Kevin's Review - 35 NCLEX Practice Questions

1. Which of the following findings would be a source of concern if noted during the assessment of a woman who is 12 hours postpartum?

A. Postural hypotension

B. Temperature of 100.4°F

C. Bradycardia — pulse rate of 55 BPM

D. Pain in left calf with dorsiflexion of the left foot

Correct Answer: D. Pain in left calf with dorsiflexion of the left foot.

Pain in the left calf with dorsiflexion of the left foot indicates a positive Homan sign and is suggestive of thrombophlebitis and should be investigated further. The risk of developing blood clots (thrombophlebitis) is increased for about 6 to 8 weeks after delivery . Typically, blood clots occur in the deep veins of the legs or pelvis (a disorder called deep vein thrombosis). Sometimes one of these clots breaks loose and travels through the bloodstream into the lungs, where it lodges in a blood vessel in the lung, blocking blood flow. This blockage is called pulmonary embolism. Blood clots may also develop in the veins just under the skin in the legs. This disorder is called superficial venous thrombosis (superficial thrombophlebitis).

- **Option A:** The postpartum period is the period after delivery of conceptus when maternal physiological and anatomical changes return to the nonpregnant state. The blood pressure could be elevated due to pain or excitement but is generally in the normal range. A significant decrease (> 20% below baseline) in blood pressure could be a sign of postpartum hemorrhage or septic shock. Conversely, high blood pressure could be a sign of pain or pre-eclampsia.
- **Option B:** A temperature of 100.4°F in the first 24 hours is most likely indicative of dehydration which is easily corrected by increasing oral fluid intake. The temperature is slightly elevated up to 37.2C (99F) along with increased shivering, sweating, or diaphoresis in the first 24 hours and normalizes within 12 hours. The temperature rise is attributable to the systemic absorption of metabolites accumulated due to muscle contractions. There could be a transient temperature rise (by 0.5C) on the third or fourth day due to breast engorgement.
- **Option C:** Bradycardia is expected to be related to circulatory changes after birth. There is generalized physical fatigue immediately after delivery. The pulse rate may be elevated a few hours after childbirth due to excitement or pain and usually normalizes on the second day. The postpartum period, also known as puerperium, starts following the expulsion of the placenta until complete physiological recovery of various organ systems. The postpartum period divides into three arbitrary phases, i.e., acute phase – the first 24 hours after delivery of the placenta, early – up to 7 days, and late – up to 6 weeks to 6 months. Each phase has its unique clinical considerations and challenges.

2. A child with fever has been admitted to the ED for several hours. Cooling measures are ordered by the physician in order for the client's temperature to come down. Which task would be appropriate to delegate to the nursing assistant?

A. Prepare and administer a tepid bath

B. Assist the child in removing outer garments

C. Educate the need for giving cool fluids

D. Tell the parent to use acetaminophen (Tylenol) instead of aspirin

Correct Answer: B. Assist the child in removing outer garments

The nursing assistant can assist with the elimination of outer garments, which enables the heat to dissipate from the child's skin. The nurse who delegates aspects of care to other members of the nursing team must balance the needs of the client with the abilities of those to which the nurse is delegating tasks and aspects of care, among other things such as the scopes of practice and the policies and procedures within the particular healthcare facility.

- **Option A:** Tepid baths are not usually given because of the potential for rebound and shivering. Registered nurses who assign, delegate and/or provide nursing care to clients and groups of clients must report all significant changes that occur in terms of the client and their condition. For example, a significant change in a client's laboratory values requires that the registered nurse report this to the nurse's supervisor and doctor.
- **Option C:** Explaining is a teaching function only appropriate for a registered nurse. The staff members' levels of education, knowledge, past experiences, skills, abilities, and competencies are also evaluated and matched with the needs of all of the patients in the group of patients that will be cared for.
- **Option D:** Advising is a teaching function that is the responsibility of the registered nurse. Delegation should be done according to the differentiated practice for each of the staff members.

3. Drugs classified as centrally acting skeletal muscle relaxants are most effective in relieving:

A. Spasm due to trauma or inflammation

B. Chronic spasm due to old injury

C. Pain from arthritis

D. Surgical complications

Correct Answer: A. Spasm due to trauma or inflammation

Centrally acting skeletal muscle relaxants are most effective in relieving spasm due to trauma or inflammation. The centrally acting muscle relaxants are a group of drugs that act in the central nervous system (CNS) to mitigate tension and spasm of skeletal muscles. Drugs within this group are structurally heterogeneous and act at a variety of receptors in the CNS.

- **Option B:** In theory, involuntary muscle spasm may result from a protective reflex preventing movement that would otherwise cause injury. In some cases, muscle spasm itself may become painful and debilitating. This phenomenon, known as the "pain-spasm-pain cycle," has not been confirmed in rigorous clinical and electrophysiologic studies.
- **Option C:** One proposed mechanism is anticholinergic inhibition of the midbrain reticular activating system resulting in depressed polysynaptic reflexes and decreased muscle tone. This is also described as an indirect inhibition of the interneuronal junction of the spinal cord.
- **Option D:** The onset of action of oral methocarbamol is 30 minutes. The drug is completely absorbed by the gastrointestinal tract and reaches peak plasma concentrations at two hours. It has a variable half-life of one to two hours and is metabolized in the liver by dealkylation, hydroxylation, and glucuronidation.

4. Which of the following signs of increased intracranial pressure (ICP) would appear first after head trauma?

A. Bradycardia

B. Large amounts of very dilute urine

C. Restlessness and confusion

D. Widened pulse pressure

Correct Answer: C. Restlessness and confusion

The earliest sign of increased ICP is a change in mental status.

- **Options A and D:** Bradycardia and widened pulse pressure occur as later signs of increased ICP.
- **Option B:** The patient may void a lot of very dilute urine if his posterior pituitary is damaged.

5. When providing care for a female client with Addison disease, the nurse should be alert for which of the following laboratory values?

A. Potassium level of 3.2 mEq/L.

B. Calcium level of 3.3 mEq/L.

C. Sodium level of 150 mg/dL.

D. Hematocrit level of 25%.

Correct Answer: D. Hematocrit level of 25%.

A client with Addison's disease is at risk for anemia. The normal hematocrit level of a female adult is 35% to 45%. A client with anemia has a low hematocrit level. Addison anemia, better known today as pernicious anemia (PA), is characterized by the presence in the blood of large, immature, nucleated cells (megaloblasts) that are forerunners of red blood cells. (Red blood cells, when mature, have no nucleus). It is thus a type of megaloblastic anemia.

- **Option A:** The client with Addison's disease has increased potassium. A deficiency of aldosterone, in particular, causes the body to excrete large amounts of sodium and retain potassium, leading to low levels of sodium and high levels of potassium in the blood.
- **Option B:** The client with Addison's disease has an increased calcium level. As not all cases of adrenal insufficiency present with hypercalcemia, adrenal insufficiency is not easily considered an etiology of hypercalcemia. The prevalence of hypercalcemia at the time of diagnosis of Addison's disease is reported to be ~5.5%–6.0%.
- **Option C:** The client with Addison's disease has a low sodium level. The kidneys are not able to retain sodium easily, so when a person with Addison disease loses too much sodium, the level of sodium in the blood falls, and the person becomes dehydrated. Severe dehydration and a low sodium level reduce blood volume and can lead to shock.

6. In a complex pediatric oncology unit, a seasoned nurse is faced with the challenge of assessing and managing pain in a non-verbal 3-year-old child undergoing treatment for acute lymphoblastic leukemia. The child's limited communicative ability due to developmental age and the distressing nature of

the current clinical situation necessitate a highly nuanced approach to pain assessment. Given these parameters, which pain assessment tool would be most useful for the nurse to accurately gauge the young patient's pain levels?

A. McGill-Melzack Pain Questionnaire

B. Simple Description Pain Intensity Scale

C. 0-10 Numeric Pain Scale

D. Faces Pain-Rating Scale

E. FLACC (Face, Legs, Activity, Cry, Consolability) Behavioral Pain Assessment Scale

F. Oucher Pain Scale

Correct Answer: E. FLACC (Face, Legs, Activity, Cry, Consolability) Behavioral Pain Assessment Scale
The FLACC Behavioral Pain Assessment Scale is a tool specifically designed for assessing pain in infants and young children who are unable to communicate their pain verbally. It evaluates five categories: Face, Legs, Activity, Cry, and Consolability, each scored from 0 to 2, providing a comprehensive and objective measure of pain based on observable behaviors. This tool is particularly suited for the clinical scenario described.

- **Option A:** The McGill-Melzack Pain Questionnaire is a comprehensive tool that requires verbal communication and abstract thinking abilities to describe pain in various dimensions. It is unsuitable for a young, non-verbal child.
- **Option B:** The Simple Description Pain Intensity Scale, while less complex than the McGill questionnaire, still relies on the child's ability to verbally describe pain, which is not feasible in this clinical scenario.
- **Option C:** The 0-10 Numeric Pain Scale requires the child to understand and quantify their pain on a scale, a task that is developmentally inappropriate for a 3-year-old child.
- **Option D:** The Faces Pain-Rating Scale uses facial expressions to depict varying levels of pain intensity. Although more child-friendly, it still necessitates a degree of abstract reasoning and the ability to match one's own pain with facial expressions, which might be challenging for a non-verbal 3-year-old.
- **Option F:** The Oucher Pain Scale uses photographs of children's faces showing different levels of distress and pain, combined with a numerical scale. While this is more suitable for children who can point to indicate their pain level, it might still be challenging for a non-verbal 3-year-old to use effectively compared to the FLACC Scale.

7. Mrs. Jordan is an elderly client diagnosed with Alzheimer's disease. She becomes agitated and combative when a nurse approaches to help with morning care. The most appropriate nursing intervention in this situation would be to:

A. Tell the client firmly that it is time to get dressed.

B. Obtain assistance to restrain the client for safety.

C. Remain calm and talk quietly to the client.

D. Call the doctor and request an order for sedation.

Correct Answer: C. Remain calm and talk quietly to the client.

Maintaining a calm approach when intervening with an agitated client is extremely important. Use a rather low voice and speak slowly to patients to increase the possibility of understanding. Divert attention of the client when agitated or behaving dangerously like getting out of bed by climbing the fence bed to promote safety and prevent risk of injury.

- **Option A:** Telling the client firmly that it is time to get dressed may increase his agitation, especially if the nurse touches him. Avoid or terminate emotionally charged situations or conversations. Avoid anger and expectation of the patient to remember or follow instructions. Do not expect more than the patient is capable of doing. Catastrophic emotional responses are prompted by task failure when the patient feels expected to perform beyond ability and becomes frustrated and angry. Responding calmly to the patient validates feelings and causes less stress.
- **Option B:** Restraints are a last resort to ensure client safety and are inappropriate in this situation. Assess the patient for reversible or irreversible dementia, causes, ability to interpret environment, intellectual thought processes, memory loss, disturbances with orientation, behavior, and socialization. Determines type and extent of dementia to establish a plan of care to enhance cognition and emotional functioning at optimal levels.
- **Option D:** Sedation should be avoided, if possible, because it will interfere with CNS functioning and may contribute to the client's confusion. Maintain consistent scheduling with allowances for patient's specific needs, and avoid frustrating situations and overstimulation. Prevents patient agitation, erratic behaviors, and combative reactions. Scheduling may need revision to show respect for the patient's sense of worth and to facilitate completion of tasks.

8. Which of the following findings meets the criteria of a reassuring FHR pattern?

A. FHR does not change as a result of fetal activity.

B. Average baseline rate ranges between 100 – 140 BPM.

C. Mild late deceleration patterns occur with some contractions.

D. Variability averages between 6 – 10 BPM.

Correct Answer: D. Variability averages between 6 – 10 BPM.

Variability indicates a well-oxygenated fetus with a functioning autonomic nervous system. The FHR is under constant variation from the baseline. This variability reflects a healthy nervous system, chemoreceptors, baroreceptors and cardiac responsiveness. Prematurity decreases variability; therefore, there is little rate fluctuation before 28 weeks. Variability should be normal after 32 weeks.

- **Option A:** FHR should accelerate with fetal movement. The FHR is controlled by the autonomic nervous system. The inhibitory influence on the heart rate is conveyed by the vagus nerve, whereas excitatory influence is conveyed by the sympathetic nervous system. Progressive vagal dominance occurs as the fetus approaches term and, after birth, results in a gradual decrease in the baseline FHR. Stimulation of the peripheral nerves of the fetus by its own activity (such as movement) or by uterine contractions causes acceleration of the FHR.
- **Option B:** Baseline range for the FHR is 120 to 160 beats per minute. The baseline rate is interpreted as changed if the alteration persists for more than 15 minutes. Prematurity, maternal anxiety, and maternal fever may increase the baseline rate, while fetal maturity decreases the baseline rate.

- **Option C:** Late deceleration patterns are never reassuring, though early and mild variable decelerations are expected, reassuring findings. Late decelerations are associated with uteroplacental insufficiency and are provoked by uterine contractions. Any decrease in uterine blood flow or placental dysfunction can cause late decelerations. Maternal hypotension and uterine hyperstimulation may decrease uterine blood flow. Postdate gestation, preeclampsia, chronic hypertension, and diabetes mellitus are among the causes of placental dysfunction. Other maternal conditions such as acidosis and hypovolemia associated with diabetic ketoacidosis may lead to a decrease in uterine blood flow, late decelerations, and decreased baseline variability.

9. Which of the following classes of medications maximizes cardiac performance in clients with heart failure by increasing ventricular contractility?

A. Beta-adrenergic blockers

B. Calcium channel blockers

C. Diuretics

D. Inotropic agents

Correct Answer: D. Inotropic agents

Inotropic agents are administered to increase the force of the heart's contractions, thereby increasing ventricular contractility and ultimately increasing cardiac output.

- **Option A:** Beta blockers work by blocking the effects of the hormone epinephrine, also known as adrenaline. They cause the heart to beat more slowly and with less force, which lowers blood pressure.
- **Option B:** Calcium channel blockers decrease the heart rate and ultimately decrease the workload of the heart.
- **Option C:** Diuretics are administered to decrease the overall vascular volume, also decreasing the workload of the heart.

10. An 8.5 lb, 6 oz infant is delivered to a diabetic mother. Which nursing intervention would be implemented when the neonate becomes jittery and lethargic?

A. Administer insulin.

B. Administer oxygen.

C. Feed the infant glucose water (10%).

D. Place the infant in a warmer.

Correct Answer: C. Feed the infant glucose water (10%)

After birth, the infant of a diabetic mother is often hypoglycemic. Treatment will depend on the baby's gestational age and overall health. Treatment includes giving the baby a fast-acting source of glucose. This may be as simple as a glucose and water mixture or formula as an early feeding. Or the baby may need glucose given through an IV. The baby's blood glucose levels are checked after treatment to see if the hypoglycemia occurs again.

- **Option A:** Second-line therapies for the treatment of persistent hypoglycemia include the use of corticosteroids or glucagon, not insulin. Glucagon is a hormone that stimulates endogenous glucose production via glycogenolysis and gluconeogenesis; thus its effectiveness depends on the infant having adequate glycogen stores. It is most useful in term infants and infants of diabetic mothers. Glucagon dosing is as a 30 mcg/kg bolus or 300 mcg/kg per minute continuous infusion.
- **Option B:** Oxygen is not administered to hypoglycemic neonates. Early initiation of breastfeeding is crucial for all infants. For asymptomatic infants at risk of neonatal hypoglycemia, the AAP recommends initiating feeds within the first hour of life and performing initial glucose screening 30 minutes after the first feed. The AAP recommends goal blood glucose levels equal to or greater than 45 mg/dL prior to routine feedings, and intervention for blood glucose <40 mg/dL in the first 4 hours of life and <45 mg/dL at 4 to 24 hours of life.
- **Option D:** Placing the infant in a warmer does not manage the hypoglycemia. In infants of diabetic mothers, lower glucose infusions rates of 3 to 5 mg/kg/minute may be used to minimize pancreatic stimulation and endogenous insulin secretion. Infants requiring higher rates of intravenous dextrose (>12 to 16 mg/kg/minute) or for more than 5 days are more likely to have a persistent cause of hypoglycemia.

11. When planning care for a client who has ingested phencyclidine (PCP), nurse Wayne is aware that the following is the highest priority?

A. Client's physical needs

B. Client's safety needs

C. Client's psychosocial needs

D. Client's medical needs

Correct Answer: B. Client's safety needs

The highest priority for a client who has ingested PCP is meeting safety needs of the client as well as the staff. Drug effects are unpredictable and prolonged, and the client may lose control easily. Phencyclidine (PCP) is a dissociative anesthetic that is a commonly used recreational drug. PCP is a crystalline powder that can be ingested orally, injected intravenously, inhaled, or smoked. PCP is available as a powder, crystal, liquid, and tablet. It produces both stimulation and depression of the CNS. PCP is a non-competitive antagonist to the NMDA receptor, which causes analgesia, anesthesia, cognitive defects, and psychosis.

- **Option A:** Depending on the dose and route of administration, PCP can have a wide range of central nervous system (CNS) manifestations. Emergency department providers should become familiar with how to manage patients with PCP toxicity since rhabdomyolysis, hypoglycemia, seizures, hypertensive crisis, coma, and trauma are several of the complications that can arise with PCP use
- **Option C:** PCP blocks the uptake of dopamine and norepinephrine, leading to sympathomimetic effects such as hypertension, tachycardia, bronchodilation, and agitation. PCP can also cause sedation, muscarinic, and nicotinic signs by binding to acetylcholine receptors and GABA receptors. Sigma receptor stimulation by PCP causes lethargy and coma.
- **Option D:** Most patients survive PCP intoxication with supportive care. Airway, breathing, circulation, and hemodynamic monitoring are essential to the care of patients with PCP toxicity. Intubation with ventilatory support may be required for airway protection. Gastrointestinal decontamination is generally unnecessary in PCP ingestions; however, activated charcoal may be beneficial with a massive ingestion of PCP or a dangerous coingestion. Activated charcoal therapy

should only be started within one hour from the time of ingestion. The activated charcoal dose is 1 g/kg, with a maximum dose of 50 g.

12. A mountaineer attempts an assault on a high mountain in the Andes and reaches an altitude of 5000 meters (16,400 ft) above sea level. What will happen to his arterial PCO2 and pH?

A. Both will be lower than normal.

B. The pH will rise and PCO2 will fall.

C. Both will be higher than normal due to physical exertion.

D. The pH will fall and PCO2 will rise

Correct Answer: B. The pH will rise and PCO2 will fall.

The mountaineer will suffer from a respiratory alkalosis. The decline in the PO2 with altitude will stimulate breathing to offset the hypoxia. Carbon dioxide is driven from the blood faster than it is produced in the tissues so PCO2 falls and pH rises.

13. The nurse reviews the activity schedule for the day and plans which activity for the manic client?

A. Brown-bag luncheon and book review

B. Tetherball

C. Paint-by-number activity

D. Deep breathing and progressive relaxation group

Correct Answer: B. Tetherball

A person who is experiencing mania is overactive and full of energy, lacks concentration, and has poor impulse control. The client needs an activity that will allow the use of excess energy yet not endanger others during the process. Tetherball is an exercise that uses the large muscle groups of the body and is a great way to expand the increased energy that the client is experiencing.

- **Option A:** Decreasing environmental stimulation may assist the client to relax; the nurse must provide a quiet environment without noise, television, and other distractions; finger foods or things the client can eat while moving around are the best options to improve nutrition.
- **Option C:** The nurse can direct their need for movement into socially acceptable, large motor activities such as arranging chairs for a community meeting or walking. Clients with mania have short attention spans, so the nurse uses simple, clear sentences when communicating; they may not be able to handle a lot of information at once, so the nurse breaks information into many small segments.
- **Option D:** Deep breathing and progressive relaxation group are a relatively sedated activity that requires concentration, a quality that is lacking in the manic state. Such activities lead to increased frustration and anxiety for the client. A primary nursing responsibility is to provide a safe environment for the client and others; for clients who feel out of control, the nurse must establish external controls emphatically and nonjudgmentally.

14. A client went to a health care facility with a complaint of difficulty opening the eyelid because of pain. The physician diagnosed the client with keratitis and is prescribed with an eye lubricant. Which of the following medicines should the nurse expect to administer?

A. hydroxypropyl methylcellulose (Lacril).

B. pilocarpine hydrochloride (Isopto Carpine).

C. timolol maleate (Timoptic).

D. apraclonidine (Lopidine).

Correct Answer: A. Hydroxypropyl methylcellulose (Lacril).

Hydroxypropyl methylcellulose (Lacril) is an eye lubricant.

- **Option B:** Pilocarpine hydrochloride (Isopto Carpine) is a miotic.
- **Option C:** Timolol maleate (Timoptic) is a ?-adrenergic blocking eye medication.
- **Option D:** Apraclonidine (Iopidine) is an ?-adrenergic agonist.

15. Which of the following are the most commonly assessed findings in cystitis?

A. Frequency, urgency, dehydration, nausea, chills, and flank pain

B. Nocturia, frequency, urgency dysuria, hematuria, fever, and suprapubic pain

C. Dehydration, hypertension, dysuria, suprapubic pain, chills, and fever

D. High fever, chills, flank pain nausea, vomiting, dysuria, and frequency

Correct Answer: B. Manifestations of cystitis include, frequency, urgency, dysuria, hematuria nocturia, fever, and suprapubic pain.

Dehydration, hypertension, and chills are not typically associated with cystitis. High fever chills, flank pain, nausea, vomiting, dysuria, and frequency are associated with pyelonephritis.

- **Option A:** Cystitis usually develops due to the colonization of the periurethral mucosa by bacteria from the fecal or vaginal flora and ascension of such pathogens to the urinary bladder. Uropathogens may have microbial virulence factors that allow them to escape host defenses and invade host tissues in the urinary tract.
- **Option C:** Acute cystitis often presents with urinary symptoms which include dysuria, urinary frequency urgency, suprapubic pain or tenderness, and occasionally hematuria. Based on a systematic review examining history and examination findings of women with uncomplicated UTI, the combination of dysuria and urinary frequency in the absence of vaginal discharge or irritation is highly predictive of uncomplicated cystitis.
- **Option D:** Cystitis may be differentiated from pyelonephritis by the absence of systemic findings such as fever, chills, or sepsis. Findings such as flank pain, costovertebral angle tenderness, nausea, and vomiting are also more indicative of upper UTI or pyelonephritis.

16. A female patient is diagnosed with deep-vein thrombosis. Which nursing diagnosis should receive highest priority at this time?

A. Impaired gas exchanges related to increased blood flow.

B. Fluid volume excess related to peripheral vascular disease.

C. Risk for injury related to edema.

D. Altered peripheral tissue perfusion related to venous congestion.

Correct Answer: D. Altered peripheral tissue perfusion related to venous congestion.

Altered peripheral tissue perfusion related to venous congestion" takes highest priority because venous inflammation and clot formation impede blood flow in a patient with deep-vein thrombosis. A deep-vein thrombosis (DVT) is a blood clot that forms within the deep veins, usually of the leg, but can occur in the veins of the arms and the mesenteric and cerebral veins. Deep-vein thrombosis is a common and important disease. It is part of the venous thromboembolism disorders which represent the third most common cause of death from cardiovascular disease after heart attacks and stroke.

- **Option A:** Option A is incorrect because impaired gas exchange is related to decreased, not increased, blood flow. Depending on the relative balance between the coagulation and thrombolytic pathways, thrombus propagation occurs. DVT is commonest in the lower limb below the knee and starts at low-flow sites, such as the soleal sinuses, behind venous valve pockets.
- **Option B:** Option B is inappropriate because no evidence suggests that this patient has a fluid volume excess. Nurses need to educate the patients on the importance of ambulation, being compliant with compression stockings, and taking the prescribed anticoagulation medications.
- **Option C:** Option C may be warranted but is secondary to altered tissue perfusion. Thrombosis is a protective mechanism that prevents the loss of blood and seals off damaged blood vessels. Fibrinolysis counteracts or stabilizes the thrombosis. The triggers of venous thrombosis are frequently multifactorial, with the different parts of the triad of Virchow contributing in varying degrees in each patient, but all result in early thrombus interaction with the endothelium. This then stimulates local cytokine production and causes leukocyte adhesion to the endothelium, both of which promote venous thrombosis.

17. Which of the following terms is used to describe the amount of stretch on the myocardium at the end of diastole?

A. Afterload

B. Cardiac index

C. Cardiac output

D. Preload

Correct Answer: D. Preload

Preload is the amount of stretch of the cardiac muscle fibers at the end of diastole. The volume of blood in the ventricle at the end of the diastole determines the preload. Also termed left ventricular end-diastolic pressure (LVEDP), preload is a measure of the degree of the ventricular stretch when the heart is at the end of diastole. Preload, in addition to afterload and contractility, is one of the three main factors that directly influence stroke volume (SV), the amount of blood pumped out of the heart in one cardiac cycle.

- **Option A:** Afterload is the force against which the ventricle must expel blood. Afterload refers to the resistance normally maintained by the aortic and pulmonic valves, the condition and tone of the aorta, and the resistance offered by the systemic and pulmonary arterioles. The afterload of any

contracting muscle is defined as the total force that opposes sarcomere shortening minus the stretching force that existed before contraction. Applying this definition to the heart, afterload can be most easily described as the “load” against which the heart ejects blood.

- **Option B:** Cardiac index is the individualized measurement of cardiac output, based on the client’s body surface area. One measure of heart function is the cardiac index. The cardiac index relies on another important parameter, cardiac output, and turns cardiac output into a normalized value that accounts for the body size of the patient. The function of the cardiac index is to create a normalized value for the cardiac function, which effectively corrects for the patient’s body size.
- **Option C:** Cardiac output is the amount of blood expelled from the heart per minute. Cardiac output (CO) is the amount of blood pumped by the heart minute and is the mechanism whereby blood flows around the body, especially providing blood flow to the brain and other vital organs. The body’s demand for oxygen changes, such as during exercise, and the cardiac output is altered by modulating both heart rate (HR) and stroke volume (SV).

18. Which of the following would be inappropriate to assess in a mother who’s breastfeeding?

A. The attachment of the baby to the breast.

B. The mother’s comfort level with positioning the baby.

C. Audible swallowing.

D. The baby’s lips smacking.

Correct Answer: D. The baby’s lips smacking

Assessing the attachment process for breast-feeding should include all of the answers except the smacking of lips. A baby who’s smacking his lips isn’t well attached and can injure the mother’s nipples.

- **Option A:** A good attachment shows much of the areola and the tissues underneath it, including the larger ducts, are in the baby’s mouth; the breast is stretched out to form a long “teat”, but the nipple only forms about one-third of the “teat”; the baby’s tongue is forward over the lower gums, beneath the milk ducts; and the baby is suckling from the breast, not from the nipple.
- **Option B:** To be well attached at the breast, a baby and his or her mother need to be appropriately positioned. The mother can be sitting or lying down, or standing, if she wishes. However, she needs to be relaxed and comfortable, and without strain, particularly of her back. The baby can breastfeed in several different positions in relation to the mother: across her chest and abdomen, under her arm, or alongside her body.
- **Option C:** When the milk ejection reflex is triggered, the baby may swallow after every suck in order to handle the rapid flow of milk. You should hear suck, swallow, pause, suck, swallow, pause. Audible swallowing after every couple of sucks should continue for about ten minutes.

19. Sonny, an African American noticed an appearance of a dark spot under a toenail. This is a typical presentation of what kind of melanoma?

A. Lentigo maligna

B. Nodular melanoma

C. Amelanotic melanoma

D. Acral lentiginous melanoma

Correct Answer: D. Acral lentiginous melanoma

Acral lentiginous melanoma, the most common form of melanoma seen in people of color, usually appears in hard-to-spot places such as under the fingernails or toenails, on the palms of the hands, or soles of the feet.

- **Option A:** Lentino maligna typically occurs on sun-damaged skin on the face, ears, arms, or upper torso.
- **Option B:** Nodular melanoma will have a tumor that grows rapidly deeper into the skin than any other type and is most frequently found on the torso, legs, and arms, as well as the scalp in older men.
- **Option C:** Amelanotic melanoma is a type of melanoma where the cancer cells do not produce melanin or pigment. It usually appears as a pink or red spot on the skin.

20. Which of the following assessment data indicated nuchal rigidity?

A. Positive Kernig's sign

B. Negative Brudzinski's sign

C. Positive homan's sign

D. Negative Kernig's sign

Correct Answer: A. Positive Kernig's sign

A positive Kernig's sign indicated nuchal rigidity, caused by an irritative lesion of the subarachnoid space. Brudzinski's sign is also indicative of the condition. To elicit the Kernig sign, clinicians typically perform the exam with the patient lying supine with the thighs flexed on the abdomen, and the knees flexed. The examiner then passively extends the legs. In the presence of meningeal inflammation, the patient will resist leg extension or describe pain in the lower back or posterior thighs, which indicates a positive sign.

- **Option B:** 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. Upon passive neck flexion, a positive test results when the patient flexes his knees and hips.
- **Option C:** Homan's sign test also called dorsiflexion sign test is a physical examination procedure that is used to test for deep vein thrombosis (DVT). A positive Homan's sign in the presence of other clinical signs may be a quick indicator of DVT. Clinical evaluation alone cannot be relied on for patient management, but when carefully performed, it remains useful in determining the need for additional testing (like D-dimer test, ultrasonography, multidetector helical computed axial tomography (CT), and pulmonary angiography)
- **Option D:** When the meninges in the spinal cord and spinal nerves are inflamed, patients will resist stretching the cord and the nerves to prevent pain resulting from this inflammation. These clinical maneuvers appear to provoke this stretching.; this is why contractures occur when performed, resulting in a positive test.

21. The nurse is caring for a male client with cirrhosis. Which assessment findings indicate that the client has deficient vitamin K absorption caused by this hepatic disease?

A. Dyspnea and fatigue

B. Ascites and orthopnea

C. Purpura and petechiae

D. Gynecomastia and testicular atrophy

Correct Answer: C. Purpura and petechiae

A hepatic disorder, such as cirrhosis, may disrupt the liver's normal use of vitamin K to produce prothrombin (a clotting factor). Consequently, the nurse should monitor the client for signs of bleeding, including purpura and petechiae. Petechiae and purpura result from a wide variety of underlying disorders and may occur at any age. Petechiae are small (1–3 mm), red, non-blanching macular lesions caused by intradermal capillary bleeding. Purpura are larger, typically raised lesions resulting from bleeding within the skin

- **Option A:** Dyspnea and fatigue suggest anemia. When patients with severe anemia develop a high output state, cardiac failure can ensue causing them to have shortness of breath from cardiac causes as well. Diseases in other organs, such as the kidneys and the liver, may cause dyspnea by a combination of the interactions discussed.
- **Option B:** Ascites and orthopnea are unrelated to vitamin K absorption. Patients with malignant ascites can have symptoms related to malignancy, which may include weight loss. On the other hand, patients with ascites due to heart failure may report dyspnea, orthopnea, and peripheral edema, and those with chylous ascites report diarrhea, steatorrhea, malnutrition, edema, nausea, enlarged lymph nodes, early satiety, fevers, and night sweats.
- **Option D:** Gynecomastia and testicular atrophy result from decreased estrogen metabolism by the diseased liver. Gynecomastia is most commonly caused by an imbalance between the hormones estrogen and testosterone. Estrogen controls female traits, including breast growth. Testosterone controls male traits, such as muscle mass and body hair.

22. The nurse is caring for a client with a burn wound on the left knee and an autograft and skin grafting was performed. Which of the following activities will be prescribed for the client post-op?

A. Elevation and immobilization of the affected leg.

B. Placing the affected leg in a dependent position.

C. Dangling of legs.

D. Bathroom privileges.

Correct Answer: A. Elevation and immobilization of the affected leg.

Autograft placed on the lower extremity requires elevation and immobilization for at least 3-7days. This period of immobilization allows the autograft time to adhere to the wound bed. Clinically, skin grafts are secured into place and often bolstered until postoperative day 5 to 7 to allow the skin graft to go through the above steps, ensuring the best skin graft take.

- **Option B:** Do not place the affected leg in a dependent position. Any buildup of fluid between the split-thickness skin graft and wound bed will jeopardize skin graft take, including seroma, hematoma, and infection. Shear or traction injury also disrupts skin graft healing.
- **Option C:** Dangling of legs puts the affected site into a dependent position, which can cause a build-up of fluid that jeopardizes the skin graft. The graft can have incomplete (less than 100%) take or complete nontake.
- **Option D:** Split-thickness skin grafts typically become adherent to the recipient wound bed 5 to 7 days following skin graft placement. The dressings placed intraoperatively are kept in place until 5 to 7 days postoperatively to minimize shear and traction to the healing skin graft.

23. During a prenatal check-up, a 27-year-old primigravida patient expresses concern regarding her recent fatigue and shortness of breath. The healthcare provider decides to check her hemoglobin levels to ensure adequate oxygen transport to both the mother and the fetus. She educates the patient about the structure of hemoglobin and its paramount role in oxygen transportation. In this context, which of the following statements accurately describes a key component of hemoglobin, fundamental to its function in oxygen transport?

A. contains 1 iron atom.

B. contain 2 globin protein molecules.

C. consists of 4 protein chains and 4 heme groups.

D. can carry 1 oxygen molecule only.

E. is bluish in color when bound to oxygen

Correct Answer: C. consists of 4 protein chains and 4 heme groups.
Each hemoglobin molecule consists of 4 globin protein chains, and each of these chains is associated with a heme group. The iron atom present in each heme group allows for the binding of an oxygen molecule, thus playing a crucial role in oxygen transport.

- **Option A:** Each hemoglobin molecule indeed contains iron atoms, but specifically, it has 4 iron atoms, each within a heme group, which bind to oxygen molecules. Therefore, this option is inaccurate.
- **Option B:** The hemoglobin molecule is composed of 4 globin protein molecules (not 2), forming a tetramer. Each globin molecule is associated with a heme group. Therefore, this option is incorrect.
- **Option D:** This statement is incorrect as each hemoglobin molecule can carry up to 4 oxygen molecules, one for each iron atom present in the heme groups.
- **Option E:** Hemoglobin appears red, not bluish, when bound to oxygen. The color change in blood is perceptible when oxygenated (bright red) and deoxygenated (dark red to bluish-red), but it doesn't turn bluish. Therefore, this statement is incorrect.

24. Situation: A 17-year-old gymnast is admitted to the hospital due to weight loss and dehydration secondary to starvation. Which of the following nursing diagnoses will be given priority for the client?

A. Altered self-image

B. Fluid volume deficit

C. Altered nutrition less than body requirements

D. Altered family process

Correct Answer: B. Fluid volume deficit

Fluid volume deficit is the priority over altered nutrition since the situation indicates that the client is dehydrated. Supervise the patient during mealtimes and for a specified period after meals (usually one hour) to ensure compliance with the dietary treatment program. For a hospitalized patient with anorexia, food is considered a medication. Liquids are more acceptable than solid. Fluids eliminate the need to choose between foods – something the patient with anorexia may find difficult.

- **Option A:** 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). Suggest disposing of “thin” clothes as weight gain occurs. Recommend consultation with an image consultant; provides an incentive to at least maintain and not lose weight. Removes visual reminder of thinner self. Positive image enhances a sense of self-esteem.
- **Option C:** Provide smaller meals and supplemental snacks, as appropriate. Gastric dilation may occur if refeeding is too rapid following a period of starvation dieting. Note: the patient may feel bloated for 3–6 weeks while the body adjusts to food intake. Make a selective menu available, and allow the patient to control choices as much as possible. Patient who gains confidence in herself and feels in control of the environment is more likely to eat preferred foods. Be alert to choices of low-calorie foods and beverages; hoarding food; disposing of food in various places, such as pockets or wastebaskets. The patient will try to avoid taking in what is viewed as excessive calories and may go to great lengths to avoid eating.
- **Option D:** Identify patterns of interaction. Encourage each family member to speak for self. Do not allow two members to discuss a third without that member’s participation. Helpful information for planning interventions. The enmeshed, over-involved family members often speak for each other and need to learn to be responsible for their own words and actions. Encourage and allow expression of feelings (crying, anger) by individuals. Often these families have not allowed free expression of feelings and need help and permission to learn and accept this.

25. Magnesium performs all of the following functions except:

A. Contributing to vasoconstriction.

B. Assisting in cardiac muscle contraction.

C. Facilitating sodium transport.

D. Assisting in protein metabolism.

Correct Answer: A. Contributing to vasoconstriction.

Magnesium contributes to vasodilation, not vasoconstriction. Magnesium plays a vital role in over 300 reactions involving metabolism. It is involved with hormone receptor binding, muscle contraction, neural activity, neurotransmitter release, vasomotor tone, and cardiac excitability.

- **Option B:** Magnesium acts as a natural calcium channel blocker, and it is a cofactor of the Na-K-ATP pump. Magnesium helps control atrioventricular node conduction. Therefore, hypomagnesemia can cause myocardial excitability resulting in arrhythmias such as ventricular tachycardia and torsades de pointes.

- **Option C:** It is necessary for the active transport of potassium and calcium across the cell membrane. ATP is dependent on magnesium for proper functioning. Roughly 50% of magnesium is located within the bone, 25% is within the muscle, and the remainder is in soft tissue, serum, and red blood cells (RBC).
- **Option D:** The intestine, bone, and kidney maintain magnesium homeostasis. Similar to calcium, magnesium is absorbed via the intestine, stored in the bone, excreted via the kidneys. Absorption of magnesium is inversely proportional to the concentration within the body; if there are low magnesium levels within the body, more magnesium will be absorbed.

26. Which of the following vitamins may not be absorbed properly when giving bile acid sequestrants?

A. Vitamin B

B. Vitamin C

C. Vitamin B12

D. Vitamin K

Correct Answer: D. Vitamin K

Vitamin K absorption may be reduced when giving these drugs. The only fat-soluble vitamin here is vitamin K, which is synthesized in the liver. Bile acid sequestrants may prevent absorption of folic acid and the fat-soluble vitamins A, D, E, and K. Other medications and vitamin supplements should be taken one hour before or four to six hours after bile acid sequestrants for optimal absorption.

- **Option A:** B vitamins play a vital role in maintaining good health and well-being. As the building blocks of a healthy body, B vitamins have a direct impact on your energy levels, brain function, and cell metabolism. Vitamin B complex helps prevent infections and helps support or promote cell health.
- **Option B:** Vitamin C is a water-soluble vitamin, antioxidant, and essential cofactor for collagen biosynthesis, carnitine and catecholamine metabolism, and dietary iron absorption. Humans are unable to synthesize vitamin C, so they can only obtain it through dietary intake of fruits and vegetables. Citrus fruits, berries, tomatoes, potatoes, and green leafy vegetables are excellent sources of vitamin C.
- **Option C:** Vitamin B12 (Cobalamin) is a water-soluble vitamin that is derived from animal products such as red meat, dairy, and eggs. Intrinsic factor is a glycoprotein that is produced by parietal cells in the stomach and necessary for the absorption of B12 in the terminal ileum. Once absorbed, B12 is used as a cofactor for enzymes that are involved in the synthesis of DNA, fatty acids, and myelin.

27. During surgery, there is an increased potential for arrhythmias when catecholamines are given with:

A. halothane (Fluothane)

B. digoxin (Lanoxin)

C. bupivacaine (Marcaine)

D. lidocaine (Xylocaine)

Correct Answer: A. halothane (Fluothane)

Arrhythmias are a result of an interaction that can occur with halothane and catecholamines. Halothane is a clear, heavy, and colorless liquid with a sweet and non-irritating odor. Halothane's structure is that of an alkane. It has primarily been used clinically as an inhalational anesthetic. Cardiorespiratory instability (i.e., hypotension, bradycardia), sensitizing the myocardium to catecholamine-induced arrhythmias, and mild liver dysfunction are relatively common side effects of halothane. Arrhythmias are especially common in neonates and children after the administration of halothane, particularly bradyarrhythmias. Other choices do not interact with halothane to cause arrhythmias.

- **Option B:** Digoxin toxicity is clinically relevant as it can lead to fatal cardiac arrhythmias. The estimated frequency is at about 0.8 to 4% of patients on steady digoxin therapy. The rate of toxicity increases as serum digoxin concentration reaches over 2.0 ng/ml. However, toxicity can also occur at lower levels, especially in the setting of other risk factors such as low body weight, advanced age, decreased renal function, and hypokalemia.
- **Option C:** Rarely, patients can exhibit toxicity to bupivacaine in doses much lower than the suggested upper limits of dosing. This toxicity appears to be due to a rare condition related to l-carnitine deficiency. Patients affected may exhibit cardiac toxicity at doses as low as 1.1 mg kg of bupivacaine injected cutaneously. Case reports exist describing these cases of low dose toxicity in patients later discovered to be deficient in l-carnitine.
- **Option D:** Signs and symptoms of mild toxicity become apparent at plasma levels greater than 5 mcg/mL, beginning with slurred speech, tinnitus, circumoral paresthesia, and feeling faint. Above 10 mcg/mL, the patient may experience seizures or loss of consciousness. The myocardium and central nervous system are further depressed at 15 mcg/mL, progressing to cardiac arrhythmias, respiratory arrest, and cardiac arrest above 20 mcg/mL.

28. The client arrives in the emergency room with a penetrating eye injury from wood chips while cutting wood. The nurse assesses the eye and notes a piece of wood protruding from the eye. What is the initial nursing action?

A. Remove the piece of wood using a sterile eye clamp.

B. Apply an eye patch.

C. Perform visual acuity tests.

D. Irrigate the eye with sterile saline.

Correct Answer: C. Perform visual acuity tests.

If the laceration is the result of a penetrating injury, an object may be noted protruding from the eye. The only option that will prevent further disruption is to assess visual acuity. Up to 40% of penetrating eye injuries are complicated by the presence of an intraocular foreign body (IOFB). It may be toxic (iron, copper, vegetable matter) or inert (glass or plastic). Vision loss may result from the mechanical injury or from post-traumatic complications such as endophthalmitis, retinal detachment, metal toxicity and sympathetic ophthalmia.

- **Option A:** This object must never be removed except by the ophthalmologist because it may be holding ocular structures in place. Do not attempt to pull out any foreign material that may be sticking out of the eye. Avoid any pressure on the globe; for example, do not press on the sclera.
- **Option B:** The application of an eye patch may disrupt the foreign body and cause further tearing of the sclera. Protect the eye from further damage by using an eye shield. Administer systemic analgesics. Administer prophylactic broad-spectrum systemic antibiotics.

- **Option D:** Irrigation of the eye may disrupt the foreign body and cause further tearing of the sclera. Prompt diagnosis, referral, removal of the IOFB, and surgical repair will help to preserve the visual acuity and the globe anatomy. Record the baseline best-corrected visual acuity in each eye and conduct a complete examination of both eyes and adnexae. Use Desmarres retractor to avoid undue pressure on the globe during an examination.

29. Joey stresses the importance of promoting 'esprit d corps' among the members of the unit. Which of the following remarks of the staff indicates that they understand what he pointed out?

A. "Let's work together in harmony; we need to be supportive of one another"

B. "In order that we achieve the same results; we must all follow the directives of Julius and not from other managers."

C. "We will ensure that all the resources we need are available when needed."

D. "We need to put our efforts together in order to raise the bar of excellence in the care we provide to all our patients."

Correct Answer: A. "Let's work together in harmony; we need to be supportive of one another"

Esprit de corps means managers should create and foster among their employees the morale, common spirit, sense of identification, feeling of pride, loyalty, devotion, honor, solidarity, unity, and cohesiveness with respect to their organization or organizational department.

- **Option B:** In the principle of unity of command, an employee should have only one boss and follow his command. If an employee has to follow more than one boss, there begins a conflict of interest and can create confusion.
- **Option C:** A company should maintain a well-defined work order to have a favorable work culture. A positive atmosphere in the workplace will boost more positive productivity.
- **Option D:** In the principle of unity of direction, whoever is engaged in the same activity should have a unified goal. This means all the people working in a company should have one goal and motive which will make the work easier and achieve the set goal easily.

30. Which pattern of nursing care involves the care given by a group of paraprofessional workers led by a professional nurse who takes care of patients with the same disease conditions and is located geographically near each other?

A. Case method

B. Modular nursing

C. Nursing case management

D. Team nursing

Correct Answer: B. Modular nursing

Modular nursing is a variant of team nursing. The difference lies in the fact that the members in modular nursing are paraprofessional workers. Modular Nursing is a modification of team nursing and focuses on the patient's geographic location for staff assignments; the unit is divided into groups referred to as modules – also called districts or pods.

- **Option A:** In case method, the nurse cares for one patient whom the nurse cares for exclusively. The Case Method evolved into what is now called private duty nursing. It was the first type of nursing care delivery system.
- **Option C:** Nursing case management provides a continuum of health care services for defined groups of patients. Its literature is multidisciplinary, emphasizing clinical specialties, case management methodology, and the health care system. Case management is a care delivery model designed to coordinate and manage patient care across the continuum of health care systems.
- **Option D:** The goal of team nursing is for a team to work democratically. In the ideal team, an RN is assigned as a Team Leader for a group of patients. The Team Leader has a core of staff reporting to her, and together they work to disseminate the care activities.

31. A child has third-degree burns of the hands, face, and chest. Which nursing diagnosis takes priority?

A. Impaired urinary elimination related to fluid loss

B. Ineffective airway clearance related to edema

C. Disturbed body image related to physical appearance

D. Risk for infection related to epidermal disruption

Correct Answer: B. Ineffective airway clearance related to edema

Initially, when a preschool client is admitted to the hospital for burns, the primary focus is on assessing and managing an effective airway. 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. Exposure to materials burn can cause inhalation injury.

- **Option A:** Acute renal failure is one of the major complications of burns and it is accompanied by a high mortality rate. Most renal failures occur either immediately after the injury or at a later period when sepsis develops. Late-onset renal failure is usually the consequence of sepsis and is often associated with other organ failure.
- **Option C:** Burn injuries are among the most serious causes of radical changes in body image. The subject of body image and self-image is essential in rehabilitation, and the nurse must be aware of the issues related to these concepts and take them seriously into account in drafting out the nursing program.
- **Option D:** Invasive infection of burn wounds is a surgical emergency because of the high concentrations of bacteria (>105 CFU) in the wound and surrounding area, together with new areas of necrosis in unburned tissues. This situation often is accompanied by signs of sepsis and changes in the burn wound such as black, blue, or brown discoloration of the eschar.

32. Before administering ephedrine, Nurse Tony assesses the patient's history. Because of ephedrine's central nervous system (CNS) effects, it is not recommended for:

A. Patients with an acute asthma attack.

B. Patients with narcolepsy.

C. Patients under age

D. Elderly patients.

Correct Answer: D. Elderly patients

Ephedrine is not recommended for elderly patients, who are particularly susceptible to CNS reactions (such as confusion and anxiety) and to cardiovascular reactions (such as increased systolic blood pressure, coldness in the extremities, and anginal pain). Ephedrine is also arrhythmogenic, and caution should be used during administration to patients who are predisposed to arrhythmias or taking other arrhythmogenic medications, particularly digitalis.

- **Option A:** Ephedrine is used for its bronchodilator effects with acute and chronic asthma. Oral formulations of ephedrine have been used historically to treat asthma via pulmonary vasoconstriction and reduction in airway edema along with beta-induced bronchodilation, but it is rarely used for this purpose in modern medicine due to unwanted cardiac effects and availability of more selective beta-agonists such as albuterol.
- **Option B:** Ephedrine is used occasionally for its CNS stimulant actions for narcolepsy. Ephedrine acts as both a direct and indirect sympathomimetic. It binds directly to both alpha and beta receptors; however, its primary mode of action is achieved indirectly, by inhibiting neuronal norepinephrine reuptake and by displacing more norepinephrine from storage vesicles. This action allows norepinephrine to be present in the synapse longer to bind postsynaptic alpha and beta receptors.
- **Option C:** It can be administered to children age 2 and older. The FDA has not formally established safety and effectiveness in pediatric populations. Additionally, ephedrine is distributed by the manufacturer in 50mg/mL vials and requires dilution before intravenous use.

33. To provide relief from the cytarabine syndrome, which drug is given?

A. Dexamethasone

B. Allopurinol

C. Alka Seltzer

D. Aspirin

Correct Answer: A. Dexamethasone

- **Option A:** Steroids such as dexamethasone may be prescribed to promote relief from cytarabine syndrome.
- **Option B:** Allopurinol is given for hyperuricemia that will result from taking some chemotherapeutic agent.
- **Options C and D:** Since cytarabine causes platelets to decrease, aspirin and aspirin-containing products are not advised unless prescribed by the physician.

34. A nurse is giving discharge instructions to a patient who is taking Synthroid (levothyroxine). The nurse instructs the client to notify the physician if which of the following occurs?

A. Cold intolerance

B. Tremors

C. Coarse, dry hair

D. Muscle cramps

Correct Answer: B. Tremors

Excessive doses of levothyroxine can produce signs and symptoms of hyperthyroidism which includes heat tolerance, tremors, nervousness, tachycardia, chest pain, hyperthermia, and insomnia.

- **Options A, C, & D:** These are signs of hypothyroidism.

35. Mrs. Johnson tells the nurse that she is very worried because her 2-year old child does not finish his meals. What should the nurse advise the mother?

A. Make the child seat with the family in the dining room until he finishes his meal

B. Provide quiet environment for the child before meals

C. Do not give snacks to the child before meals

D. Put the child on a chair and feed him

Correct Answer: Answer C. Do not give snacks to the child before meals.

If the child is hungry he/she is more likely to finish his meals. Therefore, the mother should be advised not to give snacks to the child. Set times for meals and snacks and try to stick to them. A child who skips a meal finds it reassuring to know when to expect the next one. Avoid offering snacks or pacifying hungry kids with cups of milk or juice right before a meal — this can diminish their appetite and decrease their willingness to try a new food being offered.

- **Option A:** The child is a “busy toddler.” He/she will not be able to keep still for a long time. For some kids, dinner becomes a negotiation session from the very start, and parents have been using dessert as an incentive for decades. But this doesn’t encourage healthy eating. Instead, it creates the impression that “treats” are more valuable than mealtime food.
- **Option B:** Be alert to what toddlers say through their actions. A child who is building a tower of crackers or dropping carrots on the floor may be telling you he or she is full. Pushing food on a child who’s not hungry may dull the internal cues that help kids know when they’ve eaten enough. Kids can manage their hunger when they come to expect that food will be available during certain times of the day. If a child chooses not to eat anything at all, simply offer food again at the next meal or snack time.
- **Option D:** Kids should start finger feeding around 9 months of age and try using utensils by 15-18 months. Some parents think that not letting kids feed themselves is for the best, but it takes away control that rightfully belongs to kids at this age. They need to decide whether to eat, what they will eat, and how much to eat — this is how they learn to recognize the internal cues that tell them when they’re hungry and when they’re full. Just as important, toddlers need to learn and practice the mechanics of feeding themselves.