

Kevin's Review - 35 NCLEX Practice Questions

1. Nurse Meredith is observing 8-year-old Anna during a community visit. Which of the following findings would lead the nurse to suspect that Anna is a victim of sexual abuse?

- A. The child is fearful of the caregiver and other adults.
- B. The child has a lack of peer relationships.
- C. The child has self-injurious behavior.
- D. The child has an interest in things of a sexual nature.

Correct Answer: D. The child has an interest in things of a sexual nature.

An 8-year-old child is in the latency phase of development; in this stage, the child's interest in peers, activities, and school is the priority. Interest in sex and things of a sexual nature would occur appropriately during the age of puberty, not at this time. A child who is the victim of sexual abuse, however, may show an unusual interest in sex. The assessments in the other answer choices may indicate abuse, but not necessarily sexual abuse.

- **Option A:** Another consequence of sexual abuse, according to Finkelhor and Browne (1985), is powerlessness, in which a child learns that his or her needs or requests are ignored by others; the child thus fails to develop self-efficacy to stop unwanted sexual advances. More severe sexual abuse, particularly sexual abuse involving force or penetration, may lead to greater feelings of powerlessness. Perhaps because they lack the interpersonal skills or the self-efficacy to stop unwanted sexual advances, these individuals may be less likely to refuse intercourse with aggressive partners, resulting in more sexual partners.
- **Option B:** Powerlessness could help explain findings linking more severe sexual abuse to more adult sexual risk behavior (e.g., Cinq-Mars et al., 2003; Fergusson et al., 1997). In this regard, Kallstrom-Fuqua, Weston, and Marshall (2004) found that sexual abuse severity had an indirect effect on maladaptive relationships, mediated through powerlessness; thus, having many sexual partners could be a consequence of difficulty forming close relationships.
- **Option C:** Patients with a history of childhood sexual abuse showed a marked clustering of four major risk factors for repeat Deliberate Self-Harm or DSH (unemployment, past deliberate self-poisoning, self-injury and psychiatric illness) and were significantly more likely to repeat DSH within the 6-month follow-up period.

2. Before birth, which of the following structures connects the right and left auricles of the heart?

- A. Umbilical vein
- B. Foramen ovale
- C. Ductus arteriosus
- D. Ductus venosus

Correct Answer: B. Foramen ovale

The foramen ovale is an opening between the right and left auricles (atria) that should close shortly after birth so the newborn will not have a murmur or mixed-blood traveling through the vascular system.

- **Option A:** The umbilical vein carries oxygenated, nutrient-rich blood from the placenta to the fetus, and the umbilical arteries carry deoxygenated, nutrient-depleted blood from the fetus to the

placenta. Any impairment in blood flow within the cord can be a catastrophic event for the fetus.

- **Option C:** At birth, the lungs fill with air with the first breaths, pulmonary vascular resistance drops, and blood flows from the right ventricle to the lungs for oxygenation. The increased arterial oxygen tension and the decreased flow through the ductus arteriosus allow the ductus to constrict.
- **Option D:** In utero, the ductus venosus connects the left portal vein to the inferior vena cava, allowing a portion of the venous blood to bypass the liver and return to the heart. After birth, the ductus venosus generally closes between days of life 2 to 18 in term infants

3. A provider prescribes a 24-hour urine collection for a client. Which of the following actions should the nurse take?

- A. Discard the first voiding.
- B. Keep all voidings in a container at room temperature.
- C. Ask the client to urinate and pour the urine into a specimen container.
- D. Ask the client to urinate into the toilet, stop midstream, and finish urinating into the specimen container.

Correct Answer: A. Discard the first voiding.

The nurse should discard the first voiding of the 24 hour urine specimen, and note the time. 24-hour urine protein measures the amount of protein released in urine over a 24-hour period. The normal value is less than 100 milligrams per day or less than 10 milligrams per deciliter of urine.

- **Option B:** The nurse should collect all voidings after that and keep them in a refrigerated container. A 24-hour urine collection is done by collecting the urine in a special container over a full 24-hour period. The container must be kept cool until the urine is returned to the lab.
- **Option C:** For a urinalysis, the nurse should ask the client to urinate and pour the urine into a specimen container. Urine is made up of water and dissolved chemicals, such as sodium and potassium. It also contains urea. This is made when protein breaks down. And it contains creatinine, which is formed from muscle breakdown. Normally, urine contains certain amounts of these waste products. It may be a sign of a certain disease or condition if these amounts are not within a normal range. Or if other substances are present.
- **Option D:** For a culture, the nurse should ask the client to urinate first into the toilet, then stop midstream, and finish urinating in the specimen container. A 24-hour urine collection helps diagnose kidney problems. It is often done to see how much creatinine clears through the kidneys. It's also done to measure protein, hormones, minerals, and other chemical compounds.

4. Nurse Pippy is reviewing a client's fluid intake and output record. Fluid intake and urine output should relate in which way?

- A. Fluid intake should double the urine output.
- B. Fluid intake should be approximately equal to the urine output.
- C. Fluid intake should be half the urine output.
- D. Fluid intake should be inversely proportional to the urine output.

Correct Answer: B. Fluid intake should be approximately equal to the urine output.

Normally, fluid intake is approximately equal to the urine output. Any other relationship signals an abnormality. The core principle of fluid balance is that the amount of water lost from the body must equal the amount of water taken in; for example, in humans, the output (via respiration, perspiration, urination, defecation, and expectoration) must equal the input (via eating and drinking, or by parenteral intake).

- **Option A:** Fluid intake that is double the urine output indicates fluid retention. Fluid retention (edema) occurs when the fluid isn't removed from the tissues. The two broad categories of fluid retention include generalized edema, when swelling occurs throughout the body, and localized edema when particular parts of the body are affected.
- **Option C:** Fluid intake that is half the urine output indicates dehydration. Body water is lost through the skin, lungs, kidneys, and GI tract. The loss of body water without sodium causes dehydration. Water is lost from the skin, lungs, gastrointestinal tract, and kidneys. Dehydration results when water losses from the body exceed water replacement. It may be caused by failure to replace obligate water losses.
- **Option D:** Normally, fluid intake isn't inversely proportional to the urine output. One general principle for all patient scenarios is to replace whatever fluid is being lost as accurately as possible. These fluid losses can differ depending on patients' medical conditions and differ by both volume and composition.

5. The client with hyperemesis gravidarum is at risk for developing:

- A. Respiratory alkalosis without dehydration
- B. Metabolic acidosis with dehydration
- C. Respiratory acidosis without dehydration
- D. Metabolic alkalosis with dehydration

Correct Answer: B. Metabolic acidosis with dehydration

The client with hyperemesis has persistent nausea and vomiting. With vomiting comes dehydration. When the client is dehydrated, she will have metabolic acidosis. In severe cases of hyperemesis, complications include vitamin deficiency, dehydration, and malnutrition, if not treated appropriately. Wernicke's encephalopathy, caused by vitamin-B1 deficiency, can lead to death and permanent disability if it goes untreated.

- **Option A:** Electrolyte abnormalities such as hypokalemia can also cause significant morbidity and mortality. Additionally, patients with hyperemesis may have higher rates of depression and anxiety during pregnancy. Electrolytes should be replaced as needed. Severe refractory cases of hyperemesis gravidarum may respond to intravenous or intramuscular chlorpromazine 25 to 50 mg or methylprednisolone 16 mg every 8 hours, orally or intravenously.
- **Option C:** A vomiting pregnant client will ultimately develop dehydration. Additionally, there have been case reports of injuries secondary to forceful and frequent vomiting, including esophageal rupture and pneumothorax. Initial treatment should begin with non-pharmacologic interventions such as switching the patient's prenatal vitamins to folic acid supplementation only, using ginger supplementation (250 mg orally 4 times daily) as needed, and by applying acupressure wristbands.
- **Option D:** The client will not be in alkalosis with persistent vomiting. There is no single accepted definition for hyperemesis gravidarum. However, it generally refers to extreme cases of nausea and vomiting during pregnancy. It is a clinical diagnosis. The criteria for diagnosis include vomiting that causes significant dehydration (as evidenced by ketonuria or electrolyte abnormalities) and weight loss (the most commonly cited marker for this is the loss of at least five percent of the patient's

pre-pregnancy weight) in the setting of pregnancy without any other underlying pathological cause for vomiting.

6. Nurse Nina is assigned to care for a client diagnosed with Catatonic Stupor. When Nurse Nina enters the client's room, the client is found lying on the bed with a body pulled into a fetal position. Nurse Nina should:

- A. Ask the client direct questions to encourage talking.
- B. Take the client into the dayroom to be with other clients.
- C. Sit beside the client in silence and occasionally ask an open-ended question
- D. Leave the client alone and continue with providing care to the other clients.

Correct Answer: C. Sit beside the client in silence and occasionally ask an open-ended question

Clients who are withdrawn may be immobile and mute, and require consistent, repeated interventions. Communication with withdrawn clients requires much patience from the nurse. The nurse facilitates communication with the client by sitting in silence, asking open-ended questions, and pausing to provide opportunities for the client to respond.

- **Option A:** Therapeutic communication is often most effective when patients direct the flow of conversation and decide what to talk about. To that end, giving patients a broad opening such as "What's on your mind today?" or "What would you like to talk about?" can be a good way to allow patients an opportunity to discuss what's on their mind.
- **Option B:** 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 D:** 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.

7. Dr. Wijangco orders insulin lispro (Humalog) 10 units for Alicia, a client with diabetes mellitus. When will the nurse administer this medication?

- A. When the client is eating
- B. Thirty minutes before meals
- C. Fifteen minutes before meals
- D. When the meal trays arrive on the floor

Correct Answer: A. When the client is eating

The onset action for the insulin lispro (Humalog) is 10 to 15 minutes so it must be given when the client is eating to prevent hypoglycemia. Insulin lispro is a new type of insulin. It starts working sooner than other insulin types. It also reaches peak activity faster and goes away sooner.

- **Option B:** If taking Regular insulin or longer-acting insulin, the client should generally take it 15 to 30 minutes before a meal. Short-acting, such as Regular (R) insulin, starts working within 30

minutes and lasts about 5 to 8 hours.

- **Option C:** Each type of insulin works at a different speed and lasts for a different length of time. Quick-acting, such as insulin lispro (Humalog), begins to work very quickly (5 to 15 minutes) and lasts for 3 to 4 hours.
- **Option D:** It must be given when the client is eating, not when the meal trays arrive on the floor. Rapid-acting insulin analogs should be injected within 15 min before a meal or immediately after a meal. The most commonly recommended interval between injection of short-acting (regular) insulin and a meal is 30 min.

8. Actinic keratosis typically progresses into which type of skin cancer?

- A. Cutaneous T-cell lymphoma
- B. Squamous cell carcinoma
- C. Merkel cell cancer
- D. Sebaceous carcinoma

Correct Answer: B. Squamous cell carcinoma

Actinic keratosis, also known as solar keratosis, is a dry scaly patch found on sun-damaged skin. It is a precancerous form of cutaneous squamous cell carcinoma.

- **Options A, C, & D:** Actinic keratosis is not related to the development of these types of skin cancer.

9. Mrs. dela Riva is in her first trimester of pregnancy. She has been lying all day because her OB-GYN requested her to have a complete bed rest. Which nursing intervention is appropriate when addressing the client's need to maintain skin integrity?

- A. Monitoring intake and output accurately.
- B. Instructing the client to cough and deep breathe every 2 hours.
- C. Keeping the linens dry and wrinkle-free.
- D. Using a footboard to maintain correct anatomic position.

Correct Answer: C. Keeping the linens dry and wrinkle-free.

Keeping the linens dry and wrinkle-free aids in preventing moisture and pressure from interfering with adequate blood supply to the tissues, helping to maintain skin integrity. Encourage the implementation of a turning schedule, restricting time in one position to 2 hours or less, if the patient is restricted to bed.

- **Option A:** Monitoring intake and output aids in assessing and maintaining bladder function. Assess patient's nutritional status, including weight, weight loss, and serum albumin levels. An albumin level less than 2.5 g/dL is a grave sign, indicating severe protein depletion and at high risk of skin breakdown.
- **Option B:** Coughing and deep breathing help promote gas exchange. Reinforce the importance of turning, mobility, and ambulation. These will enhance their sense of efficacy and can improve compliance with the prescribed interventions.

- **Option D:** Using a footboard is appropriate for maintaining a normal body function position. Encourage the patient to change position every 15 minutes and change chair-bound positions every hour. Use pillows or foam wedges to keep bony prominences from direct contact with each other. Keep pillows under the heels to raise off the bed.

10. Which task should be assigned to the nursing assistant?

- A. Placing the client in seclusion
- B. Emptying the Foley catheter of the preeclamptic client
- C. Feeding the client with dementia
- D. Ambulating the client with a fractured hip

Correct Answer: C. Feeding the client with dementia

Of these clients, the one who should be assigned to the care of the nursing assistant is feeding the client with dementia.

- **Option A:** Only a physician's order can place the client in seclusion.
- **Option B:** The nurse should empty the Foley catheter of the preeclamptic client because the client is unstable.
- **Option D:** A nurse or physical therapist should ambulate the client with a fractured hip.

11. Betty is a 9-year-old girl diagnosed with cystic fibrosis. Which of the following must Nurse Archie keep in mind when developing a care plan for the child?

- A. Pulmonary secretions are abnormally thick.
- B. Elevated levels of potassium are found in sweat.
- C. CF is an autosomal dominant hereditary disorder.
- D. Obstruction of the endocrine glands occurs.

Correct Answer: A. Pulmonary secretions are abnormally thick.

CF is identified by abnormally thick pulmonary secretions. Researchers now know that cystic fibrosis is an autosomal recessive disorder of exocrine gland function most commonly affecting persons of Northern European descent at a rate of 1 in 3500. It is a chronic disease that frequently leads to chronic sinopulmonary infections and pancreatic insufficiency. The most common cause of death is end-stage lung disease.

- **Option B:** Diagnosis of CF is based on elevated chloride levels detected in sweat. High levels of salt in the sweat of patients with cystic fibrosis suggested an abnormality in electrolyte transport from the sweat gland. Quinton postulated that sweat ducts in these patients were impermeable to chloride.
- **Option C:** It is a chronic, inherited disorder, particularly an autosomal recessive hereditary disorder concerning the exocrine, not endocrine glands. In 1949, Lowe et al. postulated that cystic fibrosis must be caused by a genetic defect from the autosomal recessive pattern of inheritance of the disease.

- **Option D:** The thick mucus blocks the exocrine glands. Further studies led to the hypothesis that the faulty chloride channel must be situated in the apical membranes of the lung surface or glandular epithelium to explain the respiratory and systemic organ failure associated with cystic fibrosis.

12. Which of the following immunizations should not be given to a 4-month-old sibling of a client with leukemia?

- A. Oral poliovirus vaccine (OPV)
- B. Hepatitis B vaccine
- C. Diphtheria and tetanus and pertussis (DPT) vaccine
- D. Haemophilus influenzae type b vaccines (Hib)

Correct Answer: A. Oral poliovirus vaccine (OPV)

- **Option A:** OPV is a live attenuated virus excreted in the stool. The excreted virus can be communicated to the immunosuppressed child, resulting in an overwhelming infection. Inactivated polio vaccine would be indicated because it isn't a live virus and wouldn't pose the threat of infection.
- **Options B, C, and D:** DTP, Hib, and hepatitis B vaccines can be given accordingly to the recommended schedule.

13. A female patient exhibits signs of heightened anxiety. Which response by the nurse is most likely to reduce the patient's anxiety?

- A. "Everything will be fine. Don't worry."
- B. "Read this manual and then ask me any questions you may have."
- C. "Why don't you listen to the radio?"
- D. "Let's talk about what's bothering you."

Correct Answer: D. "Let's talk about what's bothering you."

Anxiety may result from feelings of helplessness, isolation, or insecurity. This response helps reduce anxiety by encouraging the patient to express feelings. The nurse should be supportive and develop goals together with the patient to give the patient some control over an anxiety-inducing situation. Because the other options ignore the patient's feelings and block communication, they would not reduce anxiety.

- **Option A:** Recognize awareness of the patient's anxiety. Since a cause of anxiety cannot always be identified, the patient may feel as though the feelings being experienced are counterfeit. Acknowledgment of the patient's feelings validates the feelings and communicates acceptance of those feelings.
- **Option B:** Converse using a simple language and brief statements. Allow patients to talk about anxious feelings and examine anxiety-provoking situations if they are identifiable. Talking about anxiety-producing situations and anxious feelings can help the patient perceive the situation realistically and recognize factors leading to the anxious feelings.
- **Option C:** Assist the patient in developing new anxiety-reducing skills (e.g., relaxation, deep breathing, positive visualization, and reassuring self-statements). Discovering new coping methods

provides the patient with a variety of ways to manage anxiety.

14. Medical treatment of coronary artery disease includes which of the following procedures?

- A. Cardiac catheterization
- B. Coronary artery bypass surgery
- C. Oral medication administration
- D. Percutaneous transluminal coronary angioplasty

Correct Answer: C. Oral medication administration

Oral medication administration is a noninvasive, medical treatment for coronary artery disease. Nitroglycerin is the most common vasodilator used for acute cases of angina. It works to dilate or widen the coronary arteries, increasing blood flow to the heart muscle and to relax the veins, lessening the amount of blood that returns to the heart from the body. This combination of effects decreases the amount of work for the heart.

- **Option A:** Cardiac catheterization isn't a treatment but a diagnostic tool. Cardiac catheterization (cardiac cath or heart cath) is a procedure to examine how well the heart is working. A thin, hollow tube called a catheter is inserted into a large blood vessel that leads to the heart.
- **Option B:** Coronary artery bypass surgery is an invasive procedure. Coronary artery bypass grafting (CABG) is a procedure to improve poor blood flow to the heart. It may be needed when the arteries supplying blood to heart tissue, called coronary arteries, are narrowed or blocked. This surgery may lower the risk of serious complications for people who have obstructive coronary artery disease, a type of ischemic heart disease. CABG may also be used in an emergency, such as a severe heart attack.
- **Option D:** Percutaneous transluminal coronary angioplasty is an invasive, surgical treatment. Percutaneous transluminal coronary angioplasty (PTCA) is a minimally invasive procedure to open up blocked coronary arteries, allowing blood to circulate unobstructed to the heart muscle.

15. A nurse states to a client, "Things will look better tomorrow after a good night's sleep." This is an example of which communication technique?

- A. The therapeutic technique of "giving advice"
- B. The therapeutic technique of "defending"
- C. The nontherapeutic technique of "presenting reality"
- D. The nontherapeutic technique of "giving false reassurance"

Correct Answer: D. The non-therapeutic technique of "giving false reassurance."

The nurse's statement, "Things will look better tomorrow after a good night's sleep." is an example of the nontherapeutic technique of giving false reassurance. Giving false reassurance indicates to the client that there is no cause for anxiety, thereby devaluing the client's feelings.

- **Option A:** Telling the client what to do, giving opinions, or making decisions for the client, implies the client cannot handle his or her own life decisions and that the nurse is accepting responsibility.

- **Option B:** Defensiveness occurs when the nurse feels the need to defend themselves, their actions, their employers, or others for their failures and shortcomings. Again, this technique fulfills the needs of the nurse rather than the client and, as such, it is not therapeutic.
- **Option C:** Presenting reality is offering for consideration that which is real. When it is obvious that the client is misinterpreting reality, the nurse can indicate what is real. The nurse does this by calmly and quietly expressing the nurse's perceptions or the facts not by way of arguing with the client to consider, not to "convince" the client that he is wrong.

16. A toddler with otitis media has just completed antibiotic therapy. A recheck appointment should be made to:

- A. Obtain a new prescription in case the infection recurs
- B. Determine whether the ear infection has affected her hearing
- C. Make sure that she has taken all the antibiotic
- D. Document that the infection has completely cleared

Correct Answer D. Document that the infection has completely cleared

- Option D: The client should go back for an appointment following the completion of antibiotic therapy to determine whether the infection has cleared and to check for the presence of otitis media with effusion (fluid buildup in the eardrum).
- Option A: The purpose of the recheck is to determine whether the infection is gone.
- Option B: This would be done if there are repeated instances of otitis media.
- Option C: This will not determine whether the child has completed the medication.

17. The nurse is providing instructions to a Chinese-American client about the frequency and dosages of the take-home medicines. When conducting the teaching, the client continuously turns away from the nurse. The nurse should do which of the following appropriate actions?

- A. Walk around the client so that the nurse can constantly face the client.
- B. Call the attention of the client by speaking loudly.
- C. Continue with the instructions, then confirming the client's understanding.
- D. Hand over a written instruction and discuss only what the client doesn't understand.

Correct Answer: C. Continue with the instructions, verifying client understanding.

Most Chinese maintain a formal personal space with others, which is a form of respect. Most Chinese are uncomfortable with face-to-face communications, especially when eye contact is direct. If the client turns away from the nurse during a conversation, the most appropriate action is to continue with the instructions. Many cultures have very different ways of thinking about healthcare and may have traditions that go against the grain of Western medicine.

- **Option A:** Walking around to the client so that the nurse faces the client is in direct conflict with the cultural practice. Healthcare providers who are unfamiliar with cultural traditions surrounding medical care may have difficulty connecting with the patient or the patient may not feel safe and recognized, which is key to treatment acceptance.

- **Option B:** Calling attention and speaking loudly is viewed as a rude gesture. It's important that nurses avoid making assumptions about cultures they aren't familiar with. This can lead to a breakdown of trust and rapport between the nurse and their patient and reduce treatment acceptance.
- **Option D:** Discussing only what the client cannot understand is not an acceptable practice of a nurse. When communicating with a patient, ask them to repeat back to you what you said, in their own words. If there's a language barrier, a translator can help. Essentially, this will help you determine how much of what you are saying has been understood and how you might be able to change the way you communicate to improve the patient's understanding.

18. During the first several hours after a cardiac catheterization, it would be most essential for nurse Cherry to:

- A. Elevate the client's bed at 45°.
- B. Instruct the client to cough and deep breathe every 2 hours.
- C. Frequently monitor the client's apical pulse and blood pressure.
- D. Monitor client's temperature every hour.

Correct Answer: C. Frequently monitor the client's apical pulse and blood pressure.

Blood pressure is monitored to detect hypotension which may indicate shock or hemorrhage. The apical pulse is taken to detect arrhythmias related to cardiac irritability. During the procedure, a nurse is assigned to monitor vital signs. After the procedure, the nurse is also responsible for ensuring that the access site is not bleeding and the distal extremity pulses are intact.

- **Option A:** Patients should be kept lying flat for several hours after the procedure so that any serious bleeding can be avoided. Identification of the bleeding source is essential for patients with continued hemodynamic deterioration. These life-threatening bleeds are more frequent when the artery is punctured above the inguinal ligament. Most patients are managed with a reversal of anticoagulation, application of manual compression and volume resuscitation, and observation.
- **Option B:** Coughing and deep breathing every 2 hours is unnecessary. For any patient, the complication rate is dependent on multiple factors and is dependent on the demographics of the patient, vascular anatomy, comorbid conditions, clinical presentation, the procedure being performed, and the experience of the operator. The complications can be minor as discomfort at the site of catheterization to major ones like death.
- **Option D:** Temperature can be monitored for every shift. Cardiac catheterization is performed using sterile technique, and local or systemic infection is extremely rare. Routine prophylaxis for endocarditis is not recommended during cardiac catheterization procedures.

19. A nurse reinforces instructions to the mother of a child who has been hospitalized with croup. Which of the following statements, if made by the mother, would indicate the need for further instruction? Select all that apply.

- A. "I will give my child cough syrup if a cough develops."
- B. "During an attack, I will take my child to a cool location."
- C. "I will give acetaminophen (Tylenol) if my child develops a fever."
- D. "I will be sure that my child drinks at least three to four glasses of fluids every day."

E. "I will place my child in a room with dry air."

F. "I will let my child sit under the shower until the cough subsides."

Correct Answer: A, E, & F.

Croup is a common respiratory illness of the trachea, larynx, and bronchi that can lead to inspiratory stridor and barking cough. The parainfluenza virus typically causes croup, but a bacterial infection can also cause it. Croup is primarily a clinical diagnosis.

- **Option A:** Cough syrups and cold medicines are not to be given, because they may dry and thicken secretions. Cough medicines, which usually contain dextromethorphan or guaifenesin, are discouraged.
- **Option B:** During a croup attack, the child can be taken to a cool basement or garage. Provide a calm, quiet environment for the child. Anxiety affects respirations and a calm environment lessens anxiety.
- **Option C:** Acetaminophen is used if a fever develops. Educate the parents on the administration and uses of prescribed medications. This facilitates appropriate medication administration and recognition of adverse side effects.
- **Option D:** Adequate hydration of 500 to 1000 mL of fluids daily is important for thinning secretions. Advise increase fluid intake and maintain intravenous fluid as prescribed. Adequate hydration can help loosen mucus in the oropharynx and prevent dehydration.
- **Option E:** Have the child breathe moist air. Warm, moist air may help the child breathe easier. Cool mist and humidity soothe inflamed airways and decrease the viscosity of the mucus thus helps in clearing the airway.
- **Option F:** If the child has symptoms of croup, take him into the bathroom, close the bathroom door, and turn on a hot shower. Do not put your child under the shower. Sit with the child in the warm, moist air for 15 to 20 minutes.

20. Following a meticulous surgical procedure, 15-month-old David is in the pediatric surgical unit recovering from the removal of a Wilms' tumor. The multidisciplinary healthcare team is actively engaged in a comprehensive postoperative care plan aiming to promote healing, manage symptoms, and ensure David's comfort and well-being. Given David's tender age, assessing pain and discomfort necessitates a keen interpretation of behavioral and physiological indicators. The nursing staff is employing validated pediatric pain assessment tools, alongside continuous monitoring of vital signs and behavioral cues. David's parents are understandably anxious and are keen to see their child comfortable and progressing towards recovery. As part of the ongoing assessment, the nursing staff is keenly observing David for any signs indicative of his comfort level and freedom from pain, which is crucial for his overall recovery and parental reassurance. Which of the following findings would best indicate to the healthcare team that David is free from pain postoperatively?

A. Decreased appetite

B. Increased heart rate

- C. Decreased urine output
- D. Increased interest in play
- E. Restless behavior
- F. Elevated blood pressure
- G. Calm and steady breathing

Correct Answer: D. Increased interest in play.

Increased interest in play is a positive sign of comfort and a reduction in pain, particularly in children. Engaging in play reflects a level of comfort and is a positive behavioral indicator of pain relief.

- **Option A:** A decreased appetite is more likely indicative of discomfort or pain, rather than relief from pain.
- **Option B:** An increased heart rate can be a physiological response to pain or distress; it's not a sign of relief from pain.
- **Option C:** Decreased urine output can be a response to various factors including dehydration or renal complications but is not typically associated with relief from pain.
- **Option E:** Restless behavior can be a sign of discomfort or pain in children; it's not indicative of relief from pain.
- **Option F:** Elevated blood pressure can be a physiological response to pain or distress; it's not indicative of relief from pain.
- **Option G:** While calm and steady breathing can be associated with a comfortable state and potentially a relief from pain, the increased interest in play provides a more definitive behavioral indication of comfort and pain relief in a child of David's age.

21. You're preparing a patient with a malignant tumor for colorectal surgery and subsequent colostomy. The patient tells you he's anxious. What should your initial step be in working with this patient?

- A. Determine what the patient already knows about colostomies.
- B. Show the patient some pictures of colostomies.
- C. Arrange for someone who has a colostomy to visit the patient.
- D. Provide the patient with written material about colostomy care.

Correct Answer: A. Determine what the patient already knows about colostomies.

Initially, you should assess the patient's knowledge about colostomies and how it will affect his lifestyle. Review anatomy, physiology, and implications of surgical intervention. Discuss future expectations, including anticipated changes in the character of effluent. Provides knowledge base from which the patient can make informed choices, and offers an opportunity to clarify misconceptions regarding an individual situation.

- **Option B:** Include written, picture (photo, video, Internet) learning resources. This provides references for obtaining support, equipment, and additional information after discharge to support patient efforts for independence in self-care.
- **Option C:** Ascertain whether support and counseling were initiated when the possibility and/or necessity of ostomy was first discussed. This provides information about the patient's/SO's level of knowledge and anxiety about an individual situation.

- **Option D:** The patient may find it easier to accept or deal with an ostomy done to correct chronic or long-term disease than for traumatic injury, even if ostomy is only temporary. Also, patient who will be undergoing a second procedure (to convert ostomy to a continent or anal reservoir) may possibly encounter less severe self-image problems because body function eventually will be “more normal.”

22. Referencing the image below, what is the name of the structure marked #16.

- A. Loop of henle
- B. Renal medulla
- C. Renal calyx
- D. Renal blood vessels
- E. Renal capsule
- F. Renal vein
- G. Renal nerve
- H. Renal artery
- I. Renal pelvis
- J. Renal pyramid

Correct answer: #16 is the Option E. renal capsule.

The renal capsule is a thin, tough membrane that envelops the outer surface of the kidney. It provides structural support, protection from trauma and injuries, and helps maintain the kidney’s shape.

23. A male client is admitted to the substance abuse unit for alcohol detoxification. Which of the following medications is Nurse Alice most likely to administer to reduce the symptoms of alcohol withdrawal?

- A. Naloxone (Narcan)
- B. Haloperidol (Haldol)
- C. Magnesium sulfate
- D. Chlordiazepoxide (Librium)

Correct Answer: D. Chlordiazepoxide (Librium)

Chlordiazepoxide (Librium) and other tranquilizers help reduce the symptoms of alcohol withdrawal. Chlordiazepoxide is a long-acting benzodiazepine and is an FDA approved medication for adults with mild-moderate to severe anxiety disorder, preoperative apprehension and anxiety, and withdrawal symptoms of acute alcohol use disorder. Chlordiazepoxide has anti-anxiety, sedative, appetite-stimulating, and weak analgesic actions. It binds to benzodiazepine receptors at the GABA-A ligand-gated chloride channel complex and enhances GABA’s inhibitory effects.

- **Option A:** Naloxone (Narcan) is administered for narcotic overdose. Naloxone is indicated for the treatment of opioid toxicity, specifically to reverse respiratory depression from opioid use. It is useful in accidental or intentional overdose and acute or chronic toxicity. Naloxone is a pure, competitive opioid antagonist with a high affinity for the mu-opioid receptor, allowing for reversal of

the effects of opioids. The onset of action varies depending on the route of administration but can be as fast as one minute when delivered intravenously (IV) or intraosseous (IO).

- **Option B:** Haloperidol (Haldol) may be given to treat clients with psychosis, severe agitation, or delirium. Haloperidol is a first-generation (typical antipsychotic) which exerts its antipsychotic action by blocking dopamine D2 receptors in the brain. When 72% of dopamine receptors are blocked, this drug achieves its maximal effect. Haloperidol is not selective for the D2 receptor. It also has noradrenergic, cholinergic, and histaminergic blocking action. The blocking of these receptors is associated with various side effects.
- **Option C:** Magnesium sulfate and other anticonvulsant medications are only administered to treat seizures if they occur during withdrawal. Magnesium sulfate administration can be oral (PO), intramuscular (IM), intraosseous (IO), or intravenous (IV). For every 1 gram of magnesium sulfate, it contains 98.6 mg or 8.12Eq of elemental magnesium. Magnesium sulfate can be combined with dextrose 5% or water to make intravenous solutions.

24. A male client is brought to the psychiatric clinic by family members, who tell the admitting nurse that the client repeatedly drives while intoxicated despite their pleas to stop. During an interview with the nurse Linda, which statement by the client most strongly supports a diagnosis of psychoactive substance abuse?

- A. "I'm not addicted to alcohol. In fact, I can drink more than I used to without being affected."
- B. "I only spend half of my paycheck at the bar."
- C. "I just drink to relax after work."
- D. "I know I've been arrested three times for drinking and driving, but the police are just trying to hassle me."

Correct Answer: D. "I know I've been arrested three times for drinking and driving, but the police are just trying to hassle me."

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, diagnostic criteria for psychoactive substance abuse include a maladaptive pattern of such use, indicated either by continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem caused or exacerbated by substance abuse or recurrent use in dangerous situations (for example, while driving).

For this client, psychoactive substance dependence must be ruled out; criteria for this disorder include a need for increasing amounts of the substance to achieve intoxication (option A), increased time and money spent on the substance (option B), inability to fulfill role obligations (option C), and typical withdrawal symptoms.

- **Option A:** A shortened version of the term used in the ICD-10 – Mental and behavioral disorders due to psychoactive substance use. The term encompasses acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, and amnesic syndrome. For a particular substance, these conditions may be grouped together as, for example, alcohol disorders, cannabis use disorders, stimulant use disorders. Psychoactive substance use disorders are defined as being of clinical relevance; the term 'psychoactive substance use problems' is a broader one, which includes conditions and events not necessarily of clinical relevance.
- **Option B:** Production, distribution, sale, or non-medical use of many psychoactive drugs is either controlled or prohibited outside legally sanctioned channels by law. Psychoactive drugs have

different degrees of restriction of availability, depending on their risks to health and therapeutic usefulness, and classified according to a hierarchy of schedules at both national and international levels. At the international level, there are international drug conventions concerned with the control of production and distribution of psychoactive drugs: the 1961 Single Convention on Narcotic Drugs, amended by a 1972 Protocol; the 1971 Convention on Psychotropic Substances; the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

- **Option C:** It is an essential characteristic of the dependence syndrome that either substance taking or a desire to take a particular substance should be present; the subjective awareness of compulsion to use drugs is most commonly seen during attempts to stop or control substance use. This diagnostic requirement would exclude, for instance, surgical patients given opiate drugs for the relief of pain and who may show signs of an opiate withdrawal state when drugs are not given, but who have no desire to continue taking drugs.

25. A client exhibits all of the following during a physical assessment. Which of these is considered a primary defense against infection?

- A. Fever
- B. Intact skin
- C. Inflammation
- D. Lethargy

Correct Answer: B. Intact skin

Intact skin is considered a primary defense against infection. Usually, the skin prevents invasion by microorganisms unless it is damaged (for example, by an injury, insect bite, or burn). Mucous membranes, such as the lining of the mouth, nose, and eyelids, are also effective barriers. Typically, mucous membranes are coated with secretions that fight microorganisms. For example, the mucous membranes of the eyes are bathed in tears, which contain an enzyme called lysozyme that attacks bacteria and helps protect the eyes from infection. Fever, the inflammatory response, and phagocytosis (a process of killing pathogens) are considered secondary defenses against infection.

- **Option A:** Body temperature increases as a protective response to infection and injury. An elevated body temperature (fever) enhances the body's defense mechanisms, although it can cause discomfort. A part of the brain called the hypothalamus controls body temperature. Fever results from an actual resetting of the hypothalamus's thermostat. The body raises its temperature to a higher level by moving (shunting) blood from the skin surface to the interior of the body, thus reducing heat loss.
- **Option C:** Any injury, including an invasion by microorganisms, causes inflammation in the affected area. Inflammation, a complex reaction, results from many different conditions. During inflammation, the blood supply increases, helping carry immune cells to the affected area. Because of the increased blood flow, an infected area near the surface of the body becomes red and warm. The walls of blood vessels become more porous, allowing fluid and white blood cells to pass into the affected tissue. The increase in fluid causes the inflamed tissue to swell. The white blood cells attack the invading microorganisms and release substances that continue the process of inflammation.
- **Option D:** Lethargy refers to a state of lacking energy. People who are experiencing fatigue or tiredness can also be said to be lethargic because of low energy. The same medical conditions that can lead to tiredness or fatigue can also lead to lethargy.

26. 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.

27. A nurse has a four-patient assignment in the medical step-down unit. When planning care for the clients, which client would have the following treatment goals: fluid replacement, vasopressin replacement, and correction of underlying intracranial pathology?

- A. The client with diabetes mellitus.
- B. The client with diabetes insipidus.
- C. The client with diabetic ketoacidosis.
- D. The client with syndrome of inappropriate antidiuretic hormone (SIADH) secretion.

Correct Answer: B. The client with diabetes insipidus.

Maintaining adequate fluid, replacing vasopressin, and correcting underlying intracranial problems (typically lesions, tumors, or trauma affecting the hypothalamus or pituitary gland) are the main objectives in treating diabetes insipidus. Diabetes insipidus (DI) is a disease process that results in either decreased release of or response to antidiuretic hormone (ADH, also known as vasopressin or AVP), which can cause electrolyte imbalances.

- **Option A:** Diabetes mellitus does not involve vasopressin deficiencies or an intracranial disorder, but rather a disturbance in the production or use of insulin. The physiology and treatment of

diabetes are complex and require a multitude of interventions for successful disease management. Diabetic education and patient engagement are critical in management.

- **Option C:** Diabetic ketoacidosis results from severe insulin insufficiency. Fluid resuscitation and maintenance, insulin therapy, electrolyte replacement, and supportive care are the mainstays of management in diabetic ketoacidosis.
- **Option D:** An excess of vasopressin leads to SIADH, causing the client to retain fluid. The patients with SIADH have a combination of ADH-induced water retention and secondary solute loss. The overall solute loss is more prominent than water retention in patients with chronic SIADH. SIADH treatment involves correction and maintenance of corrected sodium levels and correction of underlying abnormalities such as hypothyroidism or pulmonary or CNS infection.

28. Dr. Smith has determined that the client with hepatitis has contracted the infection from contaminated food. The nurse understands that this client is most likely experiencing what type of hepatitis?

- A. Hepatitis A
- B. Hepatitis B
- C. Hepatitis C
- D. Hepatitis D

Correct Answer: A. Hepatitis A

Hepatitis A is transmitted by the fecal-oral route via contaminated food or infected food handlers. The most common mode of transmission of hepatitis A is via the fecal-oral route from contact with food, water, or objects contaminated by fecal matter from an infected individual. It is more commonly encountered in developing countries where due to poverty and lack of sanitation, there is a higher chance of fecal-oral spread.

- **Option B:** Hepatitis B is transmitted parenterally and sexually when individuals come in contact with mucous membranes or body fluids of infected individuals. Transfusion of blood and blood products, injection drug use with shared needles, needlesticks, or wounds caused by other instruments in healthcare workers and hemodialysis are all examples of parenteral and percutaneous exposures, but parenteral mode remains the dominant mode of transmission both globally and in the United States.
- **Option C:** Transmission of Hepatitis C can be parenteral, perinatal, and sexual, with the most common mode being the sharing of contaminated needles among IV drug users. Also, other high-risk groups include people who require frequent blood transfusions and organ transplantation of organs from infected donors.
- **Option D:** Hepatitis D is an RNA virus and a single species in the Deltavirus genus. It contains the hepatitis D antigen and RNA strand and uses HBsAg as its envelope protein; therefore, those who get hepatitis D virus infection have coinfection with the hepatitis B virus as well. Hepatitis D virus has similar modes of transmission as the hepatitis B virus, but perinatal transmission is uncommon.

29. The client is having fetal heart rates of 90–110 bpm during the contractions. The first action the nurse should take is:

- A. Reposition the monitor

- B. Turn the client to her left side
- C. Ask the client to ambulate
- D. Prepare the client for delivery

Correct Answer: B. Turn the client to her left side

The normal fetal heart rate is 120–160 bpm; 100–110bpm is bradycardia. The first action would be to turn the client to the left side and apply oxygen. A slow heart rate, or bradycardia, may indicate the baby is not getting enough oxygen delivery to the brain. A fast heart rate, or tachycardia, may indicate oxygen deprivation. There is an acceptable range of acceleration and deceleration – or speeding up and slowing down – of fetal heart rates during contractions and labor.

- **Option A:** Repositioning the monitor is not indicated at this time. Obstetricians and nurses must carefully review fetal monitor strips throughout labor and delivery to ensure fetal heart tones are reassuring and the baby is getting enough oxygen. If non-reassuring conditions occur, appropriate and timely actions must be taken.
- **Option C:** Asking the client to ambulate is not the best action for clients experiencing bradycardia. Generally, nursing interventions are attempted first to restore normal oxygenation to the baby. These include the administration of supplemental oxygen, changes in maternal position, increasing intravenous fluids, and the administration of medications that subdue contractions and maximize placental blood flow.
- **Option D:** There is no data to indicate the need to move the client to the delivery room at this time. If fetal heart tones remain non-reassuring despite nursing interventions, the fetus should be delivered by emergency cesarean section. Emergency cesarean section should be performed within 5 to 30 minutes depending on the circumstances.

30. The nurse in charge formulates a nursing diagnosis of Activity intolerance related to inadequate oxygenation and dyspnea for a client with chronic bronchitis. To minimize this problem, the nurse instructs the client to avoid conditions that increase oxygen demands. Such conditions include:

- A. Drinking more than 1,500 ml of fluid daily.
- B. Being overweight.
- C. Eating a high-protein snack at bedtime.
- D. Eating more than three large meals a day.

Correct Answer: B. Being overweight

Conditions that increase oxygen demands include obesity, smoking, exposure to temperature extremes, and stress. Patients with COPD can experience hypoxia during increased activity and may need oxygenation to avoid hypoxemia which puts them at risk for exacerbations of the condition.

- **Option A:** A client with chronic bronchitis should drink at least 2,000 ml of fluid daily to thin mucus secretions; restricting fluid intake may be harmful. Assess the patient's respiratory response to the activity which includes monitoring of respiratory rate and depth, oxygen saturation, and use of accessory muscles for respiration.
- **Option C:** The nurse should encourage the client to eat a high-protein snack at bedtime because protein digestion produces an amino acid with sedating effects that may ease insomnia associated with chronic bronchitis. Adequate energy reserves are needed during activity.

- **Option D:** Eating more than three large meals a day may cause fullness, making breathing uncomfortable and difficult; however, it doesn't increase oxygen demands. To help maintain adequate nutritional intake, the client with chronic bronchitis should eat small, frequent meals (up to six a day).

31. Nurse Mary witnesses a neighbor's husband sustain a fall from the roof of his house. The nurse rushes to the victim and determines the need to open the airway in this victim by using which method?

- A. Flexed position
- B. Head tilt-chin lift
- C. Jaw-thrust maneuver
- D. Modified head tilt-chin lift

Correct Answer: C. Jaw-thrust maneuver

If a neck injury is suspected, the jaw thrust maneuver is used to open the airway. The jaw thrust maneuver more directly lifts the hyoid bone and tongue away from the posterior pharyngeal wall by subluxating the mandible forward onto the sliding part of the temporomandibular joint (mandibular advancement).

- **Option A:** A flexed position is an inappropriate position for opening the airway. Direct laryngoscopy and tracheal intubation is one of the basic and the most important skills in anesthetic practice. This requires proper positioning of head and neck to adequately visualize the glottis and easily negotiate the tracheal tube through the glottic opening. The position traditionally recommended and taught to all learners of airway management is the "sniffing position" (SP). This involves neck flexion (head elevation) by putting a pillow under the head and then extending the head at the atlanto-occipital joint.
- **Option B:** The head tilt–chin lift maneuver produces hyperextension of the neck and could cause complications if a neck injury is present. To relieve upper airway obstruction, the clinician uses two hands to extend the patient's neck. While one hand applies downward pressure to the patient's forehead, the tips of the index and middle fingers of the second hand lift the mandible at the chin, which lifts the tongue from the posterior pharynx. The head-tilt/chin-lift maneuver may be used in any patient in whom cervical spine injury is NOT a concern.
- **Option D:** To perform the head-tilt maneuver, approach the patient from the side and place the palm of one hand on the patient's forehead and push down gently, rolling the patient's head towards the top. Then, using the fingers of your free hand, lightly lift the chin even further up.

32. A client at 36 weeks gestation is scheduled for a routine ultrasound prior to amniocentesis. After teaching the client about the purpose of the ultrasound, which of the following client statements would indicate to the nurse in charge that the client needs further instruction?

- A. The ultrasound will help to locate the placenta.
- B. The ultrasound identifies blood flow through the umbilical cord.
- C. The test will determine where to insert the needle.
- D. The ultrasound locates a pool of amniotic fluid.

Correct Answer: B. The ultrasound identifies blood flow through the umbilical cord.

Before amniocentesis, a routine ultrasound is valuable in locating the placenta, locating a pool of amniotic fluid, and showing the physician where to insert the needle. Color Doppler imaging ultrasonography identifies blood flow through the umbilical cord. A routine ultrasound does not accomplish this.

- **Option A:** As early as 10 weeks, the placenta can be detected by an ultrasound. The normal placenta is discoid with uniform echogenicity and rounded margins. It is usually located along the anterior or posterior uterine walls, extending into the lateral walls.
- **Option C:** Ultrasound is done before and during amniocentesis to ensure that the needle can safely pass through the walls of the abdomen and womb.
- **Option D:** The sample of amniotic fluid is removed through a fine needle inserted into the uterus through the abdomen, under ultrasound guidance.

33. While the nurse is administering medications to a client, the client states “I do not want to take that medicine today.” Which of the following responses by the nurse would be best?

- A. “That’s OK, it’s alright to skip your medication now and then.”
- B. “I will have to call your doctor and report this.”
- C. “Is there a reason why you don’t want to take your medicine?”
- D. “Do you understand the consequences of refusing your prescribed treatment?”

Correct Answer: C. “Is there a reason why you don’t want to take your medicine?”

When a new problem is identified, it is important for the nurse to collect accurate assessment data. This is crucial to ensure that client needs are adequately identified in order to select the best nursing care approaches. The nurse should try to discover the reason for the refusal which may be that the client has developed untoward side effects.

- **Option A:** It is not alright to skip medication. Be very matter-of-fact in communication style with the individual taking the medication. Do not beg, threaten, bribe, or force the individual. Do not say “I’ll get in trouble “ or “You’ll get in trouble”.
- **Option B:** If they continue to refuse, document the missed dose and state the reason (individual refused), along with other relevant information if known (i.e. they indicated nausea). In addition, contact the physician under circumstances as agreed when medication was prescribed and/or implement any steps in the ISP for missed doses.
- **Option D:** Find out if they understand what the medication is for. If they do not understand, remind them of the purpose and ask them again to take it. Find out if they understand the implications of not taking their medication. If they do not understand, remind them of the implications and ask them again to take it (In addition to physical symptoms, implications may include the need to call the physician and report the missed dose.)

34. A gravidocardiic mother is advised to observe bed rest primarily to:

- A. Allow the fetus to achieve normal intrauterine growth.

- B. Minimize oxygen consumption which can aggravate the condition of the compromised heart of the mother.
- C. Prevent perinatal infection.
- D. Reduce incidence of premature labor.

Correct Answer: B. Minimize oxygen consumption which can aggravate the condition of the compromised heart of the mother.

The activity of the mother will require more oxygen consumption. Since the heart of a gravido-cardiac is compromised, there is a need to put a mother on bedrest to reduce the need for oxygen.

- **Option A:** In cases of maternal decompensation, fetal monitoring should also be done to ensure fetal well-being. Women with moderate-risk or high-risk lesions, especially cyanotic lesions, have an increased risk of fetal growth restriction and should be followed with monthly ultrasound examinations for fetal growth.
- **Option C:** The 2011 update to the American Heart Association guideline for the prevention of cardiovascular disease (CVD) in women recommends that risk assessment at any stage of life include a detailed history of pregnancy complications. Gestational diabetes, preeclampsia, preterm birth, and birth of an infant small for gestational age are ranked as major risk factors for CVD.
- **Option D:** During the third trimester, cardiac output is further influenced by body position, where the supine position causes caval compression by the gravid uterus. This leads to a decrease in venous return, which can cause supine hypotension of pregnancy. Stroke volume normally increases in the first and second trimester and decreases in the third trimester. This decrease is due to partial vena cava obstruction.

35. Nurse Nikki knows that laboratory results supports the diagnosis of systemic lupus erythematosus (SLE) is:

- A. Elevated serum complement level
- B. Thrombocytosis, elevated sedimentation rate
- C. Pancytopenia, elevated antinuclear antibody (ANA) titer
- D. Leukocytosis, elevated blood urea nitrogen (BUN) and creatinine levels

Correct Answer: C. Pancytopenia, elevated antinuclear antibody (ANA) titer

Laboratory findings for clients with SLE usually show pancytopenia, elevated ANA titer, and decreased serum complement levels.

- **Option A:** Decreased levels of serum complement is usually associated with SLE. The cause of complement activation in SLE is the formation of immune complexes, which in turn activate complement, predominantly by means of the classical pathway.
- **Option B:** Thrombocytopenia is one of the components of pancytopenia. It is a condition in which the platelet count is decreased.
- **Option D:** Clients may have elevated BUN and creatinine levels from nephritis, but the increase does not indicate SLE. The part of the kidney most frequently troubled by SLE is part of the nephron called the glomerulus, a tuft of capillaries that functions to filter substances from the blood. For this reason, the type of kidney inflammation most commonly experienced in lupus is glomerulonephritis.