Kevin's Review - 35 NCLEX Practice Questions

1. Nurse Penny is aware that the symptoms that distinguish post-traumatic stress disorder from other anxiety disorder would be:

A. Avoidance of situation & certain activities that resemble the stress.

B. Depression and a blunted affect when discussing the traumatic situation.

C. Lack of interest in family & others.

D. Re-experiencing the trauma in dreams or flashbacks.

Correct Answer: D. Re-experiencing the trauma in dreams or flashback

Experiencing the actual trauma in dreams or flashbacks is the major symptom that distinguishes post-traumatic stress disorder from other anxiety disorders. The symptoms of PTSD include persistently re-experiencing the traumatic event, intrusive thoughts, nightmares, flashbacks, dissociation(detachment from oneself or reality), and intense negative emotional (sadness, guilt) and physiological reaction on being exposed to the traumatic reminder.

- **Option A:** Problems with sleep and concentration, irritability, increased reactivity, increased startle response, hypervigilance, avoidance of traumatic triggers also occur. There is a significant impairment in social, occupational, and other areas of functioning. However, the symptoms of PTSD overlap with acute stress disorder. For a patient to be diagnosed as PTSD, the duration of the symptoms must be more than one month.
- **Option B:** Posttraumatic stress disorder is a complex phenomenon, and it is necessary to evaluate for any co-existing psychiatric illness in the patient. After a detailed history is obtained, the next step is to have a thorough mental status examination, which helps confirm the behavioral, emotional, and cognitive aspects of PTSD. On the mental status examination, the patient would likely mention poor sleep and concentration, frequent nightmares and flashbacks related to the event, guilt or negative emotions associated with the reminder, avoidance, and increased vigilance.
- **Option C:** The initial step in the diagnosis of posttraumatic stress disorder is to obtain a detailed history. It is challenging for the patient at times to describe the nature and severity of the traumatic event, and they may choose to avoid mentioning it. However, the presentation and the duration of the symptoms are useful in making an accurate diagnosis. The health care workers must inquire about any depressive or anxiety symptoms, suicidal ideation or previous attempts, substance abuse, access to firearms.

2. Which criterion is needed for someone to give consent to a procedure?

A. An appointed guardianship

B. Unemancipated minor

C. Minimum of 21 years or older

D. An advocate for a child

Correct Answer: A. An appointed guardianship

A guardian has been appointed by a court and has full legal rights to choose management of care. A situation may arise in which a patient cannot make decisions independently but has not designated a decision-maker. In this instance, the hierarchy of decision-makers, which is determined by each state’s laws, must be sought to determine the next legal surrogate decision-maker. If this is unsuccessful, a legal guardian may need to be appointed by the court.

- **Option B:** An exception to this rule is a legally emancipated child who may provide informed consent for himself. Some, but not all, examples of an emancipated minor include minors who are (1) under 18 and married, (2) serving in the military, (3) able to prove financial independence, or (4) mothers of children (married or not).
- **Option C:** Children (typically under 17) cannot provide informed consent. As such, parents must permit treatments or interventions. In this case, it is not termed “informed consent” but “informed permission.” Legislation regarding minors and informed consent is state-based as well. It is important to understand the state laws.
- **Option D:** An advocate for the child is not legally appointed by the court. Several exceptions to the requirement for informed consent include (1) the patient is incapacitated, (2) life-threatening emergencies with inadequate time to obtain consent, and (3) voluntary waived consent. If the patient’s ability to make decisions is questioned or unclear, an evaluation by a psychiatrist to determine competency may be requested.

3. A 53 y.o. patient has undergone a partial gastrectomy for adenocarcinoma of the stomach. An NG tube is in place and is connected to low continuous suction. During the immediate postoperative period, you expect the gastric secretions to be which color?

A. Brown

B. Clear

C. Red

D. Yellow

Correct Answer: C. Red

Normally, drainage is bloody for the first 24 hours after a partial gastrectomy; then it changes to brown-tinged and then to yellow or clear. Drainage will be bloody for the first 12 hours, and then should clear and turn greenish. Continued or recurrent bleeding suggests complications. A decline in output may reflect the return of GI function.

- **Option A:** This tube will be set to suction and will drain out brownish-colored stomach acid. When it runs from brown to light green to clear, this is an indication that things are moving through the stomach and feedings may be possible.
- **Option B:** Gastric aspirate is usually cloudy and green, tan or off-white, or brown. Intestinal aspirate is generally clear and yellow to bile-colored. Pleural fluid is pale yellow and serous; tracheobronchial secretions are usually tan or off-white mucus.
- **Option D:** Normal color of gastric drainage is light yellow to green in color due to the presence of bile. Bloody drainage may be expected after gastric surgery but must be monitored closely. The presence of coffee-ground type drainage may indicate bleeding.

4. Cersei is diagnosed as having disorganized schizophrenia. Which behaviors would Nurse Sansa most likely assess in the client?

A. Absence of acute symptoms impaired role function.

B. Extreme social withdrawal, odd mannerisms, and behavior.

C. Psychomotor immobility; presence of waxy flexibility.

D. Suspiciousness toward others increased hostility.

Correct Answer: B. Extreme social withdrawal, odd mannerisms, and behavior

Disorganized schizophrenia is characterized by regressive behavior with extreme social withdrawal and frequently odd mannerisms. In the most general sense, disorganized schizophrenia refers to the disorganization of thought processes, behavior, and affect regulation (emotions). The DSM-IV included five subtypes of schizophrenia, including disorganized, paranoid, catatonic, undifferentiated, and residual. The subtypes were removed from the current version of the DSM (DSM-5, released in 2013), as it was determined that they were not helpful when treating the disorder.

- **Option A:** The absence of acute symptoms and impaired role function are more characteristic of residual-type schizophrenia. Residual-type schizophrenia is characterized by a past history of at least one episode of schizophrenia, but the person will currently have no positive symptoms (delusions, hallucinations, disorganized speech or behavior). Symptoms may represent a transition between a full-blown episode and complete remission, or it may continue for years without any further psychotic episodes.
- **Option C:** Psychomotor immobility and presence of waxy flexibility are more indicative of catatonic schizophrenia. Catatonia is a complex combination of psychomotor abnormalities and mood and thought processes. There are at least forty different signs and symptoms that have been associated with catatonia. The Diagnostic and Statistical Manual V has criteria for catatonia with specifiers, including that for schizophrenia.
- **Option D:** Suspiciousness toward others and increased hostility is more characteristic of paranoid schizophrenia. Paranoid schizophrenia is characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations. These debilitating symptoms blur the line between what is real and what isn't, making it difficult for the person to lead a typical life.

5. Before rigor mortis occurs, the nurse is responsible for:

A. Providing a complete bath and dressing change.

B. Placing one pillow under the body's head and shoulders.

C. Removing the body's clothing and wrapping the body in a shroud.

D. Allowing the body to relax normally.

Correct Answer: B. Placing one pillow under the body's head and shoulders.

The nurse must place a pillow under the deceased person's head and shoulders to prevent blood from settling in the face and discoloring it. A body undergoes complex and intricate changes after death. These post mortem changes depend on a diverse range of variables. Factors such as the ambient temperature, season, and geographical location at which the body is found, the fat content of the body, sepsis/injuries, intoxication, presence of clothes/insulation over the body, etc. determine the rate at which post-mortem changes occur in a cadaver.

- **Option A:** She is required to bathe only soiled areas of the body since the mortician will wash the entire body. Changes that occur to a body after death are a result of complex physicochemical and environmental processes. They are affected by factors within the cadaver and outside it. These factors affect the onset and either increase the rate of post-mortem changes or retard it. Factors that hasten the rate of post mortem changes include hot and humid climate, presence of body fat, open injuries on the body, sepsis or infection, and the location of the cadaver in the open.

- **Option C:** Before wrapping the body in a shroud, the nurse places a clean gown on the body and closes the eyes and mouth. Rigor Mortis appears in 1 to 2 hours after death, is completely formed 12 hours after death, is sustained for the next 12 hours, and vanishes over the next 12 hours, sometimes referred to as the 'march of rigor.'
- **Option D:** Rigor mortis appears rapidly in children and old aged individuals, in cases of persons dying of diseases or conditions involving great exhaustion such as cholera, or due to convulsions as in cases of strychnine poisoning. In such cases, the rigor disappears early as well. The effect of rigor on individual muscles can be of additional significance. The rigor of erector pilae muscles may cause elevation of hair leading to the pimpled appearance of the skin.

6. Which of the following conditions most commonly causes acute glomerulonephritis?

A. A congenital condition leading to renal dysfunction.

B. Prior infection with group A Streptococcus within the past 10-14 days.

C. Viral infection of the glomeruli.

D. Nephrotic syndrome.

Correct Answer: B. Prior infection with group A Streptococcus within the past 10-14 days.

Acute glomerulonephritis is most commonly caused by the immune response to a prior upper respiratory infection with group A Streptococcus. PSGN most commonly presents in children 1 to 2 weeks after a streptococcal throat infection, or within 6 weeks following a streptococcal skin infection. Group A Streptococcus (GAS) has been subtyped depending on the surface M protein and opacity factor, which are known to be nephrogenic and can cause PSGN.

- **Option A:** Glomerulonephritis is not a congenital condition. Nephrogenic streptococci infection precedes PSGN, which initially affects skin or oropharynx. More recently, PSGN is associated with skin infections (impetigo) more frequently than throat infections (pharyngitis).
- **Option C:** Glomerular lesions in acute GN are the result of glomerular deposition or in situ formation of immune complexes. Poor hygiene, overcrowding, and low socioeconomic status are important risk factors for streptococci outbreaks, and this explains the higher incidence of PSGN in impoverished countries. Genetic factors are expected to predispose to the condition since almost 40% of patients with PSGN gave a positive family history. There is no specific gene found to cause PSGN.
- **Option D:** Nephrotic syndrome is the combination of nephrotic-range proteinuria with a low serum albumin level and edema. It is caused by increased permeability through the damaged basement membrane in the renal glomerulus, especially infectious or thrombo-embolic. It is the result of an abnormality of glomerular permeability that may be primary with a disease-specific to the kidneys or secondary to congenital infections, diabetes, systemic lupus erythematosus, neoplasia, or certain drug use.

7. An HIV-positive client who has been started on highly active antiretroviral therapy (HAART) came back for a follow-up checkup. Which of the following will be the most helpful in determining the response to the therapy?

A. Rapid HIV antigen test

B. Western Blot analysis

C. Viral load test

D. White blood cell count

Correct Answer: C. Viral load test

A viral load test helps provide information on the health status and how well antiretroviral therapy (ART – treatment with HIV medicines) is controlling the virus.

- **Options A & B:** Rapid HIV antigen test and western blot analysis monitor the presence of antibodies to HIV, so these tests will yield a positive result after the patient is infected with HIV even if the drug therapy is effective.
- **Option D:** White blood cell count will be used to assess the impact of HIV on immune function but will not directly measure the effectiveness of the medicines.

8. At the Sunshine Pediatric Clinic, Nurse Alex is on duty and responsible for addressing phone consultations. Midway through the morning, the clinic's phone rings, and Alex answers it. On the other end is Mrs. Hamilton, a distressed mother whose 10-year-old child, Sophia, is currently undergoing chemotherapy treatment for leukemia. Mrs. Hamilton informs Nurse Alex that Sophia's younger sibling has just been diagnosed with chickenpox. Given Sophia's compromised immune status, Mrs. Hamilton is deeply concerned about her daughter's risk. Nurse Alex recalls the clinic's protocols and considers the appropriate measures to ensure Sophia's safety. Given the presented situation, which action should Nurse Alex anticipate taking next?

A. Teach the parents regarding contact and airborne precaution.

B. Administer varicella-zoster immune globulin to the client.

C. Prepare the client for admission to a private room in the hospital.

D. Educate the parent about the correct use of acyclovir (Zovirax).

E. Instruct the parents to keep the sibling isolated from Sophia.

F. Schedule an emergency appointment for Sophia at the clinic.

Correct Answer: B. Administer varicella-zoster immune globulin to the client.
Varicella-zoster immune globulin provides passive immunity to those who are at high risk and have been exposed to the virus. Given Sophia's immunocompromised state and her exposure risk, this is the most immediate and appropriate action.

- **Option A:** While educating the parents about precautions is important, it is not the most immediate action to be taken given Sophia's compromised immunity.
- **Option C:** While hospitalization might be a consideration depending on the clinical manifestations and the client's overall health, immediate passive immunization is a priority.
- **Option D:** Acyclovir can be used as a treatment for varicella in high-risk patients, but prior to the onset of the disease, passive immunization is preferred.
- **Option E:** While it is crucial to keep the infected sibling isolated, the immediate priority is to address Sophia's risk of contracting the disease given her compromised state.

- **Option F:** While evaluating Sophia might be necessary, the administration of varicella-zoster immune globulin is the priority in this scenario.

9. You are a pediatric nurse at a community health clinic, providing prenatal and postnatal education to families. Today, you are facilitating a parent group focusing on infant care. During the session, you are discussing various aspects including sleep safety, feeding, and developmental stimulation. You present several actions and ask the group to identify which action is NOT appropriate for a 2-month-old infant. Given the following options, select the action that is NOT appropriate for the care of a 2-month-old infant:

A. Place the infant on her back for naps and bedtime.

B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.

C. Talk to the infant frequently and make eye contact to encourage language development.

D. Wait until at least 4 months to add infant cereals and strained fruits to the diet.

E. Offer the infant cow's milk as a supplement to breastmilk or formula.

F. Place a soft blanket and several plush toys in the crib for comfort.

Correct Answer: E. Offer the infant cow's milk as a supplement to breastmilk or formula.
Cow's milk should not be given to infants under 1 year of age as it lacks essential nutrients present in breastmilk or infant formula, and can irritate the infant's immature gastrointestinal system.

- **Option A:** This action aligns with safe sleep recommendations to reduce the risk of sudden infant death syndrome (SIDS). Placing infants on their backs to sleep is the correct position for infants up to 1 year of age.
- **Option B:** While it may be challenging for parents to hear their infant cry, a short waiting period before responding may allow the infant to self-soothe and fall back asleep. It's a common method used in some sleep training approaches. However, at 2 months of age, immediate response to crying is often recommended to build trust and security.
- **Option C:** Talking to the infant and making eye contact are crucial for socio-emotional and language development. This interaction helps in forming a secure attachment and stimulating brain development.
- **Option D:** It is recommended to wait until around 6 months before introducing solid foods, though some pediatricians may suggest starting as early as 4 months if the infant is showing readiness signs. Hence, waiting until at least 4 months to add cereals and strained fruits is appropriate.
- **Option F:** Placing a soft blanket and plush toys in the crib can be dangerous and is not recommended as it increases the risk of suffocation and SIDS. Safe sleep guidelines recommend keeping the crib free of soft bedding, bumpers, and toys.

10. While teaching a 10-year-old child about their impending heart surgery, the nurse should

A. Explain the surgery using a model of the heart

B. Provide a verbal explanation just prior to the surgery

C. Introduce the child to another child who had heart surgery three days ago

D. Provide the child with a booklet to read about the surgery

Correct Answer: A. Explain the surgery using a model of the heart.

Based on Piaget's theory, the school-age child is in the concrete operations stage of cognitive development. During this stage, children begin to think logically about concrete events. Using something concrete, like a model will help the child understand the explanation of heart surgery.

- **Option B:** This refers to the formal operational stage where the child has the ability to think logically and understand abstract concepts. The ability to think about abstract ideas and situations is the key hallmark of the formal operational stage of cognitive development. The nurse uses a book or provides a verbal explanation about the surgery.
- **Option C:** This refers to the preoperational stage (2-7 years old). It is characterized by egocentric and concrete thinking. While they are getting better with language and thinking, they still tend to think about things in very concrete terms.
- **Option D:** The final stage of Piaget's theory, the formal operational stage, involves an increase in logic, the ability to use deductive reasoning, and an understanding of abstract ideas. At this point, people become capable of seeing multiple potential solutions to problems and think more scientifically about the world around them.

11. A client suffered from a lower leg injury and seeks treatment in the emergency room. There is a prominent deformity to the lower aspect of the leg, and the injured leg appears shorter than the other leg. The affected leg is painful, swollen and beginning to become ecchymotic. The nurse interprets that the client is experiencing:

A. Fracture

B. Strain

C. Sprain

D. Contusion

Correct Answer: A. Fracture

Common signs and symptoms of fracture include pain, deformity, shortening of the extremity, crepitus and swelling. These injuries are associated with symptoms of pain, deformity, swelling, and a wound that may be bleeding. It should be noted that the wound may not lie directly over the fracture site. The movement and neurovascular status of all involved limbs should be assessed to ascertain whether or not there is a possible nerve or vascular injury associated with the fracture.

- **Option B:** A foot strain is a stretching or tearing of the tendons and muscles in the foot. Common symptoms of strain include muscle pain and tenderness, local muscle swelling, black and blue discoloration, decrease in muscle strength, difficulty in walking, or a pop in the muscle at the time of injury.
- **Option C:** Symptoms of sprain include swelling, tenderness, bruising, pain, inability to put weight on the affected ankle, skin discoloration, and stiffness. Acute ankle sprains are commonly seen in both primary care and sports medicine practices as well as emergency departments and can result in significant short-term morbidity, recurrent injuries, and functional instability.

- **Option D:** Symptoms of contusion include discoloration of the skin, swelling, and tightness in the affected muscle or stiffness in the affected joint. A contusion, or bruise, forms when soft tissue in the body is crushed but the skin doesn't break. When this happens, blood from broken capillaries (small blood vessels) near the skin's surface may leak out under the skin. With no place to go, the blood gets trapped, often forming a red or purplish mark that hurts when it is touched.

12. Which of the following types of diets is implicated in the development of diverticulosis?

A. Low-fiber diet

B. High-fiber diet

C. High-protein diet

D. Low-carbohydrate diet

Correct Answer: A. Low-fiber diet

Low-fiber diets have been implicated in the development of diverticula because these diets decrease the bulk in the stool and predispose the person to the development of constipation. A low-fiber diet is linked to causing diverticulosis and also linked to the onset of diverticulitis. The goal will be to cut back on the low fiber foods and increase the high fiber ones.

- **Option B:** A high-fiber diet is recommended to help prevent diverticulosis. High fiber foods are the ones with whole wheat, oat, bran, whole-grain cereal, vegetables, fruit, and legumes. The dietary treatment for diverticulosis is also one of the primary ways to prevent it.
- **Option C:** A high-protein diet has no effect on the development of diverticulosis. Fiber softens and adds bulk to stools, helping them pass more easily through the colon. It also reduces pressure in the digestive tract.
- **Option D:** A low-carbohydrate diet has no effect on the development of diverticulosis. Many studies show that eating fiber-rich foods can help control diverticular symptoms. Women younger than 51 should aim for 25 grams of fiber daily. Men younger than 51 should aim for 38 grams of fiber daily. Women 51 and older should get 21 grams daily. Men 51 and older should get 30 grams daily.

13. Which clinical manifestation would lead the nurse to suspect that a client is experiencing hypermagnesemia?

A. Muscle pain and acute rhabdomyolysis

B. Hot flushed skin and diaphoresis

C. Soft-tissue calcification and hyperreflexia

D. Increased respiratory rate and depth

Correct Answer: B. Hot, flushed skin and diaphoresis

Hypermagnesemia is manifested by hot, flushed skin and diaphoresis. The client also may exhibit hypotension, lethargy, drowsiness, and absent deep tendon reflexes. The most frequent symptoms and signs may include weakness, nausea, dizziness, and confusion (less than 7.0 mg/dL). Increasing values (7 to 12 mg/dL) induce decreased reflexes, worsening confusional state, drowsiness, bladder paralysis, flushing, headache, and constipation.

- **Option A:** Muscle pain and acute rhabdomyolysis are indicative of hypophosphatemia. Mild hypophosphatemia will not be clinically apparent. Severe hypophosphatemia may have the clinical presence of altered mental status, neurological instability including seizures and focal neurologic findings such as numbness or reflexive weakness, a cardiac manifestation of possible heart failure, muscle pain, and muscular weakness.
- **Option C:** Soft-tissue calcification and hyperreflexia are indicative of hyperphosphatemia. Calcifications can also be present in skin, soft tissue, and periarticular regions. Prolonged bone demineralization can lead to bone fractures. CNS features include delirium, coma, seizures, neuromuscular hyperexcitability, (Chvostek's sign and Trousseau's phenomenon), hyperreflexia, muscle cramping (e.g., carpopedal spasm) or tetany.
- **Option D:** Increased respiratory rate and depth are associated with metabolic acidosis. The physical exam reveals signs unique to each cause such as dry mucous membranes in the patient with diabetic ketoacidosis. Hyperventilation may also be present as a compensatory respiratory alkalosis to assist with PCO2 elimination and correction of the acidemia. Compensatory reactions do not completely correct a disturbance to the normal pH range.

14. How should the nurse prepare a suspension before administration?

A. By diluting it with normal saline solution

B. By diluting it with 5% dextrose solution

C. By shaking it so that all the drug particles are dispersed uniformly

D. By crushing remaining particles with a mortar and pestle

Correct Answer: C. By shaking it so that all the drug particles are dispersed uniformly.

The nurse should shake a suspension before administration to dispersed drug particles uniformly. First, the bottle should be tabbed a few times to loosen the powder, then approximately, half the volume of water should be added, the bottle is shaken vigorously, the remaining water should be added and shaken well.

- **Option A:** In one study 75.5 % of mothers used boiled then cooled tap water and 1.8 % of mothers used distilled water, which is a correct practice. The addition of water in one step makes it difficult to get the lumps out while measuring the volume of water several times increases the percentage of error in measured volume.
- **Option B:** Only tap water should be reconstituted with a powdered suspension because a 5% dextrose solution contains chemicals that may cause decomposition of drugs and complex reactions.
- **Option D:** Crushing particles is not recommended for this drug form. Crushing or opening modified or slow-release drug capsules will cause the drug to be released all at once and could cause side effects. There may be times when tablets will need to be crushed in order to deliver essential drug therapy. This should only be done as a last resort and the practitioner must use her or his professional judgment.

15. During a nursing immunology class, a seasoned instructor shares a poignant narrative of a 4-year-old child who was found to have a rare congenital immune disorder that impairs his innate immunity. The child suffered from multiple, severe infections since infancy, which were exacerbated by an inability to effectively curtail microbial invasions from common pathogens. The

case unfurls a discussion about the pillars of the immune system, focusing on the dichotomy between innate and adaptive immunity. The students are prompted to reflect on the hallmark characteristics of innate immunity, which was compromised in this young patient, and how it fundamentally differs from adaptive immunity. Which statement encapsulates the quintessence of innate immunity?

A. The immunity to a substance is produced only after exposure to that substance and each time the body is exposed to a particular substance, the response is the same.

B. Immunity to a substance is produced only after exposure to that substance.

C. Each time the body is exposed to a particular substance, the response is the different.

D. The ability to recognize and remember a particular substance is important.

Correct Answer: A. The immunity to a substance is produced only after exposure to that substance and each time the body is exposed to a particular substance, the response is the same.
In innate immunity, the immunity to a substance is produced only after exposure to that substance and each time the body is exposed to a particular substance, the response is the same. For example, each time a bacterial cell is introduced into the body, it is phagocytized with the same speed and efficiency. In adaptive immunity, the response to them improves each time the foreign substance is encountered. The response during the second exposure is faster and stronger than the response to the first exposure because the immune system exhibits memory for the bacteria from the first exposure.

- **Option B:** Innate immunity provides immediate, non-specific defense mechanisms against a wide range of pathogens and does not require prior exposure to a specific substance or pathogen for its functioning.
- **Option C:** Innate immunity provides immediate and consistent responses to pathogens or substances without variation upon repeated exposure. It is characterized by its non-specific nature and the absence of adaptation based on prior encounters with the same threat.
- **Option D:** Innate immunity does not rely on the ability to recognize and remember a particular substance. Instead, it provides immediate, non-specific defense mechanisms against a wide range of pathogens without the need for prior recognition or memory of specific substances.

16. Four hours after a difficult labor and birth, a primiparous woman refuses to feed her baby, stating that she is too tired and just wants to sleep. The nurse should: Select all that apply.

A. Tell the woman she can rest after she feeds her baby.

B. Recognize this as a behavior of the taking-in stage.

C. Record the behavior as ineffective maternal-newborn attachment.

D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time.

E. Acknowledge this as a behavior of the letting go stage.

Correct Answer: B and D.

The behavior described is typical of this stage and not a reflection of ineffective attachment unless the behavior persists. Mothers need to reestablish their own well-being in order to effectively care for their

baby. The taking-in phase usually sets 1 to 2 days after delivery. This is the time of reflection for the woman because within the 2 to 3 day period, the woman is passive. The woman prefers to talk about her experiences during labor and birth and also her pregnancy. The woman becomes dependent on her healthcare provider or support person with some of the daily tasks and decision-making.The changes that the woman undergoes are crucial within the first 24 hours of postpartum, especially the psychological changes. These changes might affect the woman permanently if not given the appropriate attention and care.

- **Option A:** This does not take into consideration the need for the new mother to be nurtured and have her needs met during the taking-in stage. The taking-in phase provides time for the woman to regain her physical strength and organize her rambling thoughts about her new role. Encouraging the woman to talk about her experiences during labor and birth would greatly help her adjust and let her incorporate it into her new life.
- **Option C:** This dependence is mainly due to her physical discomfort from hemorrhoids or the after pains, from the uncertainty of how she could care for the newborn, and also from the extreme tiredness she feels that follows childbirth. The taking-in phase provides time for the woman to regain her physical strength and organize her rambling thoughts about her new role.
- **Option E.** During the letting go phase, the woman finally accepts her new role and gives up her old roles like being a childless woman or just a mother of one child.

17. Nurse Adams is reviewing the patient's medical history. The patient, a 70-year-old female with osteoporosis, has been admitted due to a recent hip fracture. As part of the patient's health teaching, Nurse Adams decides to discuss the importance of the skeletal system. During their conversation, Nurse Adams poses the following question to test the patient's understanding: "Given your condition, understanding the skeletal system is essential. Can you tell me which of the following is NOT considered a primary function of the skeletal system?"

A. Support and protects body structures

B. Storage of minerals

C. Blood cell formation

D. Synthesize Vitamin D

Correct Answer: D. Synthesize Vitamin D
This is a function of the integumentary system. The system synthesizes vitamin D3 which converts to calcitriol, for normal metabolism of calcium.

- **Option A:** Bone is the major supporting tissue of the body and protects internal organs (e.g., ribcage protects the heart, lungs, and other internal organs).
- **Option B:** Some minerals in the blood are taken into bone and stored. The principal minerals stored are calcium and phosphorus.
- **Option C:** Many bones contain cavities filled with bone marrow that gives rise to blood cells.

18. Which of the following nursing interventions should be implemented to manage a client with appendicitis?

A. Assessing pain.

B. Encouraging oral intake of clear fluids.

C. Providing discharge teaching.

D. Assessing for symptoms of peritonitis.

Correct Answer: D. Assessing for symptoms of peritonitis

The focus of care is to assess for peritonitis, or inflammation of the peritoneal cavity. Peritonitis is most commonly caused by appendix rupture and invasion of bacteria, which could be lethal. Monitor vital signs. Note onset of fever, chills, diaphoresis, changes in mentation, reports of increasing abdominal pain. This can be suggestive of the presence of infection or developing sepsis, abscess, peritonitis.

- **Option A:** The client with appendicitis will have pain that should be controlled with analgesia. Assess pain, noting location, characteristics, severity (0–10 scale). Investigate and report changes in pain as appropriate. Keep the client at rest in semi-Fowler's position to lessen the pain. Gravity localizes inflammatory exudate into the lower abdomen or pelvis, relieving abdominal tension, which is accentuated by a supine position.
- **Option B:** The nurse should discourage oral intake in preparation for surgery. Aperients should also be avoided as induced peristalsis may cause perforation. If appendicitis has been diagnosed regular analgesia, usually an opioid depending on the pain severity, should be given to make the patient comfortable before treatment.
- **Option C:** Discharge teaching is important; however, in the acute phase, management should focus on minimizing preoperative complications and recognizing when such may be occurring.

19. A postpartum nurse is taking the vital signs of a woman who delivered a healthy newborn infant 4 hours ago. The nurse notes that the mother's temperature is 100.2°F. Which of the following actions would be most appropriate?

A. Retake the temperature in 15 minutes.

B. Notify the physician.

C. Document the findings.

D. Increase hydration by encouraging oral fluids

Correct Answer: D. Increase hydration by encouraging oral fluids.

The mother's temperature may be taken every 4 hours while she is awake. Temperatures up to 100.4 F (38 C) in the first 24 hours after birth are often related to the dehydrating effects of labor. The most appropriate action is to increase hydration by encouraging oral fluids, which should bring the temperature to a normal reading.

- **Option A:** A focused physical examination is important and should include vital signs, an examination of the respiratory system, breasts, abdomen, perineum, and lower extremities. A patient with endometritis typically has a fever of 38°C or greater, tachycardia, and fundal tenderness.
- **Option B:** The new mother should be given discharge instructions and expectations/precautions to consider once leaving the hospital. The most important information is who and where to call if she has problems or questions. She also needs details about resuming her normal activity. Instructions vary, depending on whether the mother has had a vaginal or a cesarean delivery and any

comorbidities that may have been part of her care.

- **Option C:** Although the nurse would document the findings, the most appropriate action would be to increase the hydration. The woman who has had a vaginal delivery may resume all physical activity, including using stairs, riding or driving in a car, and performing muscle-toning exercises, as long as she experiences no limiting pain or discomfort. The key counseling is to progressively resume normal activity while being mindful of the common fatigue and exhaustion experienced while caring for a newborn.

20. For which time period would the nurse notify the health care provider that the client had no bowel sounds?

A. 2 minutes

B. 3 minutes

C. 4 minutes

D. 5 minutes

Correct Answer: D. 5 minutes

To completely determine that bowel sounds are absent, the nurse must auscultate each of the four quadrants for at least 5 minutes; 2, 3, or 4 minutes is too short a period to arrive at this conclusion. The first item to listen for is the presence of bowel sounds. To chart an assessment finding of no bowel sounds, the nurse needs to listen over the quadrant for at least five minutes. The nurse should also do the auscultation before palpation and percussion to avoid influencing bowel sounds.

- **Option A:** In most cases, bowel sounds are present, but the nurse needs to categorize them. She should listen for the intensity of the sound – whether it is soft or strong. The nurse should also listen for frequency. Hypoactive bowel sounds could indicate a problem, so if the nurse is having trouble hearing them, this is significant.
- **Option B:** Auscultating bowel sounds can allow the nurse to pinpoint areas where an obstruction may have occurred. Finding no bowel sounds can mean an ileus or obstruction above that area of the intestine.
- **Option C:** Hypoactive bowel sounds are considered as one every three to five minutes, and this can indicate diarrhea, anxiety, or gastroenteritis. Hyperactive bowel sounds are often found before a blockage. It is quite common to find one quadrant with hyperactive bowel sounds and one with none or hypoactive ones.

21. The nurse is aware that the following findings would be further evidence of a urethral injury in a male client during rectal examination?

A. A low-riding prostate

B. The presence of a boggy mass

C. Absent sphincter tone

D. A positive Hemoccult

Correct Answer: B. The presence of a boggy mass

When the urethra is ruptured, a hematoma or collection of blood separates the two sections of the urethra. This may feel like a boggy mass on rectal examination. Rupture of the urethra is an uncommon

result of penile injury, incorrect catheter insertion, straddle injury, or pelvic girdle fracture. The urethra, the muscular tube that allows for urination, may be damaged by trauma. When urethral rupture occurs, urine may extravasate (escape) into the surrounding tissues.

- **Option A:** Because of the rupture and hematoma, the prostate becomes high riding. A palpable prostate gland usually indicates a non-urethral injury. Physical examination may reveal blood at the meatus or a high-riding prostate gland upon rectal examination
- **Option C:** Absent sphincter tone would refer to a spinal cord injury. Neurologic causes — Neurologic disorders such as diabetes, multiple sclerosis, and spinal cord injury can decrease sensation and control over the lower digestive tract. Nerve damage during vaginal childbirth can also decrease anal sphincter function.
- **Option D:** The presence of blood would probably correlate with GI bleeding or a colon injury. Extravasation of blood along the fascial planes of the perineum is another indication of injury to the urethra. “Pie in the sky” findings revealed by cystography usually indicate urethral disruption.

22. You’re caring for a 28 y.o. woman with hepatitis B. She’s concerned about the duration of her recovery. Which response isn’t appropriate?

A. Encourage her to not worry about the future.

B. Encourage her to express her feelings about the illness.

C. Discuss the effects of hepatitis B on future health problems.

D. Provide avenues for financial counseling if she expresses the need.

Correct Answer: A. Encourage her to not worry about the future.

Telling her not to worry minimizes her feelings. Contract with the patient regarding time for listening. Encourage discussion of feelings/concerns. Establishing time enhances trusting relationships. Providing an opportunity to express feelings allows the patient to feel more in control of the situation. Verbalization can decrease anxiety and depression and facilitate positive coping behaviors.

- **Option B:** The patient may need to express feelings about being ill, length and cost of illness, possibility of infecting others, and (in severe illness) fear of death. She may have concerns regarding the stigma of the disease. The recovery period may be prolonged (up to 6 mo), potentiating family and/or situational stress and necessitating the need for planning, support, and follow-up.
- **Option C:** Avoid making moral judgments regarding lifestyle. The patient may already feel upset and angry and condemn self; judgments from others will further damage self-esteem. This can also start distrust issues with care workers.
- **Option D:** Assess the effect of illness on economic factors of the patient and SO. Financial problems may exist because of loss of the patient’s role functioning in the family and prolonged recovery. Make appropriate referrals for help as needed: case manager, discharge planner, social services, and/or other community agencies.

23. The nurse is assessing a client who had a fractured femur repaired with an external fixator device. Which assessment finding would cause the nurse concern regarding the development of compartment syndrome? Select all that apply.

A. Decrease in pulse rate in affected leg.

B. Paresthesia distal to area of injury.

C. Toes on affected leg cool to touch and edematous.

D. Complaints that pins are hurting.

E. Complaints of leg pain unrelieved by analgesics or repositioning.

F. Client angry and calling loudly to the nurse every ten minutes.

Correct Answer: B, C, and E.

Paresthesia, edema, and leg pain unrelieved by analgesics are classic indicators of the development of compartment syndrome. Acute compartment syndrome typically occurs within a few hours of inciting trauma. However, it can present up to 48 hours after.

- **Option A:** With a femur fracture, there will be a decrease in pulse strength. Beware that the presence or absence of a palpable arterial pulse may not accurately indicate relative tissue pressure or predict the risk for compartment syndrome. In some patients, a pulse is still present, even in a severely compromised extremity.
- **Option B:** Paresthesia, hypoesthesia, or poorly localized deep muscular pain may also be present. Classically, the presentation of acute compartment syndrome has been remembered by “The Five P’s”: pain, pulselessness, paresthesia, paralysis, and pallor. However, aside from paresthesia, which may occur earlier in the course of the condition, these are typically late findings.
- **Option C:** Acute compartment syndrome occurs when there is increased pressure within a closed osteofascial compartment, resulting in impaired local circulation. The reduction of venous outflow and arterial inflow result in decreased oxygenation of tissues causing ischemia. If the deficit of oxygenation becomes high enough, irreversible necrosis may occur.
- **Option D:** The pins do not usually cause pain, but this may be a sign of infection. Postoperatively, the pins are sometimes wrapped with xeroform or iodine impregnated gauze. Motion around the skin-pin junction is known to increase the risk of infection.
- **Option E:** Pain is typically severe, out of proportion to the injury. Early on, pain may only be present with passive stretching. However, this symptom may be absent in advanced acute compartment syndrome.
- **Option F:** Anger can be due to immobility. Acute compartment syndrome occurs more commonly in males younger than 35, which may be due to a larger relative intracompartmental muscle mass and increased likelihood of being involved in high-energy trauma.

24. Specific classification of the chemotherapeutic agent, Vincristine (Oncovin) is:

A. Hormone modulator

B. Mitotic inhibitor

C. Antineoplastic antibiotic

D. Antimetabolite

Correct Answer: B. Mitotic inhibitor

- **Option B:** Vincristine is a mitotic inhibitor that inhibits mitosis or cell division. Other examples of mitotic inhibitors are paclitaxel, docetaxel, and vinblastine.

- **Option A:** Hormone modulators work by interfering with the activity of hormones. A good example are the selective estrogen receptor modulators (Tamoxifen, Raloxifene, and Ospemifene).
- **Option C:** Antineoplastic antibiotic (e.g., doxorubicin, mitoxantrone, and bleomycin) blocks cell growth by interfering with DNA.
- **Option D:** Antimetabolites (such as Sulfanilamides) work by acting as false metabolites that prevent DNA synthesis.

25. 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.

- **Option A:** In addition, dark green leafy vegetables, such as spinach and kale, and legumes are high in iron.
- **Option B:** Mild anemia does not require that animal sources of iron be added to the diet. Many non-animal sources are available.
- **Option D:** Coffee and tea increase gastrointestinal activity and inhibit the absorption of iron.

26. Which of the following, if stated by the nurse, is correct about Hyperglycemic Hyperosmolar Nonketotic Syndrome (HHNS)?

A. “This syndrome occurs mainly in people with type 1 diabetes.”

B. “It has a higher mortality rate than diabetic ketoacidosis.”

C. “The client with HHNS is in a state of overhydration.”

D. “This condition develops very rapidly.”

Correct Answer: B. “It has a higher mortality rate than diabetic ketoacidosis.”

It is a medical emergency and has a higher mortality rate than Diabetic Ketoacidosis. The mortality rate in HHS can be as high as 20% which is about 10 times higher than the mortality seen in diabetic ketoacidosis. Diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS) are acute metabolic complications of diabetes mellitus that can occur in patients with both type 1 and 2 diabetes mellitus.

- **Option A:** Hyperglycemic Hyperosmolar Nonketotic Syndrome occurs only in people with type 2 diabetes. Hyperosmolar hyperglycemic syndrome (HHS) is a clinical condition that arises from a

complication of diabetes mellitus. Type 2 diabetes accounts for about 90% to 95% of diabetes cases. It is most commonly seen in patients with obesity.

- **Option C:** As a consequence of obesity and high body mass index (BMI), there is the resistance of the peripheral tissue to the action of insulin. The beta-cell in the pancreas continues to produce insulin, but the amount is not enough to counter the effect of the resistance of the end organ to its effect. HHS is a serious and potentially fatal complication of type 2 diabetes.
- **Option D:** This condition develops very slowly over hours or days. HHS has similar pathophysiology to DKA but with some mild dissimilarities. The hallmark of both conditions is the deficiency of insulin. As a consequence of deficiency of this key hormone, there is a decrease in glucose utilization by the peripheral tissue causing hyperglycemia.

27. What information is correct about stomach cancer?

A. Stomach pain is often a late symptom.

B. Surgery is often a successful treatment.

C. Chemotherapy and radiation are often successful treatments.

D. The patient can survive for an extended time with TPN.

Correct Answer: A. Stomach pain is often a late symptom.

Stomach pain is often a late sign of stomach cancer; outcomes are particularly poor when cancer reaches that point. In the United States, most patients have symptoms of an advanced stage at the time of presentation. The most common presenting symptoms for gastric cancers are non-specific weight loss, persistent abdominal pain, dysphagia, hematemesis, anorexia, nausea, early satiety, and dyspepsia.

- **Option B:** Surgery has minimal positive effects. Patients with localized, resectable gastric cancer have the best chance of long-term survival with surgery alone. The main goal of surgery is complete resection with adequate margins (more than 4 cm), and only 50% of patients will obtain R0.
- **Option C:** Chemotherapy and radiation have minimal positive effects. Neoadjuvant chemotherapy has been shown to downstage primary tumors and regional lymph nodes to attempt higher long-term curative resections. Neoadjuvant therapy should be offered to patients at high risk of developing distant metastases (bulky T3/T4, perigastric nodes, linitis plastica, or positive peritoneal cytology), sparing unnecessary surgery in case an emerging metastasis appears.
- **Option D:** TPN may enhance the growth of cancer. Total parenteral nutrition is known to be effective in cases of malnutrition in patients who do not have cancer. However, TPN has not been shown to positively affect the nutritional status in patients with cancer. This is due in part to the metabolic changes associated with cancer.

28. A female client with Guillain-Barre syndrome has ascending paralysis and is intubated and receiving mechanical ventilation. Which of the following strategies would the nurse incorporate in the plan of care to help the client cope with this illness?

A. Giving the client full control over care decisions and restricting visitors.

B. Providing positive feedback and encouraging active range of motion.

C. Providing information, giving positive feedback and encouraging relaxation.

D. Providing intravenously administered sedatives, reducing distractions and limiting visitors.

Correct Answer: C. Providing information, giving positive feedback, and encouraging relaxation.

The client with Guillain-Barré syndrome experiences fear and anxiety from the ascending paralysis and sudden onset of the disorder. The nurse can alleviate these fears by providing accurate information about the client's condition, giving expert care and positive feedback to the client, and encouraging relaxation and distraction. The family can become involved with selected care activities and provide diversion for the client as well.

- **Option A:** Allow the client to participate in their own care depending on ability and degree of paralysis; allow them to make informed choices about ADL as soon as possible. Promotes independence and control and preserves developmental status.
- **Option B:** Teach parents and the client about disease condition and manifestation. Provides information to relieve anxiety by knowledge of what to expect. Discuss each procedure or type of may therapy, effects of any diagnostic tests to parents and client as appropriate to age. Reduces fear of the unknown which increases anxiety.
- **Option D:** Therapeutically communicate with parents and child and answer questions in a calm and honest manner. Promotes an environment of support. Facilitate expression of concerns and an opportunity to ask inquiries regarding the condition and rehabilitation of the ailing child. Provides an opportunity to release feelings, secure information needed to overcome anxiety.

29. A client with a laryngectomy returns from surgery with a nasogastric tube in place. The primary reason for the placement of the nasogastric tube is to:

A. Prevent swelling and dysphagia

B. Decompress the stomach via suction

C. Prevent contamination of the suture line

D. Promote healing of the oral mucosa

Correct Answer: C. Prevent contamination of the suture line

- Option C: The primary reason for the NG is to maintain the patient's nutrition without contaminating the suture line which will decrease the risk of infection and improve wound healing.
- Option A: Preventing swelling and dysphagia is not a reason for the placement of the NGT.
- Option B: There is no mention of suction.
- Option D: The oral mucosa was not involved in the laryngectomy.

30. 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.

31. The client joins a support group and frequently preaches against abuse, is demonstrating the use of:

A. Denial

B. Reaction formation

C. Rationalization

D. Projection

Correct Answer: B. Reaction formation

Reaction formation is the adoption of behavior or feelings that are exactly opposite of one's true emotions. Reaction formation reduces anxiety by taking up the opposite feeling, impulse, or behavior. An example of reaction formation would be treating someone you strongly dislike in an excessively friendly manner in order to hide your true feelings.

- **Option A:** Denial is a refusal to accept a painful reality. Denial is an outright refusal to admit or recognize that something has occurred or is currently occurring. People living with drug or alcohol addiction often deny that they have a problem, while victims of traumatic events may deny that the event ever occurred.
- **Option C:** Rationalization is attempting to justify one's behavior by presenting reasons that sound logical. Rationalization is a defense mechanism that involves explaining an unacceptable behavior or feeling in a rational or logical manner, avoiding the true reasons for the behavior.
- **Option D:** Projection is attributing one's behaviors and feelings to another person. Projection is a defense mechanism that involves taking our own unacceptable qualities or feelings and ascribing them to other people. For example, if you have a strong dislike for someone, you might instead believe that they do not like you. Projection works by allowing the expression of the desire or impulse, but in a way that the ego cannot recognize, therefore reducing anxiety.

32. For a diabetic male client with a foot ulcer, the physician orders bed rest, a wet-to-dry dressing change every shift, and blood glucose monitoring before meals and bedtime. Why are wet-to-dry dressings used for this client?

A. They contain exudate and provide a moist wound environment.

B. They protect the wound from mechanical trauma and promote healing.

C. They debride the wound and promote healing by secondary intention.

D. They prevent the entrance of microorganisms and minimize wound discomfort.

Correct Answer: C. They debride the wound and promote healing by secondary intention.

For this client, wet-to-dry dressings are most appropriate because they clean the foot ulcer by debriding exudate and necrotic tissue, thus promoting healing by secondary intention. Treatment of diabetic foot ulcers should be systematic for an optimal outcome. The most important point is to identify if there is any evidence of ongoing infection, by obtaining a history of chills, fever, looking for the presence of purulence or presence of at least two signs of inflammation that includes, pain, warmth, erythema or induration of the ulcer.

- **Option A:** Moist, transparent dressings contain exudate and provide a moist wound environment. Transparent films are indicated for use as primary or secondary dressings for wounds with little to no exudate such as stage I and II pressure ulcers, partial-thickness wounds, donor sites, and wounds with necrotic tissue or slough.
- **Option B:** Dry sterile dressings protect the wound from mechanical trauma and promote healing. Dry dressings are gauze pads that lie under rolled gauze and tape – and the category also includes standard bandages. You may have this type of dressing, which is intuitive and simple for most people to take care of and change, for wounds that are relatively dry themselves.
- **Option D:** Hydrocolloid dressings prevent the entrance of microorganisms and minimize wound discomfort. Hydrocolloid dressings provide a moist and insulating healing environment which protects uninfected wounds while allowing the body's own enzymes to help heal wounds. These dressings are unique because they don't have to be changed as often as some other wound dressings and are easy to apply.

33. A female client who was found unconscious at home is brought to the hospital by a rescue squad. In the intensive care unit, the nurse checks the client's oculocephalic (doll's eye) response by:

A. Introducing ice water into the external auditory canal.

B. Touching the cornea with a wisp of cotton.

C. Turning the client's head suddenly while holding the eyelids open.

D. Shining a bright light into the pupil.

Correct Answer: C. Turning the client's head suddenly while holding the eyelids open.

To elicit the oculocephalic response, which detects cranial nerve compression, the nurse turns the client's head suddenly while holding the eyelids open. Normally, the eyes move from side to side when the head is turned; in an abnormal response, the eyes remain fixed. The oculocephalic reflex (doll's eyes reflex) is an application of the vestibular-ocular reflex (VOR) used for neurologic examination of cranial nerves 3, 6, and 8, the reflex arc including brainstem nuclei, and overall gross brainstem function.

- **Option A:** The nurse introduces ice water into the external auditory canal when testing the oculovestibular response; normally, the client's eyes deviate to the side of ice water introduction. Vestibulo–ocular reflex is an involuntary reflex that stabilizes the visual field and retinal image

during head motion by producing eye movements in a counter direction.

- **Option B:** The nurse touches the client's cornea with a wisp of cotton to elicit the corneal reflex response, which reveals brain stem function; blinking is the normal response. The corneal blink reflex is caused by a loop between the trigeminal sensory nerves and the facial motor (VII) nerve innervation of the orbicularis oculi muscles. The reflex activates when sensory stimulus contacts either free nerve endings or mechanoreceptors within the epithelium of the cornea.
- **Option D:** Shining a bright light into the client's pupil helps evaluate brain stem and cranial nerve III functions; normally, the pupil responds by constricting. The oculomotor nerve helps to adjust and coordinate eye position during movement. Several movements assist with this process: saccades, smooth pursuit, fixation, accommodation, vestibulo-ocular reflex, and optokinetic reflex.

34. The nurse is caring for the client in the ER following a head injury. The client momentarily lost consciousness at the time of the injury and then regained it. The client now has lost consciousness again. The nurse takes quick action, knowing this is compatible with:

A. Skull fracture

B. Concussion

C. Subdural hematoma

D. Epidural hematoma

Correct Answer: D. Epidural hematoma

The changes in neurological signs from an epidural hematoma begin with a loss of consciousness as arterial blood collects in the epidural space and exerts pressure. The client regains consciousness as the cerebral spinal fluid is reabsorbed rapidly to compensate for the rising intracranial pressure. As the compensatory mechanisms fail, even small amounts of additional blood can cause the intracranial pressure to rise rapidly, and the client's neurological status deteriorates quickly.

- **Option A:** Basilar skull fractures, usually caused by substantial blunt force trauma, involve at least one of the bones that compose the base of the skull. Basilar skull fractures most commonly involve the temporal bones but may involve the occipital, sphenoid, ethmoid, and the orbital plate of the frontal bone as well. Several clinical exam findings highly predictive of basilar skull fractures include hemotympanum, cerebrospinal fluid (CSF) otorrhea or rhinorrhea, Battle sign (retroauricular or mastoid ecchymosis), and raccoon eyes (periorbital ecchymosis).
- **Option B:** Concussions are a subset of the neurologic injuries known as traumatic brain injuries. Traumatic brain injuries have varying severity, ranging from mild, transient symptoms to extended periods of altered consciousness. Given the usually self-limited nature of symptoms associated with a concussion, the term mild traumatic brain injury (mTBI) is often used interchangeably to refer to a concussion, though concussions are technically a subset of mTBIs.
- **Option C:** Often, the bleeding is undetected initially, discovered as a chronic subdural hematoma. When there is a sufficient accumulation of blood to occupy a large intracranial space, the brain midline shifts toward the opposite side, encroaching on the brain structures against the inner surface of the calvarium after decreasing the volume of the lateral third and fourth ventricles. As the intracranial space becomes limited, the volumetric forces push the uncal portion of the temporal lobe toward the foramen magnum causing herniation of the brain.

35. In the management of bulimic patients, the following nursing interventions will promote a therapeutic relationship except:

A. Establish an atmosphere of trust.

B. Discuss their eating behavior.

C. Help patients identify feelings associated with binge-purge behavior.

D. Teach the patient about bulimia nervosa.

Correct Answer: B. Discuss their eating behavior.

The client is often ashamed of her eating behavior. Discussion should focus on feelings. Promote self-concept without moral judgment. Patient sees herself as weak-willed, even though part of a person may feel a sense of power and control (dieting, weight loss). Let the patient know that it is acceptable to be different from family, particularly mother. Developing a sense of identity separate from family and maintaining a sense of control in other ways besides dieting and weight loss is a desirable goal of therapy and program.

- **Option A:** Establish a therapeutic nurse-patient relationship. Within a helping relationship, the patient can begin to trust and try out new thinking and behaviors. State rules clearly regarding weighing schedule, remaining in sight during medication and eating times, and consequences of not following the rules. Without undue comment, be consistent in carrying out rules. Consistency is important in establishing trust. As part of the behavior modification program, the patient knows risks involved in not following established rules (decrease in privileges). Failure to follow rules is viewed as a patient's choice and accepted by staff in a matter-of-fact manner so as not to provide reinforcement for undesirable behavior.
- **Option C:** Respond (confront) with reality when a patient makes unrealistic statements. The patient may be denying the psychological aspects of their own situation and are often expressing a sense of inadequacy and depression. Encourage the patient to express anger and acknowledge when it is verbalized. Important to know that anger is part of self and as such is acceptable. Expressing anger may need to be taught to the patient because anger is generally considered unacceptable in the family, and therefore the patient does not express it.
- **Option D:** Determine the level of knowledge and readiness to learn. Learning is easier when it begins where the learner is. Provide written information for the patient and SO(s); these are helpful as a reminder of and reinforcement for learning. Discuss the consequences of behavior. Sudden death can occur because of electrolyte imbalances; suppression of the immune system and liver damage may result from protein deficiency, or gastric rupture may follow binge-eating and vomiting.