

Kevin's Review - 35 NCLEX Practice Questions

1. Nurse Adonai is working on the night shift with a nursing assistant. The nursing assistant comes to the nurse stating that the other nurse working on the unit is not assessing a client with abdominal pain despite multiple requests. Which of the following actions by the nurse is best?

- A. Ask the other nurse if she needs help
- B. Assess the client and let the other nurse know what should be done
- C. Ask the client if he is satisfied with his care
- D. Contact the nursing supervisor to address the situation

Answer: D. Contact the nursing supervisor to address the situation

The nurse should use a proper channel of communication. The nursing supervisor is responsible for the actions of the different members of the nursing team. Assessment and treatment of pain is often complex. The standard definition of pain is “whatever the experiencing person says it is, existing whenever the experiencing person says it does” (McCaffery, 1968, p. 65).

- **Option A:** Current health care requires effective collaboration among providers. Poor communication may lead to poor patient outcomes. Although emphasis has been placed on interprofessional communication (particularly between physicians and nurses) in the health system, little has been written about problems in communication within the medical profession.
- **Option B:** The problem of variability in clinical judgment occurs in virtually all medical fields. The type of workplace and the opportunity to discuss and receive advice about interpersonal issues appear to be important in dealing with some difficulties (e.g., overcoming misunderstandings).
- **Option C:** Patient feedback is an important source of information that should help staff implement changes that will improve care quality and patient safety. According to the NHS Confederation (2010), in some trusts, there have been “unspoken but widely held beliefs” that providing good patient experiences is “nice but not necessary” or “nice but too expensive”.

2. When a child injures the epiphyseal plate from a fracture, the damage may result in which of the following?

- A. Rheumatoid arthritis
- B. Permanent nerve damage
- C. Osteomyelitis
- D. Bone growth disruption

Correct Answer: D. Bone growth disruption

The epiphyseal plate is a significant region of bone growth. Hence, any disruption may result in limb shortening. Sometimes, changes in the growth plate from the fracture can cause problems later. For example, the bone could end up a little crooked or a bit longer or shorter than expected.

- **Option A:** Rheumatoid arthritis is a collagen disease with an autoimmune component, with no relationship to fractures. The etiology of RA remains unknown. It is thought to result from the interaction between patients’ genotype and environment. Cigarette smoking is the strongest environmental risk factor associated with rheumatoid arthritis.

- **Option B:** Nerve damage may occur with any fracture, but growth disruption is a primary concern at the epiphyseal plate. Nerves travel in close proximity to the bones and joints. A fracture or dislocation could thus potentially damage a nerve, in addition to the bony injury. As the fracture or dislocation itself is a painful and distressing injury, the presence of a nerve injury may not be recognized immediately.
- **Option C:** Osteomyelitis may occur with any fracture, but growth disruption is a primary concern at the epiphyseal plate. Osteomyelitis is a serious infection of the bone that can be either acute or chronic. It is an inflammatory process involving the bone and its structures caused by pyogenic organisms that spread through the bloodstream, fractures, or surgery.

3. A client tells the nurse that she plans to use the rhythm method of birth control. The nurse is aware that the success of the rhythm method depends on the:

- A. Age of the client
- B. Frequency of intercourse
- C. Regularity of the menses
- D. Range of the client's temperature

Correct Answer: C. Regularity of the menses

The success of the rhythm method of birth control is dependent on the client's menses being regular. Women are only fertile (an egg is present) for a few days each month. Women using the rhythm method monitor their body and analyze their past menstrual cycles to try to determine when their fertile days are. They can then either choose to not have sex during those days, or can use a "barrier" form of birth control, such as condoms or spermicide.

- **Option A:** The rhythm method is not dependent on the age of the client. The rhythm method works best for women whose cycles are consistent because it is easier to predict when she ovulates (releases an egg from her ovaries).
- **Option B:** Rhythm method is not successful when based entirely on the frequency of intercourse. Most women will have a period 14 to 16 days after ovulation, regardless of the length of their overall cycle. Counting backward from the day their period begins can be a good way to know when they ovulated.
- **Option D:** Basal temperature method relies on the client's temperature during ovulation period. The basal body temperature method is a method of natural family planning that requires only the purchase of a very accurate thermometer. The method, which calls for tracking the woman's body temperature on a daily basis, helps to determine which days of the month she is fertile.

4. Which of the following would the nurse most likely expect to find when assessing a pregnant client with abruption placenta?

- A. Excessive vaginal bleeding
- B. Rigid, board-like abdomen
- C. Tetanic uterine contractions
- D. Premature rupture of membranes

Correct Answer: B. Rigid, board-like abdomen

The most common assessment finding in a client with abruption placenta is a rigid or boardlike abdomen. Pain, usually reported as a sharp stabbing sensation high in the uterine fundus with the initial separation, also is common.

- **Option A:** It's possible for the blood to become trapped inside the uterus, so even with a severe placental abruption, there might be no visible bleeding.
- **Option C:** Uterine contractions are a common finding with placental abruption. Contractions progress as the abruption expands, and uterine hypertonus may be noted. Contractions are painful and palpable.
- **Option D:** Increased frequency of placental abruption was found in patients with early rupture of membranes. The incidence was 50% and 44% when rupture of the membranes occurred before 20 weeks or between 20-24 weeks of pregnancy, respectively.

5. The client underwent transurethral resection of the prostate gland 24 hours ago and is on continuous bladder irrigation. Nurse Yonny is aware that the following nursing interventions are appropriate?

- A. Tell the client to try to urinate around the catheter to remove blood clots.
- B. Restrict fluids to prevent the client's bladder from becoming distended.
- C. Prepare to remove the catheter.
- D. Use aseptic technique when irrigating the catheter.

Correct Answer: D. Use aseptic technique when irrigating the catheter.

If the catheter is blocked by blood clots, it may be irrigated according to physician's orders or facility protocol. The nurse should use sterile technique to reduce the risk of infection. Maintain a sterile catheter system. Provide regular catheter and meatal care with soap and water. Apply antibiotic ointment around the catheter site. Measures to prevent introduction of bacteria that may cause infection or sepsis.

- **Option A:** Urinating around the catheter can cause painful bladder spasms. Ambulate with a drainage bag dependent. Avoids backward reflux of urine, which may introduce bacteria into the bladder. Encourage the patient to void when urge is noted but not more than every 2–4 hr per protocol.
- **Option B:** Encourage the client to drink fluids to dilute the urine and maintain urine output. Encourage fluid intake to 3000 mL as tolerated. Limit fluids in the evening, once the catheter is removed. Maintains adequate hydration and renal perfusion for urinary flow. Reducing fluid intake at the right schedule decreases the need to void and interrupt sleep during the night.
- **Option C:** The catheter remains in place for 2 to 4 days after surgery and is only removed with a physician's order. Maintain continuous bladder irrigation (CBI), as indicated, in early postoperative period. Flushes bladder of blood clots and debris to maintain patency of the catheter and urine flow.

6. Situation: A 24-year-old female has an intense fear of spiders. Initial intervention for the client should be to:

- A. Encourage to verbalize her fears as much as she wants.

- B. Assist her to find meaning to her feelings in relation to her past.
- C. Establish trust through a consistent approach.
- D. Accept her fears without criticizing.

Correct Answer: D. Accept her fears without criticizing.

The client cannot control her fears although the client knows it's silly and can joke about it. Open up about your awareness of the patient's fear. This approach validates the feelings the patient is holding and demonstrates recognition of those feelings. Tell the patient that fear is a normal and appropriate response to circumstances in which pain, danger, or loss of control is anticipated or felt. This reassurance places fear within the field of normal human experiences.

- **Option A:** Allow expression of the client's fears but he should focus on other productive activities as well. Discuss the situation with the patient and help differentiate between real and imagined threats to well-being. This approach helps the patient deal with fear.
- **Option B:** Provide accurate information if irrational fears based on incorrect information are present. Replacing inaccurate beliefs into accurate information reduces anxiety. If a patient's fear is a reasonable response, empathize with him or her. Avoid false reassurances and be truthful. Reassure patients that asking for help is both a sign of strength and a step toward resolution of the problem.
- **Option C:** Be with the patient to promote safety especially during frightening procedures or treatment. The physical connection with a trusted person helps the patient feel secure and safe during a period of fear. Maintain a relaxed and accepting demeanor while communicating with the patient. The patient's feeling of stability increases in a peaceful and non-threatening environment.

7. A postpartum nurse is preparing to care for a woman who has just delivered a healthy newborn infant. In the immediate postpartum period, the nurse plans to take the woman's vital signs:

- A. Every 30 minutes during the first hour and then every hour for the next two hours.
- B. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.
- C. Every hour for the first 2 hours and then every 4 hours.
- D. Every 5 minutes for the first 30 minutes and then every hour for the next 4 hours.

Correct Answer: B. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.

The initial or acute period involves the first 6–12 hours postpartum. This is a time of rapid change with a potential for immediate crises such as postpartum hemorrhage, uterine inversion, amniotic fluid embolism, and eclampsia.

- **Option A:** The second phase is the subacute postpartum period, which lasts 2–6 weeks. During this phase, the body is undergoing major changes in terms of hemodynamics, genitourinary recovery, metabolism, and emotional status. Nonetheless, the changes are less rapid than in the acute postpartum phase and the patient is generally capable of self-identifying problems. These may run the gamut from ordinary concerns about perineal discomfort to peripartum cardiomyopathy or severe postpartum depression.
- **Option C:** The third phase is the delayed postpartum period, which can last up to 6 months. Changes during this phase are extremely gradual, and pathology is rare. This period is used to make sure the mother is stable and to educate her in the care of her baby (especially the first-time

mother). While still in the hospital, the mother is monitored for blood loss, signs of infection, abnormal blood pressure, contraction of the uterus, and ability to void. There is also attention to Rh compatibility, maternal immunization statuses, and breastfeeding. This is the time of restoration of muscle tone and connective tissue to the prepregnant state. Although change is subtle during this phase, it behooves caregivers to remember that a woman's body is nonetheless not fully restored to prepregnant physiology until about 6 months post-delivery.

- **Option D:** The immediate postpartum period most often occurs in the hospital setting, where the majority of women remain for approximately 2 days after a vaginal delivery and 3-4 days after a cesarean delivery. During this time, women are recovering from their delivery and are beginning to care for the newborn.

8. When performing an assessment about medication, the drug history should include:

- A. Complete vital signs.
- B. Client's goal of therapy.
- C. Reason for medication.
- D. Administration of OTC medications.

Correct Answer: D. Administration of OTC medications

The nurse should determine if the client is taking any other medications, especially OTC medications because their effects are often minimized. For some medical conditions, a list of previously tried medicines should also be included to help direct future prescribing (e.g. disease-modifying anti-rheumatic drugs [DMARDs] for rheumatoid arthritis). Traditionally, obtaining a medication history has been undertaken solely by doctors, but pharmacists and suitably trained pharmacy technicians now play a vital role in this process. Other choices are an important part of the assessment, but choice D is the most accurate answer.

- **Option A:** Without an accurate medication history, prescribers may inadvertently make incorrect decisions about a patient's treatment, causing harm if previously discontinued medicines are restarted, or if current medicines are omitted or prescribed at the wrong dose for the patient.
- **Option B:** There is no national guidance on which source is the 'gold standard' for obtaining reliable medication history, nor is there a consensus on how many sources should be used, since all have advantages and disadvantages. Two or more sources are often required; however, one source will usually be sufficient if deemed reliable (e.g. patients that are usually fit and well and take no regular medication).
- **Option C:** Once an accurate medication history has been obtained, this information should be documented in the patient's medical notes. The medical team should be informed if any changes to the inpatient prescription are required, ensuring a patient's medicines prescribed on admission correspond to what the patient was taking before admission unless there are any deliberate changes.

9. The nurse understands that the therapeutic effects of typical antipsychotic medications are associated with which neurotransmitters change?

- A. Decreased dopamine level
- B. Increased acetylcholine level

- C. Stabilization of serotonin
- D. Stimulation of GABA

Correct Answer: A. Decreased dopamine level

Excess dopamine is thought to be the chemical cause of psychotic thinking. The typical antipsychotics act to block dopamine receptors and therefore decrease the amount of neurotransmitter at the synapses. First-generation antipsychotics are dopamine receptor antagonists (DRA) and are known as typical antipsychotics. They include phenothiazines (trifluoperazine, perphenazine, prochlorperazine, acetophenazine, triflupromazine, mesoridazine), butyrophenones (haloperidol), thioxanthenes (thiothixene, chlorprothixene), dibenzoxazepines (loxapine), dihydroxyindole (molindone), and diphenylbutylpiperidine (pimozide).

- **Option B:** The first-generation antipsychotics work by inhibiting dopaminergic neurotransmission. Their effectiveness is best when they block about 72% of the D2 dopamine receptors in the brain. They also have noradrenergic, cholinergic, and histaminergic blocking action. Second-generation antipsychotics work by blocking D2 dopamine receptors as well as serotonin receptor antagonist action. the 5-HT2A subtype of serotonin receptor is most commonly involved.
- **Option C:** Second-generation antipsychotics are serotonin-dopamine antagonists and are also known as atypical antipsychotics. The Food and Drug Administration (FDA) has approved 12 atypical antipsychotics as of the year 2016. They are risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, paliperidone, asenapine, lurasidone, iloperidone, cariprazine, brexpiprazole, and clozapine.
- **Option D:** The typical antipsychotics do not increase acetylcholine, stabilize serotonin, stimulate GABA. GABA (gamma-aminobutyric acid) is a common neurotransmitter in the brain, and GABA-ergic neurons are thought to interact with antipsychotic medications, contributing to side effects such as tardive dyskinesia.

10. A male client with a cerebellar brain tumor is admitted to an acute care facility. The nurse formulates a nursing diagnosis of Risk for injury. Which “related-to” phrase should the nurse add to complete the nursing diagnosis statement?

- A. Related to psychomotor seizures
- B. Related to impaired balance
- C. Related to visual field deficits
- D. Related to difficulty swallowing

Correct Answer: B. Related to impaired balance

- **Option B:** A client with a cerebellar brain tumor may suffer injury from impaired balance as well as disturbed gait and incoordination.
- **Option A:** Psychomotor seizures suggest temporal lobe dysfunction.
- **Option C:** Visual field deficits, difficulty swallowing, and psychomotor seizures may result from dysfunction of the pituitary gland, pons, occipital lobe, parietal lobe, or temporal lobe — not from a cerebellar brain tumor.
- **Option D:** Difficulty swallowing suggests medullary dysfunction.

11. A nurse is monitoring a client receiving ethambutol (Myambutol) for adverse effects. The nurse determines that the client is experiencing a side effect of the medication, in which of the following?

- A. Red-orange colored bodily secretions
- B. Damaged hearing
- C. Loss of smell
- D. Difficulty distinguishing the color red from green

Correct Answer: D. Difficulty distinguishing the color yellow from orange

Ethambutol (Myambutol) causes optic neuritis characterized by decreased visual acuity and the ability to distinguish between the color red from green.

- **Option A:** Red-orange discoloration of secretions is a side effect of Rifampin.
- **Option B:** Ototoxicity is a side effect of Streptomycin.
- **Option C:** This is not a related symptom of this anti-TB medication.

12. The mother of a 2-month-old infant brings the child to the clinic for a well-baby check. She is concerned because she feels only one testis in the scrotal sac. Which of the following statements about the undescended testis is the most accurate?

- A. Normally, the testes are descended by birth.
- B. The infant will likely require surgical intervention.
- C. The infant probably has only one testis.
- D. Normally, the testes descend by one year of age.

Correct Answer: D. Normally, the testes descend by one year of age.

Normally, the testes descend by one year of age. In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated. The exam should be done in a warm room with warm hands. It is most likely that both testes are present and will descend by a year. If not, a full assessment will determine the appropriate treatment.

- **Option A:** The testes usually descend by one year of age. Most of the time, a boy's testicles descend by the time he is 9 months old. Undescended testicles are common in infants who are born early. The problem occurs less in full-term infants.
- **Option B:** Surgical intervention is unnecessary; the testes descend by one year of age. The testicles will descend normally at puberty and surgery is not needed. Testicles that do not naturally descend into the scrotum are considered abnormal. An undescended testicle is more likely to develop cancer, even if it is brought into the scrotum with surgery. Cancer is also more likely in the other testicle.
- **Option C:** In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated.

13. Nurse Kathy is assessing infantile reflexes in a 9-month-old baby; which of the following would she identify as normal?

- A. Persistent rooting
- B. Bilateral parachute
- C. Absent moro reflex
- D. Unilateral grasp

Correct Answer: B. Bilateral parachute

The parachute reflex appears to be normal at about 9 months of age. Persistence of primitive reflexes past 4 to 6 months or absence before this time when they should have been present is predictive of cerebral palsy. The presence of 5 or more abnormal reflexes correlated with the development of cerebral palsy or mental delays.

- **Option A:** The rooting reflex, mouth turning toward an object, is seen in response to light stroking on the cheek or bringing an object into the patient's visual field. Rooting begins at 32 weeks gestation and decreases after one month.
- **Option C:** The absence of the Moro reflex suggests CNS dysfunction. The Moro reflex is a protective response to the abrupt disruption of body balance and is elicited by pulling up on the arms with an infant in the supine position. The reflex develops by 28 weeks gestation and disappears by six to nine months.
- **Option D:** The grasping reflex can be elicited by providing sustained pressure on the palmar aspect of the hand, resulting in flexion of the patient's fingers grasping the object providing the pressure. This reflex develops by 28 weeks gestation and disappears by six months.

14. The nurse is educating the lady's club in a self-breast exam. The nurse is aware that most malignant breast masses occur in the Tail of Spence. On the diagram below, select where the Tail of Spence is.

- A
- B
- C
- D

Correct Answer: A.

The Tail of Spence is located in the upper outer quadrant of the breast.

- **Option B:** Option B is the areola, a dark area of skin surrounding the nipple.

15. A client who delivered by cesarean section 24 hours ago is using a patient-controlled analgesia (PCA) pump for pain control. Her oral intake has been ice chips only since surgery. She is now complaining of nausea and bloating, and states that because she had nothing to eat, she is too weak to breastfeed her infant. Which nursing diagnosis has the highest priority?

- A. Altered nutrition, less than body requirements for lactation.
- B. Alteration in comfort related to nausea and abdominal distention.
- C. Impaired bowel motility related to pain medication and immobility.
- D. Fatigue related to cesarean delivery and physical care demands of infant.

Correct Answer: C. Impaired bowel motility related to pain medication and immobility

Impaired bowel motility caused by surgical anesthesia, pain medication, and immobility is the priority nursing diagnosis and addresses the potential problem of a paralytic ileus.

- **Option A:** Altered nutrition is also an appropriate diagnosis since the woman was not able to eat adequately since the surgery, hindering her ability to breastfeed. However, it can be managed and is not the priority at the time.
- **Option B:** The woman's comfort is also altered due to nausea and bloating, but it is not considered a priority.
- **Option D:** After cesarean delivery, fatigue may overcome the client's desire to eat and breastfeed her infant. This is a correct diagnosis but it does not take priority over impaired bowel motility.

16. A clinic patient has a hemoglobin concentration of 10.8 g/dL and reports sticking to a strict vegetarian diet. Which of the following nutritional advice is appropriate?

- A. The diet is providing adequate sources of iron and requires no changes.
- B. The patient should add meat to her diet; a vegetarian diet is not advised.
- C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.
- D. A cup of coffee or tea should be added to every meal.

Correct Answer: C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.

Normal hemoglobin values range from 11.5-15.0. This vegetarian patient is mildly anemic. When food is prepared in iron cookware its iron content is increased. Anemia is defined as hemoglobin below two standard deviations of the mean for the age and gender of the patient. Iron is an essential component of the hemoglobin molecule. The most common cause of anemia worldwide is iron deficiency, which results in microcytic and hypochromic red cells on the peripheral smear.

- **Option A:** The client is mildly anemic. The cause of iron-deficiency anemia varies based on age, gender, and socioeconomic status. Iron deficiency may result from insufficient iron intake, decreased absorption, or blood loss. Iron-deficiency anemia is most often from blood loss, especially in older patients.
- **Option B:** Mild anemia does not require that animal sources of iron be added to the diet. Many non-animal sources are available. Dietary sources of iron are green vegetables, red meat, and iron-fortified milk formulas. It may also be seen with low dietary intake, increased systemic requirements for iron such as in pregnancy, and decreased iron absorption such as in celiac disease.
- **Option D:** Coffee and tea increase gastrointestinal activity and inhibit absorption of iron. The iron in food comes from two sources: animals and plants. Iron from animal sources is known as heme iron and is found in meat and fish. Iron from plants is known as nonheme iron, and is found in certain

vegetables and in iron-fortified foods such as breakfast cereals. Heme iron is better absorbed by the body than non heme iron.

17. A male client who is experiencing disordered thinking about food being poisoned is admitted to the mental health unit. The nurse uses which communication technique to encourage the client to eat dinner?

- A. Focusing on self-disclosure of own food preference.
- B. Using open-ended questions and silence.
- C. Offering opinions about the need to eat.
- D. Verbalizing reasons that the client may not choose to eat.

Correct Answer: B. Using open-ended question and silence

Open-ended questions and silence are strategies used to encourage clients to discuss their problem in a descriptive manner. At times, it's useful to not speak at all. Deliberate silence can give both nurses and patients an opportunity to think through and process what comes next in the conversation. It may give patients the time and space they need to broach a new topic. Nurses should always let patients break the silence.

- **Option A:** Sometimes during a conversation, patients mention something particularly important. When this happens, nurses can focus on their statement, prompting patients to discuss it further. Patients don't always have an objective perspective on what is relevant to their case; as impartial observers, nurses can more easily pick out the topics to focus on.
- **Option C:** Recognition acknowledges a patient's behavior and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially when it concerns a routine task like making the bed. However, saying something like "I noticed you took all of your medications" draws attention to the action and encourages it without requiring a compliment.
- **Option D:** Patients often ask nurses for advice about what they should do about particular problems or in specific situations. Nurses can ask patients what they think they should do, which encourages patients to be accountable for their own actions and helps them come up with solutions themselves.

19. The client with a head injury has been urinating copious amounts of dilute urine through the Foley catheter. The client's urine output for the previous shift was 3000 ml. The nurse implements a new physician order to administer:

- A. desmopressin (DDAVP, Stimate)
- B. Dexamethasone (Decadron)
- B. Dexamethasone (Decadron) C. ethacrynic acid (Edecrin)
- D. mannitol (Osmitrol)

Correct Answer: A. Desmopressin (DDAVP, stimate)

A complication of a head injury is diabetes insipidus, which can occur with insult to the hypothalamus, the antidiuretic storage vesicles, or the posterior pituitary gland. Urine output that exceeds 9 L per day generally requires treatment with desmopressin. Desmopressin administration can be utilized to distinguish between central vs. nephrogenic diabetes insipidus, with a positive response noted in

central diabetes insipidus, meaning the kidneys respond appropriately to desmopressin with the expected concentration of the urine and increased reabsorption of fluids, resulting in eutonic urine.

- **Option B:** Dexamethasone, a glucocorticoid, is administered to treat cerebral edema. This medication may be ordered for the head injured patient. Dexamethasone has a wide variety of uses in the medical field. As a treatment, dexamethasone has been useful in the treatment of acute exacerbations of multiple sclerosis, allergies, cerebral edema, inflammation, and shock.
- **Option C:** Ethacrynic acid is a loop diuretic that gained FDA approval for widespread use in 1967. Unlike other loop diuretics, ethacrynic acid is a novel drug due to the absence of a sulfonamide group in its structure, allowing its use in critically ill patients with life-threatening sulfa-allergies. In adults, ethacrynic acid is a choice for the relief of edema in patients with renal failure, congestive heart failure, and cirrhotic ascites in the setting of sulfonamide hypersensitivity and treatment-resistant pathologies.
- **Option D:** Mannitol is a diuretic, which would be contraindicated. Mannitol is a six-carbon, linear, simple sugar which is only mildly metabolized by the body and primarily excreted rapidly by the kidneys when given intravenously and poorly absorbed when taken orally.

20. A nurse performs an assessment on a client who is 4 hours PP. The nurse notes that the client has cool, clammy skin and is restless and excessively thirsty. The nurse prepares immediately to:

- A. Assess for hypovolemia and notify the health care provider.
- B. Begin hourly pad counts and reassure the client.
- C. Begin fundal massage and start oxygen by mask.
- D. Elevate the head of the bed and assess vital signs.

Correct Answer: A. Assess for hypovolemia and notify the health care provider.

Symptoms of hypovolemia include cool, clammy, pale skin, sensations of anxiety or impending doom, restlessness, and thirst. When these symptoms are present, the nurse should further assess for hypovolemia and notify the health care provider. Patients with hypovolemic shock have severe hypovolemia with decreased peripheral perfusion. If left untreated, these patients can develop ischemic injury of vital organs, leading to multi-system organ failure.

- **Option B:** The first factor to be considered is whether the hypovolemic shock has resulted from hemorrhage or fluid losses, as this will dictate treatment. When etiology of hypovolemic shock has been determined, replacement of blood or fluid loss should be carried out as soon as possible to minimize tissue ischemia.
- **Option C:** Medical management with uterotonic and pharmacologic agents is typically the first step if uterine atony is identified. While oxytocin is given routinely by most institutions at the time of delivery (see prevention), additional uterotonic medications may be given with bimanual massage in an initial response to hemorrhage. Uterotonic agents include oxytocin, ergot alkaloids, and prostaglandins.
- **Option D:** Initial evaluation of the patient should include a rapid assessment of the patient's status and risk factors. In postpartum women, signs or symptoms of blood loss such as tachycardia and hypotension may be masked, so if these signs are present, there should be a concern for considerable blood volume loss (greater than 25% of total blood volume). Continuous assessment of vital signs and on-going estimation of total blood loss is an important factor in ensuring safe care of the patient with PPH.

21. Which of the following drugs would be ordered by the physician to improve the platelet count in a male client with idiopathic thrombocytopenic purpura (ITP)?

- A. Acetylsalicylic acid (ASA)
- B. Corticosteroids
- C. Methotrexate
- D. Vitamin K

Correct Answer: B. Corticosteroids

Corticosteroid therapy can decrease antibody production and phagocytosis of the antibody-coated platelets, retaining more functioning platelets.

- **Option A:** ASA blocks prostaglandin synthesis. Inhibition of COX-1 results in the inhibition of platelet aggregation for about 7-10 days (average platelet lifespan).
- **Option C:** Methotrexate inhibits enzymes responsible for nucleotide synthesis which prevents cell division and leads to anti-inflammatory actions. It causes thrombocytopenia.
- **Option D:** Vitamin K is used to treat an excessive anticoagulate state from warfarin overload.

22. A 42-year-old female patient with a known history of type 1 diabetes presents to the emergency department with complaints of fatigue, increased urination, and difficulty breathing. The nurse suspects an acute episode of ketoacidosis based on her medical history and current symptoms. As the nurse continues the assessment, the patient describes various symptoms she has been experiencing over the past few days. Based on her potential acute ketoacidosis, which of the following symptoms reported by the patient would the nurse consider atypical for this condition?

- A. Persistent nausea leading to episodes of vomiting
- B. An insatiable feeling of thirst despite drinking large amounts of water
- C. A noticeable increase in weight over a short period
- D. A distinct fruity odor on her breath

Correct Answer: C. Weight gain

Diabetic ketoacidosis (DKA) is a serious complication of diabetes that occurs when the body produces high levels of blood acids called ketones. Common symptoms of DKA include nausea and vomiting, extreme thirst, frequent urination, and a fruity-scented breath. Weight gain is not typically associated with acute DKA; in fact, weight loss might be more common due to the body's inability to use glucose for energy and the subsequent breakdown of fat stores.

23. A 74-year-old woman with a history of multiple vertebral compression fractures is admitted to the rehabilitation unit. She has been diagnosed with advanced osteoporosis. The interdisciplinary team gathers to discuss her management plan. The nurse, considering the most effective interventions to

slow the progression of the patient's osteoporosis and reduce the risk of future fractures, suggests several approaches. Which of the following interventions would be appropriate recommendations for this patient? Select all that apply.

- A. Advocating for a regimen of regular weight-bearing exercises tailored to her physical capabilities.
- B. Advising a dietary plan that significantly restricts calcium intake.
- C. Strongly recommending confinement to bed to minimize the risk of potential fractures.
- D. Prioritizing the administration of nonsteroidal anti-inflammatory drugs (NSAIDs) as the primary treatment.
- E. Ensuring adequate dietary or supplemental calcium and vitamin D intake.
- F. Evaluating the home environment for fall risks and making necessary modifications.
- G. Recommending the use of bisphosphonates after consulting with her physician.

- **Option A:** Weight-bearing exercises are beneficial for patients with osteoporosis as they help in maintaining or even increasing bone density, thereby reducing the risk of fractures.
- **Option E:** Adequate dietary or supplemental calcium and vitamin D intake is crucial for bone health. Vitamin D aids in the absorption of calcium, and both are vital for maintaining and building bone density.
- **Option F:** Evaluating the home environment for fall risks is essential. By making necessary modifications, such as adding grab bars or removing tripping hazards, the risk of falls and subsequent fractures can be reduced.
- **Option G:** Bisphosphonates are a class of drugs that can help slow bone loss and are commonly prescribed for osteoporosis.
- **Option B:** Promoting a low-calcium diet is not recommended, as calcium is essential for bone health.
- **Option C:** Confinement to bed is not recommended for osteoporosis patients as it can lead to further bone loss and muscle weakness, increasing the risk of fractures. Limiting physical activity may further weaken bones and increase the risk of fractures.
- **Option D:** NSAIDs are not a primary treatment for osteoporosis. While they can help manage pain associated with fractures or other conditions, they do not directly address bone density issues and can have gastrointestinal side effects.

24. Henry is a Unit Manager I the Medical Unit. He is not satisfied with the way things are going in his unit. The patient satisfaction rate is 60% for two consecutive months and staff morale is at its lowest. He decides to plan and initiate changes that will push for a turnaround in the condition of the unit. Which of the following actions is a priority for Henry?

- A. Call for a staff meeting and take this up in the agenda.
- B. Seek help from her manager.
- C. Develop a strategic action on how to deal with these concerns.
- D. Ignore the issues since these will be resolved naturally.

Correct Answer: A. Call for a staff meeting and take this up on the agenda.

This will allow for the participation of every staff in the unit. If they contribute to the solutions of the problem, they will own the solutions; hence the chance for compliance would be greater. It's one thing to articulate the change required and entirely another to conduct a critical review against organizational objectives and performance goals to ensure the change will carry the unit in the right direction strategically, financially, and ethically.

- **Option B:** Determine the most effective means of communication for the group or individual that will bring them on board. The communication strategy should include a timeline for how the change will be incrementally communicated, key messages, and the communication channels and mediums that is planned to use.
- **Option C:** Providing a support structure is essential to assist employees to emotionally and practically adjust to the change and to build the proficiency of behaviors and technical skills needed to achieve desired results.
- **Option D:** Review the effect on the unit and how it cascades through the organizational structure to the individual. This information will start to form the blueprint for where training and support are needed the most to mitigate the impacts.

25. A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of:

- A. Hematoma
- B. Placenta previa
- C. Uterine atony
- D. Placental separation

Correct Answer: D. Placental separation

As the placenta separates, it settles downward into the lower uterine segment. The umbilical cord lengthens, and a sudden trickle or spurt of blood appears. Delivery of the placenta usually happens within 5-10 minutes after delivery of the fetus, but it is considered normal up to 30 minutes after delivery of the fetus.

- **Option A:** A hematoma is a bad bruise. It happens when an injury causes blood to collect and pool under the skin. The pooling blood gives the skin a spongy, rubbery, lumpy feel. A hematoma usually is not a cause for concern. It is not the same thing as a blood clot in a vein, and it does not cause blood clots.
- **Option B:** Placenta previa occurs when a baby's placenta partially or totally covers the mother's cervix — the outlet for the uterus. Placenta previa can cause severe bleeding during pregnancy and delivery. If the woman has placenta previa, she might bleed throughout her pregnancy and during her delivery.
- **Option C:** Atony of the uterus, also called uterine atony, is a serious condition that can occur after childbirth. It occurs when the uterus fails to contract after the delivery of the baby, and it can lead to a potentially life-threatening condition known as postpartum hemorrhage.

26. Which of the following would be a priority nursing diagnosis for the client with heart failure and pulmonary edema?

- A. Risk for infection related to stasis of alveolar secretions.
- B. Impaired skin integrity related to pressure.
- C. Activity intolerance related to pump failure.
- D. Constipation related to immobility.

Correct Answer: C. Activity intolerance related to pump failure

Activity intolerance is a primary problem for clients with heart failure and pulmonary edema. The decreased cardiac output associated with heart failure leads to reduced oxygen and fatigue. Clients frequently complain of dyspnea and fatigue. As heart failure becomes more severe, the heart is unable to pump the amount of blood required to meet all of the body's needs. To compensate, blood is diverted away from less-crucial areas, including the arms and legs, to supply the heart and brain.

- **Option A:** The client could be at risk for infection related to stasis of secretions but it is not the priority. The exchange in oxygenation and carbon dioxide gases is impeded due to the obstruction caused by the accumulation of bronchial secretions in the alveoli. Oxygen cannot diffuse easily.
- **Option B:** Impaired skin integrity related to pressure is not a priority. Skin is at risk because of impaired peripheral circulation, physical immobility, and alterations in nutritional status. Provide gentle massage around reddened or blanched areas. Improves blood flow, minimizing tissue hypoxia. Note: Direct massage of compromised areas may cause tissue injury.
- **Option D:** This is not the priority nursing diagnosis for the client with HF and pulmonary edema. Implement a graded cardiac rehabilitation program. Strengthens and improves cardiac function under stress, if cardiac dysfunction is not irreversible. Gradual increase in activity avoids excessive myocardial workload and oxygen consumption.

27. During the first few days of recovery from ostomy surgery for ulcerative colitis, which of the following aspects should be the first priority of client care?

- A. Body image
- B. Ostomy care
- C. Sexual concerns
- D. Skin care

Correct Answer: B. Ostomy care

Although all of these are concerns the nurse should address, being able to safely manage the ostomy is crucial for the client before discharge. Patients may have comorbidities that affect their ability to manage their ostomy care. Conditions such as arthritis, vision changes, Parkinson's disease, or post-stroke complications may hinder a patient's coordination and function to manage the ostomy.

- **Option A:** Help the patient identify and initiate positive coping behaviors used in the past. Successful behaviors can be fostered in dealing with current problems and stress, enhancing a patient's sense of self-control.
- **Option C:** Provide opportunity for the patient to discuss how illness has affected relationships, including sexual concerns. Stressors of illness affect all areas of life, and the patient may have difficulty coping with feelings of fatigue and pain in relation to relationship and sexual needs.
- **Option D:** Observe excessively dry skin and mucous membranes, decreased skin turgor, slowed capillary refill; Indicates excessive fluid loss or resultant dehydration.

28. Which of the following observations indicates fetal distress?

- A. Fetal scalp pH of 7.14
- B. Fetal heart rate of 144 beats/minute
- C. Acceleration of fetal heart rate with contractions
- D. Presence of long-term variability

Correct Answer: A. Fetal scalp pH of 7.14

A fetal scalp pH below 7.25 indicates acidosis and fetal hypoxia. Fetal response to oxygen deprivation is regulated by the autonomic nervous system, mediated by parasympathetic and sympathetic mechanisms. The fetus is equipped with compensatory mechanisms for transient hypoxia during labor, but prolonged, uninterrupted fetal hypoxia may lead progressively to acidosis with cell death, tissue damage, organ failure and potentially death.

- **Option B:** The fetal heart rate changes markedly in response to prolonged oxygen deprivation, making fetal heart rate monitoring a potentially valuable and commonly used tool for assessing fetal oxygenation status in real-time. Non-reassuring fetal heart rate patterns are observed in approximately 15% of labors
- **Option C:** While accelerations are associated with fetal well-being, decelerations, especially prolonged bradycardia, late decelerations, and severe variable decelerations are indicative of fetal stress and should prompt the clinician to evaluate and initiate intrauterine resuscitation with consideration for delivery of the fetus as indicated.
- **Option D:** Abnormal fetal heart rate patterns have high sensitivity, but low specificity and low predictive value to discriminate between neonates with or without metabolic acidosis. While a normal fetal heart rate pattern usually indicates reassuring fetal status, an abnormal fetal heart rate pattern does not necessarily equate with hypoxia or acidosis.

29. The nurse is aware that an adaptation of pregnancy is an increased blood supply to the pelvic region that results in a purplish discoloration of the vaginal mucosa, which is known as:

- A. Ladin's sign
- B. Hegar's sign
- C. Goodell's sign
- D. Chadwick's sign

Correct Answer: D. Chadwick's sign.

A purplish color results from the increased vascularity and blood vessel engorgement of the vagina. It can be observed as early as 6 to 8 weeks after conception, and its presence is an early sign of pregnancy.

- **Option A:** Ladin's sign is a clinical sign of pregnancy in which there is softening in the midline of the uterus anteriorly at the junction of the uterus and cervix. It occurs and is detectable with manual examination at about 6 weeks' gestation.

- **Option B:** Hegar's sign is a non-sensitive indication of pregnancy in women — its absence does not exclude pregnancy. It pertains to the features of the cervix and the uterine isthmus. It is demonstrated as a softening in the consistency of the uterus, and the uterus and cervix seem to be two separate regions.
- **Option C:** Goodell sign is an indication of pregnancy. It is a significant softening of the vaginal portion of the cervix from increased vascularization. This vascularization is a result of hypertrophy and engorgement of the vessels below the growing uterus. This sign occurs at approximately four weeks' gestation.

30. The nurse is caring for a client with an above-the-knee amputation (AKA). An important intervention that the nurse should do is:

- A. Place the client in a prone position 15–30 minutes thrice a day
- B. Keep the foot of the bed elevated on shock blocks
- C. Place trochanter rolls on either side of the affected leg
- D. Keep the client's leg elevated on two pillows

Correct Answer: A. Place the client in a prone position 15–30 minutes twice a day

- Option A: The client with an above-the-knee amputation should lie prone 15–30 minutes three times a day to prevent hip flexion contractures.
- Options B and D: Elevating the extremity after the first 24 hours will promote the development of contractures.
- Option C: Use of a trochanter roll will prevent rotation of the extremity but will not prevent contracture.

31. A 58-year-old male patient, Mr. Smith, who has been diagnosed with moderate to severe rheumatoid arthritis (RA), presents to an outpatient rheumatology clinic. He complains of joint stiffness in the morning, especially in his hands and wrists, and expresses difficulty in performing daily tasks such as buttoning his shirt. On physical examination, there is notable swelling, tenderness, and warmth in the metacarpophalangeal and proximal interphalangeal joints. After discussing various therapeutic options, the rheumatologist prescribes methotrexate to Mr. Smith. As the nurse in charge of providing patient education, which information regarding methotrexate is essential for Mr. Smith to understand? Select all that apply.

- A. The importance of regular blood tests to monitor liver function
- B. The need to avoid alcohol while taking methotrexate
- C. The potential for increased susceptibility to infections
- D. The possibility of gastrointestinal side effects
- E. The importance of taking methotrexate on an empty stomach

Correct Answers: A, B, C, and D.

- **Option A:** Methotrexate can have an impact on liver function, and regular blood tests are essential to monitor for any signs of liver toxicity. The nurse should emphasize the significance of attending these tests as scheduled to ensure the safe and effective use of the medication.
- **Option B:** Methotrexate and alcohol do not mix well. Alcohol can increase the risk of liver damage when combined with methotrexate. Therefore, patients should be informed about the importance of abstaining from alcohol during their treatment.
- **Option C:** Methotrexate can suppress the immune system, making patients more susceptible to infections. Patients need to be aware of this potential risk and should promptly report any signs of infection to their healthcare provider.
- **Option D:** Gastrointestinal side effects, such as nausea, vomiting, and diarrhea, are common with methotrexate. The nurse should inform the patient about these potential side effects and provide strategies to manage them, such as taking the medication with food or using anti-nausea medications if necessary.
- **Option E:** Methotrexate is typically taken with food to reduce the risk of gastrointestinal side effects. Taking it on an empty stomach can increase the likelihood of nausea and discomfort. Therefore, the nurse should advise the patient to take methotrexate with a meal or snack, unless otherwise directed by the prescribing physician.

32. The nurse is counseling a couple who has sought information about conceiving. The couple asks the nurse to explain when ovulation usually occurs. Which statement by the nurse is correct?

- A. Two weeks before menstruation.
- B. Immediately after menstruation.
- C. Immediately before menstruation.
- D. Three weeks before menstruation.

Correct Answer: A. Two weeks before menstruation

Ovulation occurs 14 days before the first day of the menstrual period (A). Although ovulation can occur in the middle of the cycle or 2 weeks after menstruation, this is only true for a woman who has a perfect 28-day cycle. For many women, the length of the menstrual cycle varies.

- **Option B:** After the follicle releases its egg, it changes into the corpus luteum. This structure releases hormones, mainly progesterone and some estrogen. The rise in hormones keeps the uterine lining thick and ready for a fertilized egg to implant. If the woman does get pregnant, her body will produce human chorionic gonadotropin (hCG). This is the hormone pregnancy tests detect. It helps maintain the corpus luteum and keeps the uterine lining thick. If the woman doesn't get pregnant, the corpus luteum will shrink away and be resorbed. This leads to decreased levels of estrogen and progesterone, which causes the onset of the period. The uterine lining will shed during this period.
- **Option C:** The menstrual phase is the first stage of the menstrual cycle. It's also when the woman gets her period. This phase starts when an egg from the previous cycle isn't fertilized. Because pregnancy hasn't taken place, levels of the hormones estrogen and progesterone drop. The thickened lining of the uterus, which would support a pregnancy, is no longer needed, so it sheds through the vagina. During this period, there is a release of a combination of blood, mucus, and tissue from the uterus.

- **Option D:** During each menstrual cycle, an egg develops and is released from the ovaries. The lining of the uterus builds up. If a pregnancy doesn't happen, the uterine lining sheds during a menstrual period. Then the cycle starts again.

33. When evaluating a male client for complications of acute pancreatitis, the nurse would observe for:

- A. Increased intracranial pressure
- B. Decreased urine output
- C. Bradycardia
- D. Hypertension

Correct Answer: B. Decreased urine output

Acute pancreatitis can cause decreased urine output, which results from the renal failure that sometimes accompanies this condition. AKI develops late in the course of acute pancreatitis, usually after failure of other organs. Remarkably, the kidney was the first organ to fail in only 8.9% of patients with AKI, and only a minority of patients develop isolated AKI

- **Option A:** Intracranial pressure neither increases nor decreases in a client with pancreatitis. The causes of increased intracranial pressure (ICP) can be divided based on the intracerebral components causing elevated pressures. Generalized swelling of the brain or cerebral edema from a variety of causes such as trauma, ischemia, hyperammonemia, uremic encephalopathy, and hyponatremia.
- **Option C:** Tachycardia, not bradycardia, usually is associated with pulmonary or hypovolemic complications of pancreatitis. Tachycardia and mild hypotension may result from hypovolemia from sequestration of fluid in the pancreatic bed. About 60% of patients develop low-grade pyrexia from peripancreatic inflammation without evident infection.
- **Option D:** Hypotension can be caused by a hypovolemic complication, but hypertension usually isn't related to acute pancreatitis. Release into the systemic circulation of activated enzymes and proteases may cause endothelial damage leading to extravasation of fluids from the vascular space, hypovolemia, hypotension, increased abdominal pressure, intense kidney vasoconstriction, hypercoagulability, and fibrin deposition in the glomeruli.

34. A 7-year-old girl who has just endured allogeneic stem cell transplantation will need protective environmental stimulation. Which nursing task should the nurse delegate to the nursing assistant? Select all that apply.

- A. Educating the client to perform careful handwashing after using the bathroom.
- B. Communicating with the family members about the grounds for isolation.
- C. Stock the client's room with the required PPE items.
- D. Reminding the visitors to wear a face mask, gloves, and gown.
- E. Posting the precautions for protective isolation on the door of the client's room

Correct Answer: C, D, and E

The nursing assistant is capable of stocking the room and posting the precautions on the client's door because all staff who care for clients should be familiar with the various types of isolation. Reminding visitors about previously taught information is a task of the nursing assistant although the RN is responsible for the initial teaching.

- **Option A:** Education is a complex action that should be carried out by an RN. If a CNA does something that is not in their scope of work, the hospital is within their rights to dismiss them or at least issue them with a warning.
- **Option B:** Client discussion of the reason for the protective isolation falls within the RN-level-scope of practice. The scope of practice for a CNA includes tasks such as basic daily patient care including doing all of the things for the patient that they cannot do themselves. These tasks are classified as ADLs or activities of daily living and are called this because they need to be done daily.
- **Option C:** A CNA is allowed to stock the patient's room with necessary equipment. In hospitals, certified nursing assistants are more likely to help a diverse patient population with a wide range of needs. Their patients could be young or old, and likely recovering from illness or surgery.
- **Option D:** Depending on daily needs, this can involve changing soiled sheets, cleaning up spills, changing bedpans, setting up equipment, and reducing the spread of germs and infection in the patient's living area.
- **Option E:** CNAs are primarily responsible for helping patients with ADLs, such as bathing, grooming, toileting, eating, and moving. CNAs often measure a patient's blood pressure, pulse, and temperature, and then record their findings and report them to a supervisor to determine whether action is necessary.

35. The nurse is providing dietary teaching for a client with elevated cholesterol levels. Which cooking oil is not suggested for the client on a low-cholesterol diet?

- A. Canola oil
- B. Coconut oil
- C. Safflower oil
- D. Sunflower oil

Correct Answer: B. Coconut oil

- Option B: Coconut oil is high in saturated fat and is not appropriate for the client on a low-cholesterol diet.
- Options A, C, and D: The following oils are good for the client with elevated cholesterol levels.