually monitored continuously with electronic fetal heart monitoring. Or a handheld Doppler ultrasound device may be used to check the heart rate every 15 minutes during early labor and after each contraction during late labor.
- **Option B:** Contractions that are too strong and/or too close together may cause fetal distress. If oxytocin was used to stimulate contractions, it is stopped immediately. The woman may be repositioned and given analgesics. If no drug was used to stimulate contractions, the woman may be given a drug that can slow labor (such as terbutaline, given by injection) to stop or slow the contractions.
- **Option D:** Fetal rhythm abnormalities, which include fetal heart rates that are irregular, too fast or too slow, occur in up to 2% of pregnancies and account for 10–20% of the referrals to fetal cardiologists.

35. Ms. Smith is admitted for internal radiation for cancer of the cervix. The nurse knows the client understands the procedure when she makes which of the following remarks the night before the procedure?

- A. She says to her husband, "Please bring me a hamburger and french fries tomorrow when you come. I hate hospital food."
- B. "I understand it will be several weeks before all the radiation leaves my body."
- C. "I told my daughter who is pregnant to either come to see me tonight or wait until I go home from the hospital."
- D. "I brought several craft projects to do while the radium is inserted."

Correct Answer: C. "I told my daughter who is pregnant to either come to see me tonight or wait until I go home from the hospital."

People who are pregnant should not come in close contact with someone who has internal radiation therapy. The radioactivity could possibly damage the fetus. This statement is not true. The radiation doesn't travel very far from the treatment area. So it is usually safe to be with other people. However, as a precaution, the client will need to avoid very close contact with children and pregnant women for a time.

- **Option A:** The client will be on a clear liquid or very low residue diet. Hamburgers and french fries are not allowed. Foods to avoid or reduce during radiation therapy include sodium (salt), added sugars, solid (saturated) fats, and an excess of alcohol. Some salt is needed in all diets.
- **Option B:** As soon as the radiation source is removed, the client is no longer contaminated with radioactivity. The radiation stays in the body for anywhere from a few minutes to a few days. Most people receive radiation therapy for just a few minutes. Sometimes, people receive internal radiation therapy for more time. If so, they stay in a private room to limit other people's exposure to the radiation.

- **Option D:** Craft projects usually require the client to sit. The client must remain flat with very little head elevation during the time the rods are in place. Treatment planning usually involves positioning the body, making marks on the skin, and taking imaging scans. The radiation therapy team determines whether the client will lie on their back, stomach, or side during treatment.