Kevin's Review - 35 NCLEX Practice Questions

1. A client with schizophrenia is started on Zyprexa (olanzapine). Three weeks later, the client develops severe muscle rigidity and elevated temperature. The nurse should anticipate the physician to:

A. Withhold all morning medications

B. Order CBC and CPK

C. Prescribe dantrolene C. Prescribe dantrolene

D. Transfer the client to a medical unit

Correct Answer: C. Prescribe dantrolene

- Option C: The client's symptoms suggest an adverse reaction to the medication known as neuroleptic malignant syndrome. Treatment of this reaction consists of prescribing skeletal muscle relaxants such as dantrolene which blocks the intracellular calcium release from the sarcoplasmic reticulum.
- Option A: Treatment of neuroleptic malignant syndrome consists of withdrawal of neuroleptic drugs but this medication is usually taken at bedtime.
- Option B: The physician may order these tests but it is not the priority action.
- Option D: Transferring the client to a medical unit will not solve the patient's problem.

2. The nurse is teaching a client who has been diagnosed with TB how to avoid spreading the disease to family members. Which statement(s) by the client indicate(s) that he has understood the nurse's instructions? Select all that apply.

A. "I will need to dispose of my old clothing when I return home."

B. "I should always cover my mouth and nose when sneezing."

C. "It is important that I isolate myself from family when possible."

D. "I should use paper tissues to cough in and dispose of them properly."

E. "I can use regular plates and utensils whenever I eat."

Correct Answer: B, C, D, E

Review pathology of disease (active and inactive phases; dissemination of infection through bronchi to adjacent tissues or via bloodstream and/or lymphatic system) and potential spread of infection via airborne droplet during coughing, sneezing, spitting, talking, laughing, singing.

- **Option A:** Identify others at risk like household members, close associates, and friends. Those exposed may require a course of drug therapy to prevent spread or development of infection.
- **Option B:** Instruct patient to cough or sneeze and expectorate into tissue and to refrain from spitting. Initial therapy of uncomplicated pulmonary disease usually includes four drugs, e.g., four primary drugs or combination of primary and secondary drugs.
- **Option C:** Review necessity of infection control measures. Put in temporary respiratory isolation if indicated. May help the patient understand the need for protecting others while acknowledging the patient's sense of isolation and social stigma associated with communicable diseases.

- **Option D:** Review proper disposal of tissue and good hand washing techniques. Encourage return demonstration. Compliance with multidrug regimens for prolonged periods is difficult, so directly observed therapy (DOT) should be considered.
- **Option E:** Contagious period may last only 2–3 days after initiation of chemotherapy, but in presence of cavitation or moderately advanced disease, risk of spread of infection may continue up to 3 months.

3. A client who's admitted to labor and delivery has the following assessment findings: gravida 2 para 1, estimated 40 weeks gestation, contractions 2 minutes apart, lasting 45 seconds, vertex +4 station. Which of the following would be the priority at this time?

A. Placing the client in bed to begin fetal monitoring.

B. Preparing for immediate delivery.

C. Checking for ruptured membranes.

D. Providing comfort measures.

Correct Answer: B. Preparing for immediate delivery.

This question requires an understanding of station as part of the intrapartum assessment process. Based on the client's assessment findings, this client is ready for delivery, which is the nurse's top priority.

- **Option A:** Fetal heart rate monitoring may help detect changes in the normal heart rate pattern during labor. If certain changes are detected, steps can be taken to help treat the underlying problem. Fetal heart rate monitoring also can help prevent treatments that are not needed.
- **Option C:** The membranes can break by themselves. This is called a spontaneous rupture of the membranes. It most often happens after active labor has started.
- **Option D:** Comfort measures may be given to the woman after ensuring all necessary measures to help her deliver successfully.

4. A woman with preeclampsia is receiving magnesium sulfate. The nurse assigned to care for the client determines that the magnesium therapy is effective if:

A. Ankle clonus is noted.

B. The blood pressure decreases.

C. Seizures do not occur.

D. Scotomas are present.

Correct Answer: C. Seizures do not occur.

For a client with preeclampsia, the goal of care is directed at preventing eclampsia (seizures). Seizures were a half or a third less likely to recur after treatment with magnesium. Maternal mortality was also lower in women allocated magnesium rather than phenytoin or diazepam, although this did not achieve statistical significance. Recent Cochrane reviews, however, indicated a significant reduction in maternal mortality with magnesium.

- **Option A:** Ankle clonus indicated hyperreflexia and may precede the onset of eclampsia. Although brisk or hyperactive reflexes are common during pregnancy, clonus is a sign of neuromuscular irritability that usually reflects severe preeclampsia.
- **Option B:** Magnesium sulfate is an anticonvulsant, not an antihypertensive agent. Although a decrease in blood pressure may be noted initially, this effect is usually transient.
- **Option D:** Scotomas are areas of complete or partial blindness. Visual disturbances, such as scotomas, often precede an eclamptic seizure.

5. A client who has frequent watery stools and a possible Clostridium difficile infection is hospitalized with dehydration. Which nursing action should the charge nurse delegate to an LPN/LVN?

A. Assess the client's hydration status

B. Explain the purpose of ordered stool cultures to the client and family

C. Administer metronidazole (Flagyl) 500 mg PO as ordered to the client

D. Review the client's medical history for any risk factors for diarrhea

Correct Answer: C. Administer metronidazole (Flagyl) 500 mg PO as ordered to the client

LPN/LVN education and scope of practice and education include the administration of medications. The administration of medications is recognized as the responsibility of the Registered Nurse (RN) and *Licensed Practical Nurses (LPNs). All orders for medications must be legible, complete, and non-ambiguous.

- **Option A:** The scope of practice for the registered nurse will most likely include the legal ability of the registered professional nurse to perform all phases of the nursing process including assessment, nursing diagnosis, planning, implementation, and evaluation.
- **Option B:** Teaching is a complex activity that should be carried out by a licensed nurse. An LPN can reinforce an RN’s patient teaching, but not perform independent patient education or assessments.
- **Option D:** Assessment of risk factors for diarrhea should be done by a licensed nurse. A Licensed Practical Nurse (LPN) may not perform an initial assessment. Initial assessments are to be performed by a Registered Nurse (RN). The initial assessment is to be used to determine a patient’s baseline and develop an initial nursing plan of care.

6. The nurse writes an expected outcome statement in measurable terms. An example is:

A. Client will have less pain.

B. Client will be pain-free.

C. Client will report pain acuity less than 4 on a scale of 0-10.

D. Client will take pain medication every 4 hours around the clock.

Correct Answer: C. Client will report pain acuity less than 4 on a scale of 0-10.

When developing goals for patients, the nurse needs to look at several factors. Think back to the SMART goal criteria. In order to be specific, nurses focus on questions like ‘What is the problem? What

is the response desired?' To make it measurable, 'How will the client look or behave if the healthy response is achieved? What can I see, hear, measure, observe?'

- **Option A:** One way to help nurses remember how to write goals is to make sure they are SMART. SMART goals are Specific, Measurable, Action-Oriented, Realistic, and Timely. 'Specific' refers to who, what, when, where, and why. 'Measurable' means that you can actually measure and evaluate the progress of that goal in a concrete way. 'Action-oriented' means there are actions that can be taken to reach the goal. 'Realistic' includes the ability to work on the goal, having the resources, attitudes, abilities, and skills to reach this goal, and how realistic it is to come to fruition. Finally, 'Timely' means that there is an end time frame or date at which the goal is going to be evaluated.
- **Option B:** Goal setting occurs in the third phase of the process, planning. Is the goal for nursing care to heal patients? To help them get better? To help them get well? While these are certainly at the forefront of nurses' minds, how do you evaluate these statements? What if the definition of wellness is different from one person to another? This is why nursing goal statements that are patient-centered and measurable are so important.
- **Option D:** Considering action-oriented, 'Are there steps and nursing interventions needed to reach that goal? Is this a realistic outcome for the patient? Have we considered all of the factors involved, including the client's capabilities and limitations? Does the patient have what he or she needs to reach that goal?' And finally, 'Is it timely? When do we expect the goal to be reached?'

7. For Rico who has chronic pancreatitis, which nursing intervention would be most helpful?

A. Allowing liberalized fluid intake

B. Counseling to stop alcohol consumption

C. Encouraging daily exercise

D. Modifying dietary protein

Correct Answer: B. Counseling to stop alcohol consumption.

Chronic pancreatitis typically results from repeated episodes of acute pancreatitis. More than half of chronic pancreatitis cases are associated with alcoholism. Counseling to stop alcohol consumption would be the most helpful for the client. Explore the availability of treatment programs and rehabilitation of chemical dependency if indicated.

- **Option A:** Resume oral intake with clear liquids and advance diet slowly to provide a high-protein, high-carbohydrate diet, when indicated. Oral feedings given too early in the course of illness may exacerbate symptoms. Loss of pancreatic function and reduced insulin production may require the initiation of a diabetic diet.
- **Option C:** Daily exercise would be helpful but not the most beneficial intervention. Review the importance of initially continuing a bland, low-fat diet with frequent small feedings and restricted caffeine, with a gradual resumption of a normal diet within individual tolerance.
- **Option D:** Dietary protein modification is not necessary for chronic pancreatitis. Maintain NPO status and gastric suctioning in the acute phase. Prevents stimulation and release of pancreatic enzymes (secretin), released when chyme and HCl enter the duodenum.

8. Breast self examination (BSE) is one of the ways to detect breast cancer earlier. The nurse is conducting health teaching to female clients in a clinic.

During evaluation the clients are asked to state what they learned. Which of the following statements made by a client needs further teaching about BSE?

A. “BSE is done after menstruation.”

B. “BSE palpation is done by starting at the center going to the periphery in a circular motion.”

C. “BSE can be done in a lying position.”

D. “BSE should start from age 20.”

Correct Answer: B. “BSE palpation is done by starting at the center going to the periphery in a circular motion.”

- **Option B:** This client needs further teaching as palpation in BSE should start at the periphery going to the center in a circular motion.
- **Option A:** BSE is performed 7-10 days after menstruation when the breast are less tender and lumpy.
- **Option C:** The breast can be examined in a lying position since this position flattens the breast and makes it easier to examine.
- **Option D:** All women age 20 and older must do self-breast exams where breast tumors can be easily detected at this age.

9. A patient in the cardiac unit is concerned about the risk factors associated with atherosclerosis. Which of the following are hereditary risk factors for developing atherosclerosis?

A. Family history of heart disease

B. Overweight

C. Smoking

D. Age

Correct Answer: A. Family history of heart disease

Family history of heart disease is an inherited risk factor that is not subject to a lifestyle change. Having a first-degree relative with heart disease has been shown to significantly increase risk. ASCVD is multifactorial etiology. The most common risk factors include hypercholesterolemia (LDL-cholesterol), hypertension, diabetes mellitus, cigarette smoking, age (male older than 45 years and female older than 55 years), male gender, and strong family history (male relative younger than 55 years and female relative younger than 65 years).

- **Option B:** Also, a sedentary lifestyle, obesity, diets high in saturated and trans-fatty acids, and certain genetic mutations contribute to risk. While a low level of high-density lipoprotein (HDL)-cholesterol is considered a risk factor, pharmacological therapy increasing HDL-cholesterol has yielded negative results raising concerns about the role of HDL in ASCVD.
- **Option C:** Smoking is a risk factor that is subject to lifestyle change and can reduce risk significantly. For the most part atherosclerosis and its pathology can be prevented. All healthcare workers who look after patients should educate patients on the need to exercise regularly, discontinue smoking, maintain healthy body weight, eat a healthy diet, and remain compliant with the medications used to lower lipids.

- **Option D:** Advancing age increases the risk of atherosclerosis but is not a hereditary factor. It has been reported that 75% of acute myocardial infarctions occur from plaque rupture and the highest incidence of plaque rupture was observed in men over 45 years; whereas, in women, the incidence increases beyond age 50 years.

10. Which of the following is a bulk-forming agent?

A. Glycerin

B. FiberCon

C. Lactulose

D. Milk of Magnesia

Correct Answer: B. FiberCon

FiberCon is the bulk-forming agent. Polycarbophil is used to treat constipation. It is known as a bulk-forming laxative. It increases the bulk in the stool, an effect that helps to cause movement of the intestines. It also works by increasing the amount of water in the stool, making the stool softer and easier to pass. Choices A and B are incorrect because they are hyperosmotic agents.

- **Option A:** This medication is used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations (e.g., diaper rash, skin burns from radiation therapy). Emollients are substances that soften and moisturize the skin and decrease itching and flaking.
- **Option C:** Lactulose is used in preventing and treating clinical portal-systemic encephalopathy; first used in clinical practice in 1966. Its chief mechanism of action is by decreasing the intestinal production and absorption of ammonia. Lactulose, also known as 1,4 beta galactoside-fructose, is a non-absorbable synthetic disaccharide made up of galactose and fructose. The human small intestinal mucosa does not have the enzymes to split lactulose, and hence lactulose reaches the large bowel unchanged. Lactulose is metabolized in the colon by colonic bacteria to monosaccharides, and then to volatile fatty acids, hydrogen, and methane.
- **Option D:** Milk of Magnesia is a saline laxative. This medication is used for a short time to treat occasional constipation. It is a laxative (osmotic-type) that is thought to work by drawing water into the intestines, an effect that helps to cause movement of the intestines. This medication is also used to treat symptoms caused by too much stomach acid such as heartburn, upset stomach, or indigestion. It is an antacid that works by lowering the amount of acid in the stomach.

11. The nurse is evaluating the status of a client who had a craniotomy 3 days ago. The nurse would suspect the client is developing meningitis as a complication of surgery if the client exhibits:

A. A negative Kernig’s sign.

B. A positive Brudzinski’s sign.

C. Absence of nuchal rigidity.

D. A Glascow Coma Scale score of 15.

Correct Answer: B. A positive Brudzinski’s sign

Signs of meningeal irritation compatible with meningitis include nuchal rigidity, positive Brudzinski’s sign, and positive Kernig’s sign. Brudzinski’s sign is positive when the client flexes the hips and knees

in response to the nurse gently flexing the head and neck onto the chest. Brudzinski's sign is characterized by reflexive flexion of the knees and hips following passive neck flexion. To elicit this sign, the examiner places one hand on the patient's chest and the other hand behind the patient's neck. The examiner then passively flexes the neck forward and assesses whether the knees and hips flex.

- **Option A:** Kernig's sign is positive when the client feels pain and spasm of the hamstring muscles when the knee and thigh are extended from a flexed-right angle position. The Kernig sign is one of the eponymous clinical signs of meningitis. This test typically is performed in patients while supine and is described as resistance (or pain) with passive extension of the knees. This resistance is thought to be due to meningeal inflammation in the setting of meningitis or other clinical entities that may irritate the meninges.
- **Option C:** Nuchal rigidity is characterized by a stiff neck and soreness, which is especially noticeable when the neck is fixed. Nuchal rigidity is an inability to flex the neck forward due to rigidity of the neck muscles. Similar to Kernig's sign, research has shown that many people with meningitis don't have the Brudzinski sign or nuchal rigidity.
- **Option D:** A Glasgow Coma Scale of 15 is a perfect score and indicates the client is awake and alert with no neurological deficits. The Glasgow Coma Scale (GCS) is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses. Reporting each of these separately provides a clear, communicable picture of a patient's state.

12. 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.

13. An incoherent female client with a history of hypothyroidism is brought to the emergency department by the rescue squad. Physical and laboratory

findings reveal hypothermia, hypoventilation, respiratory acidosis, bradycardia, hypotension, and nonpitting edema of the face and pretibial area. Knowing that these findings suggest severe hypothyroidism, nurse Libby prepares to take emergency action to prevent the potential complication of:

A. Thyroid storm.

B. Cretinism.

C. Myxedema coma.

D. Hashimoto's thyroiditis.

Correct Answer: C. Myxedema coma.

Severe hypothyroidism may result in myxedema coma, in which a drastic drop in the metabolic rate causes decreased vital signs, hypoventilation (possibly leading to respiratory acidosis), and nonpitting edema. Patients are most commonly presenting for emergency services with altered mental status and hypothermia, below 35.5 degrees C (95.9 degrees F). The lower the body temperature, the worst is the prognosis. The absence of mild diastolic hypertension in severely hypothyroid patients is a warning sign of impending myxedema coma.

- **Option A:** Thyroid storm is an acute complication of hyperthyroidism. Thyroid storm, also known as thyrotoxic crisis, is an acute, life-threatening complication of hyperthyroidism. It is an exaggerated presentation of thyrotoxicosis. It comes with sudden multisystem involvement.
- **Option B:** Cretinism is a form of hypothyroidism that occurs in infants. Congenital hypothyroidism (CH) is defined as thyroid hormone deficiency present at birth. CH must be diagnosed promptly because delay in treatment can lead to irreversible neurological deficits. Before the newborn screening program, CH was one of the most common preventable causes of intellectual disability.
- **Option D:** Hashimoto's thyroiditis is a common chronic inflammatory disease of the thyroid gland in which autoimmune factors play a prominent role. Hashimoto thyroiditis is an autoimmune disease that destroys thyroid cells by cell and antibody-mediated immune processes. It is the most common cause of hypothyroidism in developed countries. This disease is also known as chronic autoimmune thyroiditis and chronic lymphocytic thyroiditis. The pathology of the disease involves the formation of antithyroid antibodies that attack the thyroid tissue, causing progressive fibrosis.

14. When administering topical ophthalmic preparations, the nurse must assess:

A. Visual acuity

B. Intraocular movements

C. Color of the sclera

D. Blinking reflex

Correct Answer: A. Visual acuity

The nurse must assess visual acuity, extraocular eye movements, tearing, and discharge when administering topical eye medications. Topical ophthalmic medications are widely prescribed by growing numbers of eye-care professionals. Increasingly, these agents are being prescribed by optometrists and ophthalmic-trained nurses in addition to ophthalmologists and general practitioners. As the number and variety of topical agents on the market rises, and as the number of clinicians

involved in prescribing those agents increases; the risk of systemic adverse effects will also increase.

- **Option B:** It is the elderly population who are at the greatest risk of experiencing systemic adverse effects of topical agents. Chronic ophthalmic diseases, and hence long term ophthalmic drop treatments, are more prevalent among older people. Such individuals are also likely to have other medical conditions (e.g. cardiac, respiratory, or neurological disease) that may be induced or exacerbated by topical ophthalmic agents. Moreover, polypharmacy is common in elderly people, and this is associated with an increased risk of drug interactions.
- **Option C:** To apply the eye ointment, wash hands first. To avoid contamination, be careful not to touch the tube tip or let it touch the eye or any other surface. Tilt the head back, look upward, and pull down the lower eyelid to make a pouch.
- **Option D:** If using another kind of eye medication (e.g., drops or ointments), apply the eye drops first and wait at least 5 minutes before applying this eye ointment. Use eye drops before eye ointments to allow the eye drops to enter the eye. If using another type of eye ointment, wait at least 10 minutes after using this medication before applying it.

15. The depressed client verbalizes feelings of low self-esteem and self-worth typified by statements such as "I'm such a failure… I can't do anything right!" The best nursing response would be:

A. To tell the client this is not true; that we all have a purpose in life.

B. To remain with the client and sit in silence; this will encourage the client to verbalize feelings.

C. To reassure the client that you know how the client is feeling and that things will get better.

D. To identify recent behaviors or accomplishments that demonstrate skill ability.

Correct Answer: D. To identify recent behaviors or accomplishments that demonstrate skill ability.

Feelings of low self-esteem and worthlessness are common symptoms of the depressed client. An effective plan of care to enhance the client's personal self-esteem is to provide experiences for the client that are challenging but will not be met with failure. Reminders of the client's past accomplishments or personal successes are ways to interrupt the client's negative self-talk and distort the cognitive view of self. Silence may be interpreted as agreement.

- **Option A:** Assess the self-esteem level of the patient. Signs of low self-esteem include withdrawal from social relationships, feeling of inadequacy, neglect of personal hygiene and dress, and rejecting self which all may indicate a negative thought pattern. Allow the patient to perform personal care activities. Paying attention to grooming serves as a first step towards achieving positive self-image.
- **Option B:** Give positive feedback after a task is achieved. Positive reinforcement has a big part in building self-esteem. Teach visualization techniques that can help the client replace negative self-images with more positive images and thoughts to promote a healthier and more realistic self-image by helping the client choose more positive thoughts and actions.
- **Option C:** This gives advice and devalues the client's feelings. Encourage the client to participate in a group therapy where the members share the same situations/feelings that they have to minimize the feelings of isolation and provide an atmosphere where positive feedback and a more realistic appraisal of self are available. Involve the client in activities that he or she wants to improve by using problem-solving skills. Assess and evaluate the need for more teaching in this area.

16. The type of fluid used to manipulate fluid shifts among compartments states is:

A. Whole blood

B. TPN

C. Albumin

D. Ensure

Correct Answer: C. Albumin

Albumin is a colloid that is used to manipulate fluid shifts among compartments. Albumin is also a colloid fluid administered to patients in need of fluid resuscitation, especially in the setting of trauma (i.e. hypovolemic shock) or in the setting of large-volume paracentesis. Strength albumin has over crystalloids is that it leads to an increase in intravascular oncotic pressure. There are some situations in which a patient needs improved oncotic pressure, and this characteristic can be advantageous.

- **Option A:** Whole blood is used to replace blood volume. Whole Blood is the simplest, most common type of blood donation. It's also the most flexible because it can be transfused in its original form, or used to help multiple people when separated into its specific components of red cells, plasma, and platelets.
- **Option B:** TPN is used for patients who are unable to take in food or fluid. Total parenteral nutrition (TPN) supplies all daily nutritional requirements. TPN can be used in the hospital or at home. Because TPN solutions are concentrated and can cause thrombosis of peripheral veins, a central venous catheter is usually required.
- **Option D:** Ensure is a high-calorie nutritional supplement; it is not used to manipulate fluid shifts. It contains well-balanced proportions of macronutrients that conform to guidelines for Dietary Reference Intake and the latest American Heart Association Guidelines for healthy diets.

17. The nurse evaluates the treatment of Mrs. Montez with somatoform disorder as successful if:

A. Mrs. Montez practices self-medication rather than changing health care providers.

B. Mrs. Montez recognizes that physical symptoms increase anxiety level.

C. Mrs. Montez researches treatment protocols for various illnesses.

D. Mrs. Montez verbalizes anxiety directly rather than displacing it.

Correct Answer: D. Mrs. Montez verbalizes anxiety directly rather than displacing it.

Mrs. Montez with somatoform disorder unconsciously displaces anxiety onto physical symptoms. The ability to recognize and verbalize anxious feelings directly rather than displacing them is a criterion of treatment success. Clients may keep a detailed journal of their physical symptoms; the nurse might ask them to describe the situation at the time such as whether they were alone or with others, whether any disagreements were occurring, and so forth.

- **Option A:** Teach the client coping strategies. Emotion-focused strategies include progressive relaxation, deep breathing, guided imagery, and distractions such as music or other activities; problem-focused coping strategies include problem-solving methods, applying the process to identified problems, and role-playing interactions with others.

- **Option B:** Provide education about feared or actual medical conditions. This helps the client understand the condition in a more realistic light and helps alleviate fear and anxiety about a particular health concern. Discuss symptoms with the client and when they began, what makes them better or worse and how they have been managing these symptoms. This helps make a more definitive diagnosis and helps determine how to best treat the client. Helping the client determine the etiology of symptoms helps them to recognize and avoid situations that make symptoms worse.
- **Option C:** This indicates the continuation of the problem. Encourage behavior modification such as praising the client and offering more attention when symptoms improve. Change the focus from what's wrong to what's right. Helps the client feel accomplished and more positive about improvements in health condition instead of focusing on the symptoms.

18. Which of the following would the nurse assess in a client experiencing abruptio placenta?

A. Bright red, painless vaginal bleeding

B. Concealed or external dark red bleeding

C. Palpable fetal outline

D. Soft and nontender abdomen

Correct Answer: B. Concealed or external dark red bleeding

A client with abruptio placentae may exhibit concealed or dark red bleeding, possibly reporting sudden intense localized uterine pain. The uterus is typically firm to board-like, and the fetal presenting part may be engaged.

- **Option A:** Painless vaginal bleeding during the second or third trimester of pregnancy is the usual presentation in placenta previa. The bleeding may be provoked from intercourse, vaginal examinations, labor, and at times there may be no identifiable cause. On speculum examination, there may be minimal bleeding to active bleeding.
- **Option C:** On physical examination, the uterus tends to be soft and fetal parts are readily palpable. With placenta previa, the presenting part is unengaged and malpresentation is common, seen in up to 50% of cases.
- **Option D:** Abdominal examination usually finds the uterus non-tender, soft and relaxed. Leopold's Maneuvers may find the fetus in an oblique or breech position or lying transverse as a result of the abnormal position of the placenta. Malpresentation is found in about 35% cases.

19. When planning care for a male client with burns on the upper torso, which nursing diagnosis should take the highest priority?

A. Ineffective airway clearance related to edema of the respiratory passages

B. Impaired physical mobility related to the disease process

C. Disturbed sleep pattern related to facility environment

D. Risk for infection related to breaks in the skin

Correct Answer: A. Ineffective airway clearance related to edema of the respiratory passages

When caring for a client with upper torso burns, the nurse's primary goal is to maintain respiratory integrity. Therefore, option A should take the highest priority. Immediately assess the patient's airway,

breathing, and circulation. Be especially alert for signs of smoke inhalation, and pulmonary damage: singed nasal hairs, mucosal burns, voice changes, coughing, wheezing, soot in the mouth or nose, and darkened sputum.

- **Option B:** This nursing diagnosis isn't appropriate because burns aren't a disease. Note circulation, motion, and sensation of digits frequently. Edema may compromise circulation to extremities, potentiating tissue necrosis and the development of contractures.
- **Option C:** Disturbed sleep pattern may be appropriate, but don't command a higher priority than the ineffective airway clearance because they don't reflect immediately life-threatening problems. Initially, the patient may use denial and repression to reduce and filter information that might be overwhelming. Some patients display a calm manner and alert mental status, representing a dissociation from reality, which is also a protective mechanism.
- **Option D:** Examine wounds daily, note and document changes in appearance, odor, or quantity of drainage. Indicators of sepsis (often occurs with full-thickness burn) requiring prompt evaluation and intervention. Note: Changes in sensorium, bowel habits, and the respiratory rate usually precede fever and alteration of laboratory studies.

20. A client is being tapered off opioids and the nurse is watchful for signs of withdrawal. What is one of the first signs of withdrawal?

A. Fever

B. Nausea

C. Diaphoresis

D. Abdominal cramps

Correct Answer: C. Diaphoresis

Diaphoresis is one of the early signs that occur between 6 and 12 hours. Fever, nausea, and abdominal cramps are late signs that occur between 48 and 72 hours. According to Diagnostic and Statistical Manual of Mental Disorders (DSM–5) criteria, signs, and symptoms of opioid withdrawal include lacrimation or rhinorrhea, piloerection "goose flesh," myalgia, diarrhea, nausea/vomiting, pupillary dilation and photophobia, insomnia, autonomic hyperactivity (tachypnea, hyperreflexia, tachycardia, sweating, hypertension, hyperthermia), and yawning.

- **Option A:** A fever can be a withdrawal symptom among people who have been addicted to various substances, or even after a period of intense substance use. Fever symptoms may range from mild to severe. Although mild fevers can accompany a variety of substance withdrawal syndromes and are usually self-limiting, fever can also be a component of a particularly dangerous type of alcohol withdrawal.
- **Option B:** Prolonged use of these drugs changes the way nerve receptors work in the brain, and these receptors become dependent upon the drug to function. If the client becomes physically sick after he stops taking an opioid medication, it may be an indication that he's physically dependent on the substance.
- **Option D:** The symptoms the client is experiencing will depend on the level of withdrawal he is experiencing. Also, multiple factors dictate how long a person will experience the symptoms of withdrawal. Because of this, everyone experiences opioid withdrawal differently. However, there's typically a timeline for the progression of symptoms.

21. A client with a hiatal hernia has been taking magnesium hydroxide for relief of heartburn. Overuse of magnesium-based antacids can cause the client to have:

A. Constipation

B. Weight gain

C. Anorexia

D. Diarrhea

Correct Answer: D. Diarrhea

- Option D: Overuse of magnesium-containing antacids have a laxative effect that results in diarrhea.
- Option A: Antacids containing calcium and aluminum cause constipation
- Options B and C: Weight gain and anorexia are not associated with the use of magnesium antacids.

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

A. Every 30 minutes during the first hour and then every hour for the next two hours.

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

C. Every hour for the first 2 hours and then every 4 hours.

D. Every 5 minutes for the first 30 minutes and then every hour for the next 4 hours.

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

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

- **Option A:** The second phase is the subacute postpartum period, which lasts 2–6 weeks. During this phase, the body is undergoing major changes in terms of hemodynamics, genitourinary recovery, metabolism, and emotional status. Nonetheless, the changes are less rapid than in the acute postpartum phase and the patient is generally capable of self-identifying problems. These may run the gamut from ordinary concerns about perineal discomfort to peripartum cardiomyopathy or severe postpartum depression.
- **Option C:** The third phase is the delayed postpartum period, which can last up to 6 months. Changes during this phase are extremely gradual, and pathology is rare. This period is used to make sure the mother is stable and to educate her in the care of her baby (especially the first-time mother). While still in the hospital, the mother is monitored for blood loss, signs of infection, abnormal blood pressure, contraction of the uterus, and ability to void. There is also attention to Rh compatibility, maternal immunization statuses, and breastfeeding. This is the time of restoration of muscle tone and connective tissue to the prepregnant state. Although change is subtle during this phase, it behooves caregivers to remember that a woman?s body is nonetheless not fully restored to prepregnant physiology until about 6 months post-delivery.

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

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

A. Cancer

B. Coronary artery disease

C. Liver failure

D. Renal failure

Correct Answer: B. Coronary artery disease

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

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

24. Nurse Mary is caring for a client with bulimia. Strict management of dietary intake is necessary. Which intervention is also important?

A. Fill out the client's menu and make sure she eats at least half of what is on her tray.

B. Let the client eat her meals in private. Then engage her in social activities for at least 2 hours after each meal.

C. Let the client choose her own food. If she eats everything she orders, then stay with her for 1 hour after each meal.

D. Let the client eat food brought in by the family if she chooses, but she should keep a strict calorie count.

Correct Answer: C. Let the client choose her own food. If she eats everything she orders, then stay with her for 1 hour after each meal

Allowing the client to select her own food from the menu will help her feel some sense of control. Assisting patients to remain strong and adhere to treatment requires nurses to develop a relationship that is caring, empathetic and trusting, and in line with the person-centered approach to care. Patients affected by eating disorders require individualized support to better understand their condition, rediscover their identity, learn to accept themselves, enhance a positive body image and sense of self-worth, and achieve a balance in their lives so that they can move towards better health and wellbeing.

- **Option A:** She must then eat 100% of what she selected. During the early stages of treatment when patients are still new to recovery, they look to nurses to provide them with a highly structured environment, which sometimes involves nurses making food and behavioral decisions on their behalf. While this might not be an ongoing issue for primary care nurses, they may still be required to offer decisive advice on these areas. Here, it is imperative that nurses offer such advice with a clear message that patients have the power to make these decisions themselves.

- **Option B:** Remaining with the client for at least 1 hour after eating will prevent purging. As treatment progresses, patients eventually grow to appreciate nurses who act as role models and educate them on how to normalize their diet and involvement in social activities. Towards the end of treatment, nurses become more of a support system, encouraging the patient to move forward autonomously, while providing them with guidance on where to seek help if it is needed.
- **Option D:** Bulimic clients should only be allowed to eat food provided by the dietary department. From awareness of the eating disorder to recovery maintenance, the role of the primary care nurse evolves, but what doesn't change is the positive influence nurses can have on those with an eating disorder. With the skills of listening, empathy, adaptability, and communication, primary care nurses can assist in identifying at-risk individuals and optimizing the delivery of a multidisciplinary and holistic approach to care.

25. Nurse Janet is assigned in the oncology section of the hospital. Which of the following orders should the nurse question if a client is on radiation therapy?

A. Bland diet

B. Aspirin every 4 hours

C. Saline rinses every 2 hours

D. Analgesics before meals

Correct Answer: B. Aspirin every 4 hours

- **Option B:** Radiation therapy makes the platelet count decrease. Thus, nursing responsibilities should be directed at promoting safety by avoiding episodes of hemorrhage or bleeding such as physical trauma and aspirin administration.
- **Options A and C:** Bland diet and saline rinses every 2 hours should also be done to manage stomatitis, a complication of radiation therapy.
- **Option D:** Analgesics are given before meals to alleviate the pain caused by stomatitis.

26. Within a few hours of alcohol withdrawal, nurse John should assess the male client for the presence of:

A. Disorientation, paranoia, tachycardia

B. Tremors, fever, profuse diaphoresis

C. Irritability, heightened alertness, jerky movements

D. Yawning, anxiety, convulsions

Correct Answer: C. Irritability, heightened alertness, jerky movements

Alcohol is a central nervous system depressant. These symptoms are the body's neurological adaptation to the withdrawal of alcohol. Alcohol withdrawal symptoms occur when patients stop drinking or significantly decrease their alcohol intake after long-term dependence. Withdrawal has a broad range of symptoms from mild tremors to a condition called delirium tremens, which results in seizures and could progress to death if not recognized and treated promptly.

- **Option A:** Alcohol withdrawal can range from very mild symptoms to severe form, which is named delirium tremens. The hallmark is autonomic dysfunction resulting from the excitation of the central nervous system. Mild signs/symptoms can arise within six hours of alcohol cessation. If symptoms do not progress to more severe symptoms within 24 to 48 hours, the patient will likely recover.
- **Option B:** Mild symptoms can be insomnia, tremulousness, hyperreflexia, anxiety, gastrointestinal upset, headache, palpitations. Moderate symptoms include alcohol withdrawal seizures (rum fits) that can occur 12 to 24 hours after cessation of alcohol and are typically generalized in nature. There is a 3% incidence of status epilepticus in these patients. About 50% of patients who have had a withdrawal seizure will progress to delirium tremens.
- **Option D:** Delirium tremens is the most severe form of alcohol withdrawal, and its hallmark is that of an altered sensorium with significant autonomic dysfunction and vital sign abnormalities. It includes visual hallucinations, tachycardia, hypertension, hyperthermia, agitation, and diaphoresis. Symptoms of delirium tremens can last up to seven days after alcohol cessation and may last even longer.

27. Which of the following symptoms would a client in the early stages of peritonitis exhibit?

A. Abdominal distention

B. Abdominal pain and rigidity

C. Hyperactive bowel sounds

D. Right upper quadrant pain

Correct Answer: B. Abdominal pain and rigidity

Abdominal pain-causing rigidity of the abdominal muscles is characteristic of peritonitis. During the physical exam, pertinent findings include fever and abdominal tenderness to palpation which usually is diffuse with wall rigidity in more septic presentations.

- **Option A:** Abdominal distention may occur as a late sign but not early on. It is important to conduct a thorough exam as certain thoracic or pelvic pathologies can mimic peritoneal irritation (empyema causing diaphragmatic irritation and cystitis/pyelonephritis causing peritoneum adjacent pain).
- **Option C:** Bowel sounds may be normal or decreased but not increased. Important to note, approximately 30% of individuals with SBP will be asymptomatic on presentation. Patients will present with a variable amount of clinical manifestation of the underlying disease process, ranging from insidious mild limited disease to an acute fulminant systemic process.
- **Option D:** Right upper quadrant pain is characteristic of cholecystitis or hepatitis. Concerning signs present in a high percentage of individuals with diagnosed peritonitis include vague constitutional symptoms such as fever chills, abdominal pain +/- discomfort, diarrhea, and ileus.

28. A nurse is caring for a client who is disoriented to time, place, and person and is attempting to get out of bed and pull out an intravenous (I.V.) line that is supplying hydration and antibiotics. The client has a vest restraint and bilateral soft wrist restraints. Which nursing actions would be appropriate? Select all that apply.

A. Perform a face-to-face behavior evaluation every hour.

B. Tie the restraints in quick-release knots.

C. Tie the restraints to the side rails of the bed.

D. Document the client's condition.

E. Document alternative methods used before the restraints were applied.

F. Document the client's response to the intervention.

Correct Answer: A, B, D, E, & F.

Preventing a client from falling or harming him- or herself is of utmost importance. Applying restraints should be a last resort when all other alternative interventions have been attempted.

- **Option A:** A face-to-face evaluation must be performed every hour. After restraint placement, patients should be reevaluated every hour and moved at regular intervals to prevent sequelae such as pressure ulcers, rhabdomyolysis, and paresthesias.
- **Option B:** Restraints should be tied in knots that can be released quickly and easily. Physical restraints encompass hand mitts, soft cloth limb restraints, leather limb restraints, enclosed beds, belts, and vests.
- **Option C:** Restraints should never be secured to side rails because doing so can cause injury if the side rail is lowered without untying the restraint. Ideally, a restraint team should include at least five people, including the team leader.
- **Options D, E, and F:** The nurse should document the client's condition, any alternative methods used before the restraints were applied, and the client's response to the interventions. Document appropriate clinical indication and have a standardized checklist prepared for staff to monitor and supply patient needs effectively.

29. A client with a chronic obstructive pulmonary disease is prescribed with ipratropium (Combivent). Upon a review of the medical history of the client, the nurse questions the prescription if which of the following is noted?

A. History of smoking

B. History of allergy to egg

C. History of allergy to peanut

D. History of a previous infection

Correct Answer: C. History of allergy to peanut

The client with a peanut allergy should not take ipratropium because the product contains soy lecithin, which is in the same plant family as peanuts.

30. You are the charge nurse on the pediatric unit when a pediatrician calls wanting to admit a child with rubeola (measles). Which of these factors is of most concern in determining whether to admit the child to your unit?

A. No negative-airflow rooms are available on the unit

B. The infection control nurse liaison is not on the unit today

C. There are several children receiving chemotherapy on the unit

D. The unit is not staffed with the usual number of RNs

Correct Answer: A. No negative-airflow rooms are available on the unit

Because clients with rubeola require the implementation of airborne precautions, which include placement in a negative airflow room, this child cannot be admitted to the pediatric unit. An airborne isolation room is also known as a negative pressure room. This negative pressure room is usually a single-occupancy patient-care room frequently used to isolated individuals with confirmed or suspected airborne infections. The other circumstances may require actions such as staff reassignments but would not prevent the admission of a client with rubeola.

- **Option B:** The absence of the infection control nurse liaison should not prevent the admission of the child with rubeola. Before transferring a patient with an airborne infection, one must always communicate with the relevant department first. The earlier the airborne prevention methods are adopted, the lower the risk of transmission to other patients and healthcare staff.
- **Option C:** The clients receiving therapy can be transferred to a different location far from the isolation room. The door to the room of the isolation area must be kept closed to maintain negative pressure even if the client is not in the room. The windows in the room should remain closed at all times; opening the window may cause the reversal of airflow, which counters the benefits of a negative pressure room.
- **Option D:** Only healthcare providers immunized to the organism in question should enter a room where airborne precautions are in place for varicella or measles. A respirator is not necessary for immunized individuals but is required for non-immunized workers who provide care.

31. The nurse explains to the parents of a 1-year-old child admitted to the hospital in a sickle cell crisis that the local tissue damage the child has on admission is caused by which of the following?

A. Autoimmune reaction complicated by hypoxia.

B. Lack of oxygen in the red blood cells.

C. Obstruction to circulation.

D. Elevated serum bilirubin concentration.

Correct Answer: C. Obstruction to circulation

Characteristic sickle cells tend to cause “log jams” in capillaries. This results in poor circulation to local tissues, leading to ischemia and necrosis. Red blood cells become more rigid. There is a release of adhesion molecules, causing interaction of this deformed, sickled RBC to the endothelium. This increased adhesion of erythrocytes followed by the formation of heterocellular aggregates physically causes small vessel occlusion and resultant local hypoxia.

- **Option A:** Sickle cell disease is an inherited disease, not an autoimmune reaction. Sickle cell disease is an autosomal recessive disorder of a gene mutation. On chromosome 11, nucleotide mutation leads to substitution of glutamic acid to valine at position six on the beta-globin subunit. This leads to changes in the physical properties of the globin chain.
- **Option B:** The basic defect in sickle cell disease is an abnormality in the structure of RBCs. The erythrocytes are sickle-shaped, rough in texture, and rigid. Red blood cells with normal hemoglobin are smooth, disk-shaped, and flexible, like doughnuts without holes. They can move through the blood vessels easily. Cells with sickle cell hemoglobin are stiff and sticky. When they lose their oxygen, they form into the shape of a sickle or crescent, like the letter C.

- **Option D:** Elevated serum bilirubin concentrations are associated with jaundice, not sickle cell disease. Sickle cell crisis patient evaluation warrants routine laboratory examination such as CBC with differential, a reticulocyte count, and a complete metabolic panel including liver function tests.

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

A

B

C

D

Correct Answer: A.

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

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

33. A client with cystic fibrosis is taking pancreatic enzymes. The nurse should administer this medication:

A. Once per day in the morning

B. Three times per day with meals

C. Once per day at bedtime

D. Four times per day

Correct Answer: B. Three times per day with meals

Pancreatic enzymes should be given with meals for optimal effects. These enzymes assist the body in digesting needed nutrients. Chronic, supportive therapy for patients with CF includes regular pancreatic enzymes, fat-soluble vitamins (A, D, E, K), mucolytics, bronchodilators, antibiotics, and anti-inflammatory agents.

- **Option A:** A new class of medications known as CFTR modulator therapies is designed to correct the dysfunction by improving production, intracellular processing, or function of the CFTR protein caused by the mutated gene. Each medication is targeted at a specific dysfunction caused by a specific gene mutation.
- **Option C:** Individuals with CF are encouraged to consume a high-fat diet with supplemental fat-soluble vitamins to compensate for malabsorption. Additionally, patients living with CF are encouraged to consume a high-calorie diet to maintain a healthy weight and combat chronic inflammation and frequent infections that are commonly encountered.
- **Option D:** According to the Cystic Fibrosis Foundation, women should consume 2500 to 3000 calories a day, while men should consume 3000 to 3700 calories a day. Those living in hot climates or who participate in activities that cause sweating are encouraged to consume additional sodium in their diet.

34. Which of the following meal choices is suitable for a 6-month-old infant?

A. Pea puree, formula, and orange juice

B. Honey cereals, carrot stick, apple juice

C. Rice cereal, mashed sweet potato, formula

D. Melba toast, banana puree, whole milk

Correct Answer: C. Rice cereal, mashed sweet potato, formula

- Option C: A 6 month-old baby can now be introduced to solid food other than breast milk. Start offering foods that are easily digested such as rice cereal, apple juice, and formula.
- Option A: A 6 month-old infant has a sensitive stomach. Giving an acidic fruit such as orange is not advisable.
- Option B: Honey containing products are discouraged due to the risk of botulism.
- Option D: Whole milk should be offered after 9 to 12 months of age.

35. Nurse Hazel teaches the client with angina about common expected side effects of nitroglycerin including:

A. High blood pressure

B. Stomach cramps

C. Headache

D. Shortness of breath

Correct Answer: C. Headache

Because of its widespread vasodilating effects, nitroglycerin often produces side effects such as headache, hypotension, and dizziness. Headaches can be severe, throbbing, and persistent and may occur immediately after use. Vasodilation and venous pooling can increase the amount of blood in the cranial space, resulting in increased intracranial pressures; this can cause persistent, throbbing headaches, along with confusion, fever, vertigo, nausea, vomiting, and visual disturbances.

- **Option A:** Nitroglycerin produces hypotension instead of hypertension due to its vasodilating effects. Many of these adverse effects are secondary to the hypotensive effects of nitroglycerin. Patients may report symptoms of orthostatic hypotension which manifest as dizziness, weakness, palpitations, and vertigo. Profound hypotension may occur in patients with preload-dependent conditions.
- **Option B:** Stomach cramps are not a side effect of nitroglycerin. Some patients can be more sensitive to the hypotension caused by nitrates, which can result in nausea, vomiting, diaphoresis, pallor, and collapse even at therapeutic doses. Nitroglycerin is both a protein-bound drug, and it undergoes hepatic metabolism. Therefore it has numerous drug interactions. Before prescribing, providers should determine if the patient is taking any medications that may interact with nitroglycerin.
- **Option D:** Difficulty of breathing is one of the side effects of nitroglycerin. In the event of overdose, monitoring of vital signs may be necessary to monitor the hemodynamic effects of nitroglycerin. Continuous monitoring of blood pressure, heart rate, respiratory rate, and oxygen saturation is recommended. As intracranial pressure increases, symptoms will progress to dyspnea secondary to a reduced respiratory effort, heart block, bradycardia, paralysis, seizures, coma, and, eventually, death.