

# Kevin's Review - 35 NCLEX Practice Questions

**1. Which of the following tests can be useful as a diagnostic and therapeutic tool in the biliary system?**

- A. Ultrasonography
- B. MRI
- C. Endoscopic retrograde cholangiopancreatography (ERCP)
- D. Computed tomography scan (CT scan)

**Correct Answer: C. Endoscopic retrograde cholangiopancreatography (ERCP)**

ERCP permits direct visualization of the pancreatic and common bile ducts. Its therapeutic value is in retrieving gallstones from the distal and common bile ducts and dilating strictures. Endoscopic retrograde cholangiopancreatography (ERCP) is a combined endoscopic and fluoroscopic procedure in which an endoscope is advanced into the second part of the duodenum, thus allowing other tools to be passed into the biliary and pancreatic ducts via the major duodenal papilla.

- **Option A:** Ultrasonography aids in the diagnosis of cholecystitis, gallstones, pancreatitis, and metastatic disease. It also identifies edema, inflammation, and fatty or fibrotic infiltrates or calcifications. A procedure that uses high-energy sound waves to look at tissues and organs inside the body. The sound waves make echoes that form pictures of the tissues and organs on a computer screen (sonogram). Ultrasonography may be used to help diagnose diseases, such as cancer.
- **Option B:** MRI detects hepatic neoplasms, cysts, abscesses, and hematomas. Magnetic resonance imaging (MRI) uses a large magnet and radio waves to look at organs and structures inside the body. Health care professionals use MRI scans to diagnose a variety of conditions, from torn ligaments to tumors. MRIs are very useful for examining the brain and spinal cord.
- **Option D:** A CT Scan can be done without a contrast medium. It can detect tumors, cysts, pseudocysts, abscesses, hematomas, and obstructions of the liver, biliary tract and pancreas. The CT scan is essentially an X-ray study, where a series of rays are rotated around a specified body part, and computer-generated cross-sectional images are produced. The advantage of these tomographic images compared to conventional X-rays is that they contain detailed information of a specified area in cross-section, eliminating the superimposition of images, which provides a tremendous advantage over plain films.

**2. A client with a very dry mouth, skin, and mucous membranes is diagnosed with dehydration. Which intervention should the nurse perform when caring for a client diagnosed with fluid volume deficit?**

- A. Assessing urinary intake and output.
- B. Obtaining the client's weight weekly at different times of the day.
- C. Monitoring arterial blood gas (ABG) results.
- D. Maintaining I.V. therapy at the keep-vein-open rate.

**Correct Answer: A. Assessing urinary intake and output.**

For the client with fluid volume deficit, assessing the client's urine output (using a urometer if necessary) is essential to ensure an output of at least 30 ml/hour. Assess color and amount of urine. Report urine output less than 30 ml/hr for 2 consecutive hours. A normal urine output is considered normal not less than 30ml/hour. Concentrated urine denotes fluid deficit.

- **Option B:** The client should be weighed daily, not weekly, and at the same time each day, usually in the morning. Weigh daily with the same scale, and preferably at the same time of day. Weight is the best assessment data for possible fluid volume imbalance. An increase of 2 lbs a week is considered normal.
- **Option C:** Monitoring ABGs is not necessary for this client. Rather, serum electrolyte levels would most likely be evaluated. Monitor serum electrolytes and urine osmolality, and report abnormal values. Elevated blood urea nitrogen suggests fluid deficit. Urine-specific gravity is likewise increased.
- **Option D:** The client also would have an I.V. rate of at least 75 ml/hour, if not higher, to correct the fluid volume deficit. Administer parenteral fluids as prescribed. Consider the need for an IV fluid challenge with an immediate infusion of fluids for patients with abnormal vital signs.

**3. Dervid, an adolescent has a history of truancy from school, running away from home and “borrowing” other people’s things without their permission. The adolescent denies stealing, rationalizing instead that as long as no one was using the items, it was all right to borrow them. It is important for the nurse to understand the psychodynamically, this behavior may be largely attributed to a developmental defect related to the:**

- A. Id
- B. Ego
- C. Superego
- D. Oedipal complex

**Correct Answer: C. Superego**

This behavior shows a weak sense of moral consciousness. According to Freudian theory, personality disorders stem from a weak superego. The primary action of the superego is to suppress entirely any urges or desires of the id that are considered wrong or socially unacceptable. It also tries to force the ego to act morally rather than realistically. Finally, the superego strives for moral perfections, without taking reality into account.

- **Option A:** According to Freud, the id is the source of all psychic energy, making it the primary component of personality. The id is the only component of personality that is present from birth. This aspect of personality is entirely unconscious and includes instinctive and primitive behaviors. The id is driven by the pleasure principle, which strives for immediate gratification of all desires, wants, and needs. If these needs are not satisfied immediately, the result is a state anxiety or tension. For example, an increase in hunger or thirst should produce an immediate attempt to eat or drink.
- **Option B:** The ego operates based on the reality principle, which strives to satisfy the id's desires in realistic and socially appropriate ways. The reality principle weighs the costs and benefits of an action before deciding to act upon or abandon impulses. In many cases, the id's impulses can be satisfied through a process of delayed gratification—the ego will eventually allow the behavior, but only in the appropriate time and place.
- **Option D:** The Oedipal complex, also known as the Oedipus complex, is a term used by Sigmund Freud in his theory of psychosexual stages of development to describe a child's feelings of desire for his or her opposite-sex parent and jealousy and anger toward his or her same-sex parent. Essentially, a boy feels that he is competing with his father for possession of his mother, while a girl

feels that she is competing with her mother for her father's affections. According to Freud, children view their same-sex parent as a rival for the opposite-sex parent's attention and affections.

**4. Which of the following complications of gastric resection should the nurse teach the client to watch for?**

- A. Constipation
- B. Dumping syndrome
- C. Gastric spasm
- D. Intestinal spasms

**Correct Answer: B. Dumping syndrome**

Dumping syndrome is a problem that occurs postprandially after gastric resection because ingested food rapidly enters the jejunum without proper mixing and without the normal duodenal digestive processing. Dumping syndrome is treated primarily by diet modification, medical treatment with somatostatin analogs, or surgical intervention for refractory cases.

- **Option A:** Diarrhea, not constipation, may also be a symptom. The most common post-gastrectomy complications following gastric resection include nutritional deficiencies, dumping syndrome, small gastric remnant, post-vagotomy diarrhea, delayed gastric emptying, afferent or efferent loop syndrome, roux stasis, and bile reflux gastritis.
- **Option C:** Gastric spasms don't occur, but antispasmodics may be given to slow gastric emptying. Internal hernias are a known cause of acute abdominal pain in patients with gastric resection and Roux-en-Y reconstruction. Three types of trans-mesenteric hernias commonly occur in these patients.
- **Option D:** Intestinal spasms don't occur, but antispasmodics may be given to slow gastric emptying. Afferent and Efferent Loop Syndromes are well-established complications of gastric resection. Afferent loop syndrome is an uncommon obstruction that may result from the internal hernia, marginal ulceration, adhesions, recurrent cancer, or intussusception in patients with Billroth II gastrectomy.

**5. A client slammed a door on the unit several times. The nurse responds, "You seem angry." The client states, "I'm not angry." What therapeutic communication technique has the nurse employed and what defense mechanism is the client unconsciously demonstrating?**

- A. Making observations and the defense mechanism of suppression
- B. Verbalizing the implied and the defense mechanism of denial
- C. Reflection and the defense mechanism of projection
- D. Encouraging descriptions of perceptions and the defense mechanism of displacement

**Correct Answer: B. Verbalizing the implied and the defense mechanism of denial**

This is an example of the therapeutic communication technique of verbalizing the implied. The nurse is putting into words what the client has only implied by words or actions. Denial is the refusal of the client to acknowledge the existence of a real situation, the feelings associated with it, or both.

- **Option A:** Making observations refers to verbalizing what the nurse perceives. Sometimes clients cannot verbalize or make themselves understood, or the client may not be ready to talk. Forcing the unwanted information out of the awareness is known as suppression. In most cases, however, this removal of anxiety-provoking memories from our awareness is believed to occur unconsciously.
- **Option C:** Reflection is directing client actions, thoughts, and feelings back to the client; may use the same words. This encourages the client to recognize and accept his feelings. Projection is a defense mechanism that involves taking our own unacceptable qualities or feelings and ascribing them to other people.
- **Option D:** Encouraging descriptions of perceptions refers to asking the client to verbalize what he or she perceives. To understand the client, the nurse must see things from the client's perspective. Displacement involves taking out our frustrations, feelings, and impulses on people or objects that are less threatening.

**6. Which method would a nurse use to determine a client's potential risk for suicide?**

- A. Wait for the client to bring up the subject of suicide.
- B. Observe the client's behavior for cues of suicide ideation.
- C. Question the client directly about suicidal thoughts.
- D. Question the client about future plans.

**Correct Answer: C. Question the client directly about suicidal thoughts.**

Directly questioning a client about suicide is important to determine suicide risk. A host of thoughts and behaviors are associated with self-destructive acts. Although many assume that people who talk about suicide will not follow through with it, the opposite is true; a threat of suicide can lead to the completed act, and suicidal ideation is highly correlated with suicidal behaviors. A clear and complete evaluation and clinical interview provide the information upon which to base a suicide intervention. Although risk factors offer major indications of the suicide danger, nothing can substitute for a focused patient inquiry. However, although all the answers a patient gives may be inclusive, a therapist often develops a visceral sense that his or her patient is going to commit suicide. The clinician's reaction counts and should be considered in the intervention.

- **Option A:** The client may not bring up this subject for several reasons, including guilt regarding suicide, wishing not to be discovered, and his lack of trust in staff. Determine whether the person has any thoughts of hurting him or herself. Suicidal ideation is highly linked to completed suicide. Some inexperienced clinicians have difficulty asking this question. They fear the inquiry may be too intrusive or that they may provide the person with an idea of suicide. In reality, patients appreciate the question as evidence of the clinician's concern. A positive response requires further inquiry.
- **Option B:** Behavioral cues are important, but direct questioning is essential to determine suicide risk. If suicidal ideation is present, the next question must be about any plans for suicidal acts. The general formula is that more specific plans indicate greater danger. Although vague threats, such as a threat to commit suicide sometime in the future, are the reason for concern, responses indicating that the person has purchased a gun, has ammunition, has made out a will, and plans to use the gun are more dangerous. The plan demands further questions. If the person envisions a gun-related death, determine whether he or she has the weapon or access to it.
- **Option D:** Indirect questions convey to the client that the nurse is not comfortable with the subject of suicide and, therefore, the client may be reluctant to discuss the topic. Determine what the patient believes his or her suicide would achieve. This suggests how seriously the person has been

considering suicide and the reason for death. For example, some believe that their suicide would provide a way for family or friends to realize their emotional distress. Others see their death as a relief from their own psychic pain. Still others believe that their death would provide a heavenly reunion with a departed loved one. In any scenario, the clinician has another gauge of the seriousness of the planning.

**7. The client with ovarian cancer is receiving Tamoxifen (Nolvadex). Which of the following indicates a side effect specific to this medication?**

- A. Weak and brittle nails
- B. Facial twitching
- C. Convulsions
- D. Constipation

**Correct Answer: D. Constipation**

Tamoxifen (Nolvadex) is an antineoplastic medication that may increase calcium levels. Signs of hypercalcemia include constipation, abdominal pain, hypotonicity of muscle, nausea, and vomiting.

- **Options A, B, & C:** These are signs of hypocalcemia.

**8. The nurse is caring for a 6-year-old client admitted with a diagnosis of conjunctivitis. Before administering eye drops, the nurse should recognize that it is essential to consider which of the following?**

- A. The eye should be cleansed with warm water, removing any exudate, before instilling the eyedrops.
- B. The child should be allowed to instill his own eye drops.
- C. The mother should be allowed to instill the eyedrops.
- D. If the eye is clear from any redness or edema, the eye drops should be held.

**Correct Answer: A. The eye should be cleansed with warm water, removing any exudate, before instilling the eyedrops.**

Before instilling eye drops, the nurse should cleanse the area with water. Cleanse the eyelids and lashes with cotton balls or gauze pledgets moistened with normal saline or water. This prevents debris to be carried into the eye when the conjunctival sac is exposed.

- **Option B:** A 6-year-old child is not developmentally ready to instill his own eye drops. An ophthalmic assistant, technician, nurse or physician instills eye drops during a routine eye examination or during treatment for ocular disease.
- **Option C:** Although the mother of the child can instill the eye drops, the area must be cleansed before administration. Use each cotton ball or pledget for only one stroke, moving from the inner to the outer canthus of the eye.
- **Option D:** Although the eye might appear to be clear, the nurse should instill the eyedrops, as ordered, so answer D is incorrect. Allow the prescribed number of drops to fall in the lower conjunctival sac but do not allow to fall onto the cornea. Release the lower lid after the drops are instilled. Instruct the patient to close eyes slowly, move the eye and not to squeeze or rub.

**9. A child is admitted to the pediatric unit with a diagnosis of suspected meningococcal meningitis. Which of the following nursing measures should the nurse do first?**

- A. Assess vital signs
- B. Institute seizure precautions
- C. Assess neurologic status
- D. Place in respiratory isolation

**Correct Answer: D. Place in respiratory isolation**

The initial therapeutic management of acute bacterial meningitis includes isolation precautions, initiation of antimicrobial therapy, and maintenance of optimum hydration. Nurses should take necessary precautions to protect themselves and others from possible infection. The patient with suspected or confirmed N. meningitidis should follow droplet precaution. This should be continued until after 24 hours of effective antibiotics administration.

- **Option A:** Prompt recognition and immediate initiation of treatment are of utmost importance in the management of bacterial meningitis. Patients can present with abnormal vital signs, including fever, tachypnea, tachycardia, and hypotension. Hypotension with elevated pulse rate is suggestive of early vascular instability.
- **Option B:** Complications of meningococcal meningitis can arise early or late in the disease course and can adversely impact morbidity and mortality. Late complications of meningococcal meningitis include chronic pain, skin scarring, and neurologic impairment. Other common complications include hearing impairment, visual impairment, and seizures.
- **Option C:** Assessment should be performed after the patient is placed on respiratory isolation in order to avoid infecting other patients. Prompt antibiotic administration, especially within one hour, has been proven to improve morbidity and mortality, as well as prevent complications such as increased intracranial pressure and septic shock.

**10. The nurse expects that a type 1 diabetic may receive how much of his or her morning dose of insulin preoperatively?**

- A. 10-20%
- B. 25-40%
- C. 50-60%
- D. 85-90%

**Correct Answer: C. 50-60%**

Surgical procedures may result in a number of metabolic perturbations that can alter normal glucose homeostasis. Patients with type 1 diabetes mellitus who are using long-acting insulins, such as glargine, should continue these as normal when fasting. Patients taking premixed insulins or fixed-combination insulins are more of a challenge. It may not be feasible or economical to change the patient's premixed insulin just before surgery. In these situations, the patient can take  $\frac{1}{2}$  –  $\frac{3}{4}$  of the morning dose, followed by administration of a dextrose-containing intravenous fluid and frequent blood glucose checks.

- **Option A:** However, in patients who take high doses of basal insulin (>60% of total daily insulin) or total daily insulin dose is greater than 80 units or are at high risk of hypoglycemia (elderly, renal or hepatic insufficiency, prior hypoglycemic episodes); basal insulin dose should be reduced by 50 to 75% to minimize hypoglycemia risk.
- **Option B:** Patients who are on home insulin therapy should reduce the dose of long-acting basal insulin (glargine, detemir) by 20-25% the evening before surgery. If they routinely take basal insulin only in the morning, then the reduced dose should instead be administered on the morning of surgery.
- **Option D:** If the patient is prone to morning hypoglycemia, the dose can be reduced by 20%. Thus, the diabetic patient may receive 80% of his or her morning dose of insulin preoperatively.

**11. What event occurring in the second trimester helps the expectant mother to accept the pregnancy?**

- A. Lightening
- B. Ballotment
- C. Pseudocyesis
- D. Quickening

**Correct Answer: D. Quickening**

Quickening is the first fetal movement felt by the mother that makes the woman realize that she is truly pregnant. In early pregnancy, the fetus is moving but too weak to be felt by the mother. In the 18th-20th week of gestation, the fetal movements become stronger thus the mother already feels the movements.

- **Option A:** Lightening is one of the major signs that labor is approaching. It happens when the baby's head literally "drops" lower into the pelvis, becoming engaged within the pubic bones. This starts the baby's descent down and out into the world. Lightening can start as early as a few weeks before labor actually begins.
- **Option B:** Ballotment is a sharp upward push against the uterine wall with a finger inserted into the vagina for diagnosing pregnancy by feeling the return impact of the displaced fetus also.
- **Option C:** Pseudocyesis is defined by the DSM-5 as a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy, which may include abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery.

**12. Chemotherapy dosing is usually based on the total body surface. What should the nurse do before administering chemotherapy?**

- A. Get the body mass index (BMI).
- B. Ask the client about intake and output.
- C. Weigh and measure the height of the patient on the day of administration.
- D. Ask the client for the height and weight.

**Correct Answer: C. Weigh and measure the height of the patient on the day of administration.**

To assure that the client obtains optimal doses of chemotherapy, dosing is usually based on the total body surface (BSA), which requires an accurate current measurement of height and weight on the day of the administration.

- **Options A & B:** These will not provide the information needed.
- **Option D:** This will lead to an inaccurate value in determining the true body total surface.

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

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

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

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

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

**14. Which of the following symptoms is the most common clinical finding associated with bladder cancer?**

- A. Suprapubic pain
- B. Dysuria
- C. Painless hematuria



D. Urinary retention

**Correct Answer: C. Painless hematuria**

Painless hematuria is the most common clinical finding in bladder cancer. Other symptoms include frequency, dysuria, and urgency, but these are not as common as the hematuria. Bladder carcinoma (BC) is the most common neoplasm of the urinary system. Urothelial carcinoma (UC) is the most common histologic type of BC (approximately 90%). The definition of UC is the invasion of the basement membrane or lamina propria or deeper by neoplastic cells of urothelial origin.

- **Option A:** Suprapubic pain and urinary retention do not occur in bladder cancer. The WHO has replaced the old term transitional cell carcinoma with urothelial carcinoma. Invasion is referred to as 'micro invasion' when the depth of invasion is 2 mm or less. The World Health Organization (2016) classifies bladder cancers based on differentiation as low grade (grade 1 and 2) or high grade (grade 3).
- **Option B:** Other less common symptoms include painful micturition, frequency, constitutional symptoms such as fatigue, weight loss, and a pelvic mass. In developing countries, schistosomiasis infection is an important cause of BC. Schistosoma haematobium ova embedded in the bladder wall leading to irritation, chronic inflammation, squamous metaplasia, and dysplasia, with further progression leading to squamous cell carcinoma of the urinary bladder.
- **Option D:** Complications of UC include symptoms related to the tumor and treatment of adverse effects. Complications related to the tumor include weight loss, fatigue, UTI, metastasis, and urinary obstruction leading to chronic kidney failure. The adverse effects of surgical management include UTI, urinary leak, pouch stones, urinary tract obstruction, erectile dysfunction, and vaginal narrowing.

**15. Gio told his nurse that the FBI is monitoring and recording his every movement and that microphones have been placed in the unit walls. Which action would be the most therapeutic response?**

- A. Confront the delusional material directly by telling Gio that this simply is not so.
- B. Tell Gio that this must seem frightening to him but that you believe he is safe here.
- C. Tell Gio to wait and talk about these beliefs in his one-on-one counseling sessions.
- D. Isolate Gio when he begins to talk about these beliefs.

**Correct Answer: B. Tell Gio that this must seem frightening to him but that you believe he is safe here.**

The nurse must realize that these perceptions are very real to the client. Acknowledging the client's feelings provides support; explaining how the nurse sees the situation in a different way provides reality orientation. Recognize the client's delusions as the client's perception of the environment. Recognizing the client's perception can help you understand the feelings he or she is experiencing.

- **Option A:** Confronting the delusional material directly will not work with this client and may diminish trust. Attempt to understand the significance of these beliefs to the client at the time of their presentation. Important clues to underlying fears and issues can be found in the client's seemingly illogical fantasies.
- **Option C:** Telling the client to wait and talk about these beliefs in his one-on-one counseling session will reinforce the delusion. Initially do not argue with the client's beliefs or try to convince the client that the delusions are false and unreal. Arguing will only increase a client's defensive position, thereby reinforcing false beliefs. This will result in the client feeling even more isolated and

misunderstood.

- **Option D:** Isolation will increase anxiety. Distraction with a radio or activities would be a better approach. Interact with clients on the basis of things in the environment. Try to distract the client from their delusions by engaging in reality-based activities (e.g., card games, simple arts and crafts projects, etc). When thinking is focused on reality-based activities, the client is free of delusional thinking during that time. Helps focus attention externally.

**16. A nurse is giving discharge instructions to the parents of a healthy newborn. Which of the following instructions should the nurse provide regarding car safety and the trip home from the hospital?**

- A. The infant should be restrained in an infant car seat, properly secured in the back seat in a rear-facing position.
- B. The infant should be restrained in an infant car seat, properly secured in the front passenger seat.
- C. The infant should be restrained in an infant car seat facing forward or rearward in the back seat.
- D. For the trip home from the hospital, the parent may sit in the back seat and hold the newborn.

**Correct Answer: A. The infant should be restrained in an infant car seat, properly secured in the back seat in a rear-facing position.**

All infants under 1 year of age weighing less than 20 lbs. should be placed in a rear-facing infant car seat secured properly in the back seat. Rear-facing car safety seats for infants are perhaps the least controversial; rear-facing car seats have superior effectiveness in preventing serious injury in infants from car crashes. Children < 24 months riding in rear-facing car seats were 1.76 times less likely be seriously injured from all types of car crashes relative to children riding in forward-facing safety seats

- **Option B:** Infant car seats should never be placed in the front passenger seat. States have implemented their own individual mandates for car safety seats, with stringent recommendations from the AAP incorporated into law in New Jersey and Oklahoma and with states including West Virginia (WV) and North Carolina having the most lenient requirements (Bae, Anderson, Silver, & Macinko, 2014; NCPSC, 2013). WV requires that children under 7 years be restrained in a car safety or booster seat, without specifying the timing of the transition.
- **Option C:** The infant should always face rearward in the back seat while on a car seat. For side crashes, children < 24 months riding in forward-facing car seats were 5.5 times more likely to get injured as compared to those riding in rear-facing car seats. Accident data (such as from Sweden) indicate that increased duration of rear-facing car safety seat usage can decrease injuries and deaths relating to automobile accidents (SafetyBeltSafe USA, 2013).
- **Option D:** Infants should always be placed in an approved car seat during travel, even on that first ride home from the hospital. Consistent with research, the American Academy of Pediatrics (AAP) and National Highway Traffic Safety Administration (NHTSA) have developed evidence-based practice guidelines for car safety seat use, which vary by the size and weight of the child, emphasizing the use of rear seats among infants less than 2 years of age (AAP, 2013; NHTSA, 2014).

**17. A male client in a behavioral-health facility receives a 30-minute psychotherapy session, and the provider uses a current procedure terminology (CPT) code that bills for a 50-minute session. Under the False Claims Act, such illegal behavior is known as:**

- A. Unbundling
- B. Overbilling
- C. Upcoding
- D. Misrepresentation

**Correct Answer: C. Upcoding**

Upcoding is the practice of using a CPT code that's reimbursed at a higher rate than the code for the service actually provided. Upcoding is fraudulent medical billing in which a bill sent for a health service is more expensive than it should have been based on the service that was performed. An upcoded bill can be sent to any payer—whether a private health insurer, Medicaid, Medicare, or the patient. Unbundling, overbilling, and misrepresentation aren't the terms used for this illegal practice.

- **Option A:** Unbundling refers to using multiple CPT codes for those parts of the procedure, either due to misunderstanding or in an effort to increase payment.
- **Option B:** Overbilling (sometimes spelled as over-billing) is the practice of charging more than is legally or ethically acceptable on an invoice or bill.
- **Option D:** A misrepresentation is a false statement of a material fact made by one party which affects the other party's decision in agreeing to a contract. If the misrepresentation is discovered, the contract can be declared void, and depending on the situation, the adversely impacted party may seek damages.

**18. A child is undergoing remission induction therapy to treat leukemia. Allopurinol is included in the regimen. The main reason for administering allopurinol as part of the client's chemotherapy regimen is to:**

- A. Prevent uric acid from precipitating in the ureters
- B. Enhance the production of uric acid to ensure adequate excretion of urine
- C. Prevent metabolic breakdown of xanthine to uric acid
- D. Ensure that the chemotherapy doesn't adversely affect the bone marrow

**Correct Answer: C. Prevent metabolic breakdown of xanthine to uric acid**

The massive cell destruction resulting from chemotherapy may place the client at risk for developing renal calculi; adding allopurinol decreases this risk by preventing the breakdown of xanthine to uric acid. These clients can have increased uric acid levels due to release of uric acid from the dying cancer cells.

- **Option A:** Allopurinol and oxypurinol both inhibit xanthine oxidase, an enzyme in the purine catabolism pathway that converts hypoxanthine to xanthine to uric acid. Allopurinol undergoes metabolism in the liver, where it transforms into its pharmacologically active metabolite, oxypurinol.
- **Option B:** Urate production is accelerated by purine-rich diets, endogenous purine production, and high cell breakdown, and it is responsible for a minority of cases of hyperuricemia. Foods rich in purine include all meats but specifically organ meats (kidneys, liver, "sweet bread"), game meats, and some seafood (anchovies, herring, scallops).
- **Option D:** Allopurinol doesn't act in the manner described in this option. To prevent tumor lysis syndrome, allopurinol shall be initiated 2 to 3 days before starting chemotherapy and continued until 3 to 7 days after chemotherapy.

**19. Maya, who is admitted to a hospital, is scheduled to have her general checkup and physical assessment. Nurse Timothy observed a reddened area over her left hip. Which should the nurse do first?**

- A. Massage the reddened area for a few minutes.
- B. Notify the physician immediately.
- C. Arrange for a pressure-relieving device.
- D. Turn the client to the right side for 2 hours.

**Correct Answer: D. Turn the client to the right side for 2 hours**

Turning the client to the right side relieves the pressure and promotes adequate blood supply to the left hip. Encourage the patient to change position every 15 minutes and change chair-bound positions every hour. During sitting, the pressure over the sacrum may exceed 100 mm Hg. The pressure needed to close capillaries is around 32 mm Hg; any pressure above 32 mm Hg leads to ischemia.

- **Option A:** A reddened area is never massaged, because this may increase the damage to the already reddened, damaged area. Massage only around the affected area. This is to increase tissue perfusion. Massaging the actual reddened area may damage the skin further.
- **Option B:** The health care provider does not need to be notified immediately. However, the health care provider should be informed of this finding the next time he is on the unit. Educate the patient and caregiver about the causes of pressure. This information can assist the patient or caregiver in finding methods to prevent skin breakdown.
- **Option C:** Arranging for a pressure-relieving device is appropriate, but this is done after the client has been turned. Use pillows or foam wedges to keep bony prominences from direct contact with each other. Keep pillows under the heels to raise off bed. These measures reduce shearing forces on the skin.

**20. Which of the following conditions is most commonly responsible for myocardial infarction?**

- A. Aneurysm
- B. Heart failure
- C. Coronary artery thrombosis
- D. Renal failure

**Correct Answer: C. Coronary artery thrombosis**

Coronary artery thrombosis causes occlusion of the artery, leading to myocardial death. Myocardial infarction occurs when a coronary artery is so severely blocked that there is a significant reduction or break in the blood supply, causing damage or death to a portion of the myocardium (heart muscle).

- **Option A:** An aneurysm is an outpouching of a vessel and doesn't cause an MI. On exertion, elevated blood pressure could cause expansion of the aneurysmal cavity, aggravating the coronary ischemia, and eventually would have produced myocardial infarction. However, this only occurs in very rare cases.

- **Option D:** Renal failure can be associated with MI but isn't a direct cause. All-cause mortality of dialysis patients with acute myocardial infarction (AMI) is 59% at 1 year and about 73% at 2 years. AMI in patients with nondialysis-dependent advanced CKD is also associated with poor long-term cardiovascular outcomes and survival.
- **Option B:** Heart failure is usually the result of an MI. It produces both a vasculopathy and left ventricular dysfunction and fibrosis. It produces both a vasculopathy and left ventricular dysfunction and fibrosis. Endothelial dysfunction in the coronary arteries can lead to acute coronary events. Left ventricular dysfunction will cause the progression of heart failure, and left ventricular fibrosis and dysfunction provide an arrhythmic substrate.

**21. The client's vision is tested with a Snellen chart. The results of the tests are documented as 20/60. The nurse interprets this as:**

- A. The client can read at a distance of 60 feet what a client with normal vision can read at 20 feet.
- B. The client is legally blind.
- C. The client's vision is normal.
- D. The client can read only at a distance of 20 feet what a client with normal vision can read at 60 feet.

**Correct Answer: D. The client can read only at a distance of 20 feet what a client with normal vision can read at 60 feet.**

Vision that is 20/20 is normal, that is, the client is able to read from 20 feet what a person with normal vision can read from 20 feet. A client with a visual acuity of 20/60 only can read at a distance of 20 feet of what a person with normal vision can read at 60 feet. The results of visual acuity are classically reported using 20/20 (6/6 when using meters) for standard vision. The numerator describes the distance from the chart, typically 20 ft (6 m). The denominator describes the distance that an individual with normal vision (20/20 vision) can read the same line on the chart.

- **Option A:** An individual with 20/60 vision would be able to distinguish the same optotype at 20 ft that another individual with normal (20/20) vision distinguishes at 60 ft. In the logMAR, visual acuity is reported as a single number where 0.0 is standard vision.
- **Option B:** The WHO describes individuals with low vision as having a best-corrected vision of 20/60 or worse, and blind as best corrected vision worse than 20/400, whereas legal blindness is identified as 20/200 in the United States.
- **Option C:** Although 20/20 visual acuity has been referred to as "perfect vision," it is important to remember that this is only one aspect of vision and does not include other elements such as depth perception, peripheral vision, and colorblindness.

**22. Beta-adrenergic agonists such as albuterol are given to Reggie, a child with asthma. Such drugs are administered primarily to do which of the following?**

- A. Dilate the bronchioles
- B. Reduce secondary infections
- C. Decrease postnasal drip
- D. Reduce airway inflammation

**Correct Answer: A. Dilate the bronchioles**

Beta-adrenergic agonists, such as albuterol, are highly effective bronchodilators and are used to dilate the narrow airways associated with asthma. Albuterol and levalbuterol are examples of short-acting bronchodilators. They have a quick onset of action, within 5 to 15 minutes, and a duration of action of 4 to 6 hours. Their administration is most often by nebulizer or inhaler.

- **Option B:** Antibiotics are used to prevent secondary infection. Antibiotics cannot help with asthma attacks and guidelines do not recommend routinely prescribing antibiotics after an asthma attack. They should only be prescribed after an asthma attack if there is strong evidence that there is a bacterial infection. For example, a bacterial chest infection or pneumonia.
- **Option C:** Decongestants may be given to decrease postnasal drip. Oral decongestants such as pseudoephedrine are useful in relieving symptoms but are not recommended for extended daily use due to their side-effect profile. Intranasal decongestants such as xylometazoline are alpha-agonists that are delivered directly to nasal tissue to produce vasoconstriction.
- **Option D:** Corticosteroids may be used for their anti-inflammatory effect. Montelukast can be an alternative. Montelukast is a leukotriene receptor antagonist available in 4 mg granules, or 4 mg and 5 mg chewable tablets, as well as in a 10 mg tablet formulation. Single evening dosing prescription is by age and FDA approved for asthma control from 12 months of age.

**23. Which of the following statements about intravenous administration of steroids is true?**

- A. Steroids administered intravenously must be diluted.
- B. Steroids administered intravenously can be either in diluted or undiluted form.
- C. Steroids should be given IV push only.
- D. Intravenous administration of steroids is contraindicated in acutely ill clients.

**Correct Answer: B. Steroids administered intravenously can be either in diluted or undiluted form.**

IV steroids can either be diluted or given without dilution. The route of administration for corticosteroids depends on many factors, primarily being the disorder treated. The route can be parenteral, oral, inhaled, topical, injected (intramuscular, intraarticular, intralesional, intradermal, etc.), and rectal. The clinician must keep many factors in mind upon deciding to initiate corticosteroid therapy, including the route of administration, preparation, dosing, frequency, and duration of treatment.

- **Option A:** Parenteral administration is often used in more emergent therapy as well as in those unable to tolerate medication by mouth. Oral administration is more common for chronic treatment. Patients should receive non-systemic therapy whenever possible, to minimize systemic exposure.
- **Option C:** When administering Methylprednisolone sodium succinate in high doses intravenously it should be given over a period of at least 30 minutes. Doses up to 250 mg should be given intravenously over a period of at least five minutes.
- **Option D:** The toxicity of corticosteroids accounts for one of the most common causes of iatrogenic illness in patients on chronic therapy. No specific reversal agent exists for corticosteroids. Their effect in excess is manageable by gradual taper and addressing the particular complication (e.g., hyperglycemia, infection, hypertension).

**24. 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 Glasgow 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.

***25. A nurse is assessing a clinic patient with a diagnosis of hepatitis A. Which of the following is the most likely route of transmission?***

- A. Sexual contact with an infected partner
- B. Contaminated food
- C. Blood transfusion
- D. Illegal drug use

**Correct Answer: B. Contaminated food**

Hepatitis A is the only type that is transmitted by the fecal-oral route through contaminated food. HAV is a single-stranded, positive-sense, linear RNA enterovirus of the Picornaviridae family. In humans, viral replication depends on hepatocyte uptake and synthesis, and assembly occurs exclusively in the liver cells. Virus acquisition results almost exclusively from ingestion (eg, fecal-oral transmission)

- **Option A:** Hepatitis B infection, caused by the hepatitis B virus (HBV), is commonly transmitted via body fluids such as blood, semen, and vaginal secretions. [1] Consequently, sexual contact, accidental needle sticks or sharing of needles, blood transfusions, and organ transplantation are routes for HBV infection.
- **Option C:** Before widespread screening of the blood supply in 1992, hepatitis C was also spread through blood transfusions and organ transplants. Now, the risk of transmission to recipients of blood or blood products is extremely low.
- **Option D:** Today, most people become infected with hepatitis B, C, or D by sharing needles, syringes, or any other equipment used to prepare and inject drugs.

**26. Immunosuppression following kidney transplantation is continued:**

- A. For life
- B. 24 hours after transplantation
- C. A week after transplantation
- D. Until the kidney is not anymore rejected

**Correct Answer: A. For life.**

After an organ transplant, the client will need to take immunosuppressant (anti-rejection) drugs. These drugs help prevent the immune system from attacking (“rejecting”) the donor organ. Typically, they must be taken for the lifetime of the transplanted organ. Organ rejection is a constant threat. Keeping the immune system from attacking the transplanted organ requires constant vigilance. So, it’s likely that the transplant team will make adjustments to the anti-rejection drug regimen.

- **Option B:** One risk of a kidney transplant is that the body will reject (fight) the new kidney. This can happen if the body’s immune system realizes that the kidney is from someone else. To prevent this from happening, the client must take medicines to weaken the immune system. These medicines are called immunosuppressants, or anti-rejection medicines.
- **Option C:** Once the client recovered from the transplant surgery, he may be able to start a new exercise routine. Exercise can help improve heart and lung health, prevent weight gain and even improve mood. Talk to the doctor about the types of exercise that are right, how often one should exercise, and for how long.
- **Option D:** Though kidney transplants are often successful, there are some cases when they are not. It is possible that the body may refuse to accept the donated kidney shortly after it is placed in the body. It is also possible the new kidney may stop working overtime.

**27. The nurse is caring for a neonate whose mother is diabetic. The nurse will expect the neonate to be:**

- A. Hypoglycemic, small for gestational age
- B. Hyperglycemic, large for gestational age
- C. Hypoglycemic, large for gestational age
- D. Hyperglycemic, small for gestational age

**Correct Answer: C. Hypoglycemic, large for gestational age**



The infant of a diabetic mother is usually large for gestational age. After birth, glucose levels fall rapidly due to the absence of glucose from the mother. Hypoglycemia is caused by hyperinsulinemia due to hyperplasia of fetal pancreatic beta cells consequent to maternal-fetal hyperglycemia. Because the continuous supply of glucose is stopped after birth, the neonate develops hypoglycemia because of insufficient substrate.

- **Option A:** The infant will not be small for gestational age. Fetal macrosomia (>90th percentile for gestational age or >4000 g in the term infant) occurs in 15-45% of diabetic pregnancies. It is most commonly observed as a consequence of maternal hyperglycemia. When macrosomia is present, the infant appears puffy, fat, ruddy, and often hypotonic.
- **Option B:** The infant will not be hyperglycemic. Stimulation of fetal insulin release by maternal hyperglycemia during labor significantly increases the risk of early hypoglycemia in these infants. Perinatal stress may have an additive effect on hypoglycemia due to catecholamine release and glycogen depletion.
- **Option D:** The infant will be large, not small, and will be hypoglycemic, not hyperglycemic. The overall risk of hypoglycemia is anywhere from 25-40%, with LGA and preterm infants at the highest risk. Fetal growth is assessed by plotting birth weight against gestational age on standard growth curves. Infants whose weight exceeds the 90th percentile for gestational age are classified as large for gestational age (LGA).

**28. You are a pediatric nurse at a bustling city hospital. Today, you are assigned to the infant care unit. Mrs. Walker, a worried first-time mother, comes to you expressing deep concerns about sudden infant death syndrome (SIDS) affecting her 3-month-old son, particularly since she recently read a distressing article about a local SIDS case. She is seeking information on the age range when infants are at the highest risk for SIDS to better understand and potentially mitigate the risk for her son. Given Mrs. Walker's concerns, you decide to elucidate on the age range predisposition for SIDS with the following options:**

- A. At 1 to 2 years of age.
- B. At 1 week to 1 year of age, peaking at 2 to 4 months.
- C. At 6 months to 1 year of age, peaking at 10 months.
- D. At 6 to 8 weeks of age.
- E. At birth to 6 weeks of age.
- F. At 4 to 6 months of age.

**Correct Answer: B. At 1 week to 1 year of age, peaking at 2 to 4 months.**

This is the correct answer. The majority of SIDS cases occur during this age range, with a peak incidence between 2 to 4 months of age. In providing this information to Mrs. Walker, you alleviate some of her concerns, emphasizing the importance of following the recommended infant care guidelines, including placing the infant on his back to sleep, ensuring a firm sleep surface, and keeping the sleep area free from soft bedding and toys to mitigate the risks of SIDS.

- **Option A:** This age range is beyond the typical age range for a diagnosis of SIDS. The risk for SIDS significantly decreases after the infant reaches 1 year of age.

- **Option C:** The risk of SIDS starts to significantly decrease after 6 months of age, thus this age range is less likely for a SIDS diagnosis compared to the 1 week to 1-year age range.
- **Option D:** While SIDS can occur at this age, the peak incidence is typically between 2 to 4 months of age.
- **Option E:** SIDS is less common in the first month of life; the risk increases after 1 month of age and peaks between 2 to 4 months.
- **Option F:** This age range is within the broader age range where SIDS is a concern, but it's not the peak period.

**29. Rocky has started taking haloperidol (Haldol). Which of the following instructions is most appropriate for Ricky before taking haloperidol?**

- A. Should report feelings of restlessness or agitation at once.
- B. Use sunscreen outdoors on a year-round basis.
- C. Be aware you'll feel increased energy taking this drug.
- D. Avoid eating sugar-free sweets.

**Correct Answer: A. Should report feelings of restlessness or agitation at once**

Haloperidol is a first-generation (typical) antipsychotic medication that is used widely around the world. Food and Drug Administration (FDA) approved the use of haloperidol is for schizophrenia, Tourette syndrome (control of tics and vocal utterances in adults and children), hyperactivity (which may present as impulsivity, difficulty maintaining attention, severe aggressivity, mood instability, and frustration intolerance), severe childhood behavioral problems (such as combative, explosive hyperexcitability), intractable hiccups. It is a typical antipsychotic because it works on positive symptoms of schizophrenia, such as hallucinations and delusions.

- **Option A:** Agitation and restlessness are adverse effects of haloperidol and can be treated with anticholinergic drugs. Due to the blockade of the dopamine pathway in the brain, typical antipsychotic medications such as haloperidol have correlations with extrapyramidal side effects.
- **Option B:** Haloperidol isn't likely to cause photosensitivity or control essential hypertension. Due to potential side effects development, patients receiving haloperidol require monitoring, especially when receiving the intramuscular form. It can be easily monitored by taking blood levels. It has a therapeutic range of 2 to 15 ng/ml in serum. Blood levels should be monitored at 12-hour or 24-hour intervals or after the last dose of haloperidol use in a patient.
- **Option C:** Although the client may experience increased concentration and activity, these effects are due to a decrease in symptoms, not the drug itself. Haloperidol is a first-generation (typical antipsychotic) which exerts its antipsychotic action by blocking dopamine D2 receptors in the brain. When 72% of dopamine receptors are blocked, this drug achieves its maximal effect. Haloperidol is not selective for the D2 receptor. It also has noradrenergic, cholinergic, and histaminergic blocking action. The blocking of these receptors is associated with various side effects.  
Option D: Haloperidol may produce anticholinergic side effects such as dry mouth, hence the health care provider will teach the client interventions to relieve symptoms such as chewing a sugarless hard candy or gum.

**30. Which factor is least significant during assessment when gathering information about cultural practices?**

- A. Language, timing
- B. Touch, eye contact
- C. Biocultural needs
- D. Pain perception, management expectations

**Correct Answer: C. Biocultural needs**

Cultural practices do not influence biocultural needs because they are inborn risks that are related to a biological need and not a learned cultural belief or practice. Culturally competent healthcare professionals learn about different groups and the values that drive them. They develop nonjudgmental acceptance of cultural and noncultural differences in patients and coworkers, using diversity as a strength that empowers them to achieve mutually acceptable healthcare goals.

- **Option A:** When a patient doesn't speak English and there is no interpreter, spend more time visiting to allay patients' anxiety. Learn key phrases from the family and use flashcards to enhance communication. When all else fails, sign language does work. Remember that making the effort shows the patient that you care. You are using the language of the heart and building trust.
- **Option B:** Both the clinician and the interpreter must pay particular attention to nonverbal feedback during communication with the patient to ensure understanding of the patient's concerns and desires. During the exchange, the clinician and the interpreter must be able to convey caring and support to gain patients' confidence and trust, particularly when they are revealing sensitive information.
- **Option D:** Culture influences patients' perceptions of illness, pain, and healing. These perceptions may conflict with clinicians' views based on the medical model. Keep an open mind and listen actively to what patients say about their illness.

**31. You're caring for Beth who underwent a Billroth II procedure (surgical removal of the pylorus and duodenum) for treatment of a peptic ulcer. Which findings suggest that the patient is developing dumping syndrome, a complication associated with this procedure?**

- A. Flushed, dry skin.
- B. Headache and bradycardia.
- C. Dizziness and sweating.
- D. Dyspnea and chest pain.

**Correct Answer: C. Dizziness and sweating.**

After a Billroth II procedure, a large amount of hypertonic fluid enters the intestine. This causes extracellular fluid to move rapidly into the bowel, reducing circulating blood volume and producing vasomotor symptoms. Vasomotor symptoms produced by dumping syndrome include dizziness and sweating, tachycardia, syncope, pallor, and palpitations.

- **Option A:** Dumping syndrome occurs in patients who have had gastric surgery. Symptoms of early dumping occur within 10 to 30 minutes after a meal. Late dumping can present 1 to 3 hours after a high-carbohydrate meal. In early dumping, the symptoms usually occur within 10 to 30 minutes after a meal. The rapid transit of hyperosmolar chyme from the stomach into the duodenum causes fluid to shift from the vasculature to the intestinal lumen, leading to increased volume in the small bowel.

- **Option B:** There may be GI or vasomotor symptoms. GI symptoms include nausea, vomiting, diarrhea, or belching. Vasomotor symptoms include shock, syncope, near-syncope, palpitations, dizziness, desire to lie down, or diaphoresis. The suggested division of meals recommended is at least six times per day. Liquids should be withheld until 30 minutes after the meal. In addition, simple sugars and milk products should be avoided.
- **Option D:** The enteric nervous system plays a major role in the regulation of gastric emptying, involving several gastrointestinal (GI) hormones and extrinsic innervation. Late dumping, also known as postprandial hyperinsulinemic hypoglycemia, usually occurs 1 to 3 hours after a high-carbohydrate meal. There is an association with hypoglycemia, but the exact mechanism is unknown. It is proposed that the rapid absorption of carbohydrates exaggerates the glucose-mediated insulin response.

**32. What is the best way to check for patency of the arteriovenous fistula for hemodialysis?**

- A. Pinch the fistula and note the speed of filling on release.
- B. Use a needle and syringe to aspirate blood from the fistula.
- C. Check for capillary refill of the nail beds on that extremity.
- D. Palpate the fistula throughout its length to assess for a thrill.

**Correct Answer: D. Palpate the fistula throughout its length to assess for a thrill.**

The vibration or thrill felt during palpation ensures that the fistula has the desired turbulent blood flow. Assess for patency at least every 8 hours. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency. Auscultate the vascular access with a stethoscope to detect a bruit or “swishing” sound that indicates patency.

- **Option A:** Pinching the fistula could cause damage. To prevent injuries, place an armband on the patient or a sign over the bed that says no BP measurements, venipunctures, or injections on the affected side. When blood flow through the vascular access is reduced, it can clot.
- **Option B:** Aspirating blood is a needless invasive procedure. Narrowing, also known as stenosis, of the blood vessel is the most common problem. This results in insufficient blood flow through the fistula or graft. Clotting can also cause decreased flow. If you don’t feel a thrill (vibration), the access may be clotted.
- **Option C:** Patients with an AVF for hemodialysis will present with evidence of a surgical incision on the lateral wrist, volar forearm, or upper arm. A working AVF will have a palpable thrill and continuous bruit. Superficial fistulas have a palpable thrill, a bruit, or even a pulsatile mass. It may be possible to auscultate a machinery-like murmur over the fistula.

**33. A male client is admitted for treatment of the syndrome of inappropriate antidiuretic hormone (SIADH). Which nursing intervention is appropriate?**

- A. Infusing I.V. fluids rapidly as ordered.
- B. Encouraging increased oral intake.
- C. Restricting fluids.
- D. Administering glucose-containing I.V. fluids as ordered.

**Correct Answer: C. Restricting fluids**

To reduce water retention in a client with SIADH, the nurse should restrict fluids. Administering fluids by any route would further increase the client's already heightened fluid load. Syndrome of inappropriate antidiuretic hormone ADH release (SIADH) is a condition defined by the unsuppressed release of antidiuretic hormone (ADH) from the pituitary gland or non-pituitary sources or its continued action on vasopressin receptors.

- **Option A:** SIADH is characterized by impaired water excretion leading to hyponatremia with hypervolemia or euvolemia. SIADH treatment involves correction and maintenance of corrected sodium levels and correction of underlying abnormalities such as hypothyroidism or pulmonary or CNS infection. The goal of sodium correction is more than 130 mEq/L.
- **Option B:** In patients with mild to moderate symptoms, the mainstay of the treatment is the restriction of oral water intake with the goal of less than 800 mL/day. If hyponatremia is persistent, sodium chloride in the form of oral salt tablets or intravenous saline can be given.
- **Option D:** Loop diuretics such as furosemide (20 mg twice daily) can also be added to salt tablets as it helps decrease the urine concentration and thereby increase water excretion, particularly among the patients whose urine osmolality is much higher than serum osmolality (greater than 500 mOsm/kg).

**34. Nurse Betina should begin screening for lead poisoning when a child reaches which age?**

- A. 3 months
- B. 12 months
- C. 24 months
- D. 30 months

**Correct Answer: B. 12 months**

The nurse should start screening a child for lead poisoning at age 12 months and perform repeat screening at age 24, 30, and 36 months. The Advisory Committee on Childhood Lead Poisoning Prevention recommends that all children enrolled in Medicaid be screened for elevated blood lead levels at 12 and 24 months of age or at 36 to 72 months of age if they have not previously been screened.

- **Option A:** High-risk infants, such as premature infants and formula-fed infants not receiving iron supplementation, should be screened for iron deficiency anemia at 6 months. Early use and overuse of cow's milk exacerbates existing causes of iron deficiency in infants. Less often, the problem is due to a severe blood loss or something interfering with the body's ability to absorb iron, such as a medication the infant is taking or a chronic illness involving the stomach or intestines.
- **Option C:** The American Academy of Pediatrics (AAP) recommends that a risk assessment be performed for lead exposure at well-child visits at 6 months, 9 months, 12 months, 18 months, 24 months, and at 3, 4, 5, and 6 years of age. A blood lead level test should be done only if the risk assessment comes back positive.
- **Option D:** The American Academy of Pediatrics (AAP), as part of an expert committee representing several national healthcare organizations, makes the following recommendation: routine obesity screening of children aged 2 years old or older should include a yearly assessment of weight. BMI changes should be monitored by calculating and plotting BMI on the Centers for Disease Control and Prevention (CDC) growth charts at every healthcare visit.

**35. The nurse implements which of the following for the client who is starting a Schilling test?**

- A. Administering methylcellulose (Citrucel).
- B. Starting a 24- to 48 hour urine specimen collection.
- C. Maintaining NPO status.
- D. Starting a 72 hour stool specimen collection.

**Correct Answer: B. Starting a 24- to 48 hour urine specimen collection.**

Urinary vitamin B12 levels are measured after the ingestion of radioactive vitamin B12. A 24-to 48- hour urine specimen is collected after administration of an oral dose of radioactively tagged vitamin B12 and an injection of non-radioactive vitamin B12. In a healthy state of absorption, excess vitamin B12 is excreted in the urine; in a malabsorption state or when the intrinsic factor is missing, vitamin B12 is excreted in the feces.

- **Option A:** Citrucel is a bulk-forming agent. Laxatives interfere with the absorption of vitamin B12. The patient is given radiolabeled vitamin B12 orally, following an intramuscular (IM) dose of unlabeled vitamin B12 one hour later. The injection is given to ensure that none of the radioactive B12 binds to any vitamin B12 depleted tissues, for example, the liver. A 24-hour urine collection monitors the absorption and the excretion.
- **Option C:** The client is NPO 8 to 12 hours before the test but is not NPO during the test. If the previous stage provides an abnormal result, stage 2 can be done to assess whether there is a deficiency of intrinsic factor. Stage 1 is repeated along with an oral dose of intrinsic factor. A 24-hour urine collection is carried out to assess the level of vitamin B12.
- **Option D:** A stool collection is not part of the Schilling test. If stool contaminates the urine collection, the results will be altered. During Stage 1, a healthy person will be able to absorb the administered radioactive B12 in their terminal ileum. It will then be excreted in the urine. If there are any defects with the cubam receptor at the terminal ileum, the result will show a low level of labeled cobalamin in urine as it will remain in the intestines and is likely to be excreted in feces.