

Kevin's Review - 35 NCLEX Practice Questions

1. Restraints can be used for all of the following purposes except to:

- A. Prevent a confused patient from removing tubes, such as feeding tubes, I.V. lines, and urinary catheters.
- B. Prevent a patient from falling out of bed or a chair.
- C. Discourage a patient from attempting to ambulate alone when he requires assistance for his safety.
- D. Prevent a patient from becoming confused or disoriented.

Correct Answer: D. Prevent a patient from becoming confused or disoriented.

By restricting a patient's movements, restraints may increase stress and lead to confusion, rather than prevent it. Restraints in a medical setting are devices that limit a patient's movement. Restraints can help keep a person from getting hurt or doing harm to others, including their caregivers. They are used as a last resort. The other choices are valid reasons for using restraints.

- **Option A:** Sometimes hospital patients who are confused need restraints so that they do not remove catheters and tubes that give them medicine and fluids. A nurse who has special training in using restraints can begin to use them. A doctor or another provider must also be told restraints are being used. The doctor or other provider must then sign a form to allow the continued use of restraints.
- **Option B:** Restraints may be used to keep a person in proper position and prevent movement or falling during surgery or while on a stretcher. Patients who are restrained also need to have their blood flow checked to make sure the restraints are not cutting off their blood flow. They also need to be watched carefully so that the restraints can be removed as soon as the situation is safe.
- **Option C:** Restraints can also be used to control or prevent harmful behavior or get out of bed, fall, and hurt themselves. Restraints should not cause harm or be used as punishment. Health care providers should first try other methods to control a patient and ensure safety. Restraints should be used only as a last choice.

2. Signs of hypoglycemia include:

- A. Fruity breath, thirst, flushed skin
- B. Diarrhea, itching, hypertension
- C. Anxiety, weakness, pallor, sweating
- D. Muscle ache, fever, thirst

Correct Answer: C. Anxiety, weakness, pallor, sweating

These are signs of hypoglycemia, along with restlessness, chills, confusion, nausea, hunger, tachycardia, weakness, or headache. Neurogenic signs and symptoms can either be adrenergic (tremor, palpitations, anxiety) or cholinergic (hunger, diaphoresis, paresthesias). Neurogenic symptoms and signs arise from sympathoadrenal involvement (either norepinephrine or acetylcholine release) in response to perceived hypoglycemia.

- **Option A:** These are signs of hyperglycemia. Symptoms of severe hyperglycemia include polyuria, polydipsia, and weight loss. As the patient's blood glucose increases, neurologic symptoms can develop. The patient may experience lethargy, focal neurologic deficits, or altered mental status. The patient can progress to a comatose state.

- **Option B:** Neuroglycopenic signs and symptoms are signs and symptoms that result from direct central nervous system (CNS) deprivation of glucose. These include behavioral changes, confusion, fatigue, seizure, coma, and potential death if not immediately corrected.
- **Option D:** Patients who have diabetes can present with symptoms of hypoglycemia at relatively higher serum glucose levels. The chronic hyperglycemia alters the “set point” in which neuroglycopenic/neurogenic symptoms become apparent. This phenomenon is referred to as “pseudohypoglycemia” because the serum glucose may be within normal range despite symptom presentation.

3. Which beliefs guide the constructivist paradigm? Select all that apply.

- A. There are multiple realities.
- B. The truth is objective.
- C. Context does not matter as much as truth.
- D. The participant (subject) is an active part of the study.
- E. Knowledge is gained through facts.

Correct Answer: A, D

Constructivism implies that reality is constructed through human interaction. Knowledge is a human product and is socially and culturally constructed. Individuals create meaning through their interactions with each other and with the environment in which they live. Social constructivism emphasizes the importance of culture and context in the process of knowledge construction and accumulation.

- **Option A:** In social constructivism, human interests are important for research purposes and knowledge is constructed through social interaction. Such knowledge is shared rather than an individual experience. According to constructivists, reality is a subjective creation. There is no single reality. Race, for example, is a social construct. Claiming that people are different based on the skin of their color is a (subjective) social construct.
- **Option B:** The aim of constructivist research is to understand particular situations or phenomena. Rich data is gathered from which ideas can be formed. The interaction of a number of people is researched, mostly to solve social problems of the target group.
- **Option C:** Learners add to and reshape their mental models of reality through social collaboration, building new understandings as they actively engage in learning experiences. Scaffolding, i.e. guidance and support, play an important role in the learning process. Research is, of course, largely a learning process and researchers on any level can use it to gain knowledge and to structure their research.
- **Option D:** Social constructivism is based on the principles of constructivism. Like positivism, social constructivism also uses observation to gather information. Different from positivism, the researcher is part of what is being observed in social constructivism.
- **Option E:** Positivism and constructivism are not the same. Both are epistemologies that present a different idea of what constitutes knowledge. However, positivism is a philosophical stance that emphasizes that knowledge should be gained through observable and measurable facts, whereas constructivism states that reality is a social construct.

4. A male client is diagnosed with primary herpes genitalis. Which instruction should the nurse provide?

- A. "Apply one applicator of terconazole intravaginally at bedtime for 7 days."
- B. "Apply one applicator of tioconazole intravaginally at bedtime for 7 days."
- C. "Apply acyclovir ointment to the lesions every 3 hours, six times a day for 7 days."
- D. "Apply sulconazole nitrate twice daily by massaging it gently into the lesions."

Correct Answer: C. "Apply acyclovir ointment to the lesions every 3 hours, six times a day for 7 days."

A client with primary herpes genitalis should apply topical acyclovir ointment in sufficient quantities to cover the lesions every 3 hours, six times a day for 7 days. The benefits of acyclovir include its low side effect profile, which allows it to be tolerated for long periods. Suppressive treatment with acyclovir can prevent or delay up to 80% of recurrences, thus reducing shedding by greater than 90%.

- **Option A:** Terconazole is used to treat vulvovaginal candidiasis. There are also prescription therapies: nystatin 100000-unit vaginal tablet for 14 nights, terconazole 80 mg one suppository vaginally for 3 nights, terconazole 0.8% cream vaginally for 3 nights, butoconazole 2% cream one applicator vaginally once (do not use during the first trimester of pregnancy).
- **Option B:** Tioconazole is used to treat vulvovaginal candidiasis. For vaginal candidiasis, several over the counter options are available: clotrimazole 1% cream vaginally for 7 to 14 nights, clotrimazole 2% cream vaginally for 3 nights, miconazole 2% cream vaginally for 7 nights, miconazole 4% cream vaginally for 3 nights, miconazole 100 mg suppository vaginally for 3 nights, tioconazole 6.5% ointment vaginally once.
- **Option D:** Sulconazole nitrate is used to treat tinea versicolor. Topical medications are considered the first-line therapy for pityriasis versicolor. Topical treatments are divided into nonspecific antifungal agents (sulfur plus salicylic acid, selenium sulfide 2.5%, and zinc-pyrithione) that primarily remove dead tissue and prevent further invasion, and specific antifungal drugs, that have fungicidal or fungistatic effects.

5. Which of the following metabolic effects may be a consequence of the administration of adrenergic agents?

- A. Hypoglycemia
- B. Metabolic acidosis
- C. Hyperglycemia
- D. Respiratory alkalosis

Correct Answer: C. Hyperglycemia

Epinephrine-induced hyperglycemia is markedly accentuated by concomitant elevations of glucagon and cortisol or in patients with diabetes. In both cases, the effect of epinephrine on hepatic glucose production is converted from a transient to a sustained response, thereby accounting for the exaggerated hyperglycemia.

- **Option A:** Hypoglycemia increases plasma levels of both epinephrine and norepinephrine. These catechols are released primarily from the adrenal medulla. However, it is well documented that hypoglycemic increases muscle sympathetic nerve activity, and that both alpha and beta-adrenergic activity increase.
- **Option B:** Drugs that selectively bind to alpha-2 receptors may cause hypotension, dry mouth, and sedation. At higher doses, respiratory depression and somnolence may occur. These effects are

most pronounced with clonidine and similarly acting drugs.

- **Option D:** Selective binding to beta-1 receptors commonly causes tachycardia, palpitations, and hypertension. Tachyarrhythmias and anxiety can also be common. High doses may induce dangerous arrhythmias. An example of a selective beta-1 receptor agonist is dobutamine.

6. Before administering a nasogastric feeding to a client hospitalized following a CVA, the nurse aspirates 40mL of residual. The nurse should:

- A. Replace the aspirate and administer the feeding
- B. Discard the aspirate and withhold the feeding
- C. Discard the aspirate and begin the feeding
- D. Replace the aspirate and withhold the feeding

Correct Answer: A. Replace the aspirate and administer the feeding

- Option A: The nurse should replace the aspirate and administer the feeding because the amount of aspirated was less than 50mL.
- Options B and C: The aspirate should not be discarded.
- Option D: The feeding should not be withheld.

7. Positive symptoms of schizophrenia include which of the following?A. Hallucinations, delusions, and disorganized thinking

- A. Flat affect, avolition, and anhedonia
- B. Somatic delusions, echolalia, and a flat affect
- C. Waxy flexibility, alogia, and apathy
- D. Hallucinations, delusions, and disorganized thinking

Correct Answer: A. Hallucinations, delusions, and disorganized thinking

The positive symptoms of schizophrenia are distortions of normal functioning. Option A lists the positive symptoms of schizophrenia. The typical positive symptoms of schizophrenia, such as hallucinatory experiences or fixed delusional beliefs, tend to be very upsetting and disruptive—not a positive experience at all for you or someone you care about who is experiencing them. From the outside, a person with positive symptoms might seem distracted, as if they are listening to something (psychiatrists call this “responding to internal stimuli”).

- **Option A:** A flat affect, alogia, apathy, avolition, and anhedonia refer to the negative symptoms. Negative symptoms list the diminution or loss of normal function. Avolition is a form of emotional or behavioral paralysis that can diminish your drive to participate in social activities and meet goals as well as your ability to complete daily tasks. Many people mistake this negative symptom for “laziness.” In Greek, an means “without” and hedone means “pleasure,” so in simple terms, anhedonia is a state where you are unable to feel pleasure. For people with schizophrenia, this can mean a lack of enthusiasm for activities, hobbies, passions, and pleasures once enjoyed.
- **Option B:** As negative symptoms indicate deficits in functioning they are also called deficit symptoms. Negative symptoms, including lack of emotion, decreased joy or motivation, delayed speech, and difficulty beginning and sustaining activities, can be scary and extremely debilitating.

The most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes negative symptoms as “restricted emotional expression and avolition,” and includes the following five types.

- **Option C:** Defined in DSM-5 as a “decrease in verbal output or verbal expressiveness,” alogia (also known as “poverty of speech”) can make it nearly impossible to communicate your thoughts and carry on a conversation. People with alogia may answer a monosyllabic “yes” or “no” when responding to questions and/or experience delays in getting the words out. It should be noted that these speech delays are not the same as those caused by positive symptoms like auditory or visual hallucinations and disorganized thinking.

8. The following are all nursing diagnoses appropriate for a gravida 1 para 0 in labor. Which one would be most appropriate for the primigravida as she completes the early phase of labor?

- A. Impaired gas exchange related to hyperventilation
- B. Alteration in placental perfusion related to maternal position
- C. Impaired physical mobility related to fetal-monitoring equipment
- D. Potential fluid volume deficit related to decreased fluid intake

Correct Answer: D. Potential fluid volume deficit related to decreased fluid intake

Clients admitted in labor are told not to eat during labor, to avoid nausea and vomiting. Ice chips may be allowed, but this amount of fluid might not be sufficient to prevent fluid volume deficit. Provide clear fluids (e.g., clear broth, tea, cranberry juice, jell-O, popsicles) and ice chips, as permitted. Helps promote hydration and may provide some calories for energy production.

- **Option A:** Impaired gas exchange related to hyperventilation would be indicated during the transition phase. Assess FHR changes during a contraction, noting decelerations and accelerations. Detects severity of hypoxia and possible cause. The fetus is vulnerable to potential injury during labor, owing to situations that reduce oxygen levels, such as cord prolapse, prolonged head compression, or uteroplacental insufficiency.
- **Option B:** Instead of Impaired physical mobility, Risk for ineffective coping would be more appropriate at this stage of labor. Reinforce breathing and relaxation techniques during contractions. Minimizes anxiety and provides a distraction, which may block the perception of pain impulses within the cerebral cortex.
- **Option C:** Fluid volume deficit is not correct in relation to the stem. Monitor intake & output. Note urine specific gravity. Encourage the client to empty the bladder at least once every 1 1/2–2 hr. Intake and output should be approximately equal, depending on degree of hydration. Concentration of urine increases as urine output decreases and may warn of dehydration. Fetal descent may be impaired if the bladder is distended.

9. Which of the following classes of drugs is most widely used in the treatment of cardiomyopathy?

- A. Antihypertensive
- B. Beta-adrenergic blockers
- C. Calcium channel blockers

D. Nitrates

Correct Answer: B. Beta-adrenergic blockers

By decreasing the heart rate and contractility, beta-adrenergic blockers improve myocardial filling and cardiac output, which are primary goals in the treatment of cardiomyopathy.

- **Option A:** Antihypertensives aren't usually indicated because they would decrease cardiac output in clients who are often already hypotensive. Many antihypertensive drugs have their primary action on systemic vascular resistance. Some of these drugs produce vasodilation by interfering with sympathetic adrenergic vascular tone (sympatholytics) or by blocking the formation of angiotensin II or its vascular receptors.
- **Option C:** Calcium channel blockers are sometimes used for the same reasons as beta-adrenergic blockers; however, they aren't as effective as beta-adrenergic blockers and cause increased hypotension. These channels are responsible for regulating the influx of calcium into muscle cells, which in turn stimulates smooth muscle contraction and cardiac myocyte contraction. In cardiac nodal tissue, L-type calcium channels play an important role in pacemaker currents, and in phase 0 of the action potentials.
- **Option D:** Nitrates aren't used because of their dilating effects, which would further compromise the myocardium. Nitrates exert their effects by dilating venous vessels, coronary arteries, and small arterioles; its maximal vasodilation is in the venous vessels.

10. Which of the following statements is TRUE of conception?

- A. Within 2-4 hours after intercourse, conception is possible in a fertile woman.
- B. Generally, fertilization is possible 4 days after ovulation.
- C. Conception is possible during menstruation in a long menstrual cycle.
- D. To avoid conception, intercourse must be avoided 5 days before and 3 days after menstruation.

Correct Answer: A. Within 2-4 hours after intercourse conception is possible in a fertile woman.

The sperms when deposited near the cervical os will be able to reach the fallopian tubes within 4 hours. If the woman has just ovulated (within 24 hours after the rupture of the Graafian follicle), fertilization is possible.

- **Option B:** Following ovulation, the egg is capable of fertilization for only 12 to 24 hours. Contact between the egg and sperm is random. Once the egg arrives at a specific portion of the tube, called the ampullary-isthmic junction, it rests for another 30 hours.
- **Option C:** Conception during menstrual period is unlikely because the ovulation time is several days away, decreasing any chances of getting pregnant during this time. However, there are exceptions. This applies to women who have a typical 28 to 30 day or longer cycle. If the woman has a shorter cycle, that means that she may ovulate earlier in the cycle.
- **Option D:** The likelihood of getting pregnant right before menstruation is extremely low. For women with a typical 28- to 30-day cycle or longer and their cycles are regular, it is fairly safe to say that ovulation occurred between Day 11 and Day 21. The egg is only available for 12 to 24 hours for conception.

11. Which client outcome is most appropriately achieved in a community approach setting in psychiatric nursing?

- A. The client performs activities of daily living and learns about crafts.
- B. The client is able to prevent aggressive behavior and monitors his use of medications.
- C. The client demonstrates self-reliance and social adaptation.
- D. The client experiences anxiety relief and learns about his symptoms.

Correct Answer: C. The client demonstrates self-reliance and social adaptation.

A therapeutic community is designed to help individuals assume responsibility for themselves, to learn how to respect and communicate with others, and to interact in a positive manner. The therapeutic community (TC) is an intensive and comprehensive treatment model developed for use with adults that has been modified successfully to treat adolescents with substance use disorders.

- **Option A:** The core goal of TCs has always been to promote a more holistic lifestyle and to identify areas for change such as negative personal behaviors—social, psychological, and emotional—that can lead to substance use. Residents make these changes by learning from fellow residents, staff members, and other figures of authority.
- **Option B:** The theoretical framework for the TC model considers substance use a symptom of much broader problems and, in a residential setting, uses a holistic treatment approach that has an impact on every aspect of a resident's life. Residents are distinguished along dimensions of psychological dysfunction and social deficits. The community provides habilitation, in which some TC residents develop socially productive lifestyles for the first time in their lives, and rehabilitation, in which other residents are helped to return to a previously known and practiced or rejected healthy lifestyle (De Leon, 1994).
- **Option D:** The remaining answer choices may be outcomes of psychiatric treatment, but the use of a therapeutic community approach is concerned with the promotion of self-reliance and cooperative adaptation to being with others. Part of the ecological approach to treatment in the TC is the creation of a safe and nurturing environment, within which adolescents can begin to experience healthy living. It is important for the staff of the TC to understand what type of home, neighborhood, and social environment from which each adolescent comes. Many adolescents enrolled in the TC come from unsafe physical and psychological environments; the characteristics of the home and neighborhood do not facilitate healthy living, and many risk factors may be environmental.

12. A postpartum client has a temperature of 101.4°F, with a uterus that is tender when palpated, remains unusually large, and not descending as normally expected. Which of the following should the nurse assess next?

- A. Lochia
- B. Breasts
- C. Incision
- D. Urine

Correct Answer: A. Lochia

The data suggests an infection of the endometrial lining of the uterus. The lochia may be decreased or copious, dark brown in appearance, and foul-smelling, providing further evidence of a possible infection.

- **Option B:** All the client's data indicate a uterine problem, not a breast problem. Typically, transient fever, usually 101°F, may be present with breast engorgement. Symptoms of mastitis include influenza-like manifestations.

- **Option C:** Localized infection of an episiotomy or C-section incision rarely causes systemic symptoms, and uterine involution would not be affected.
- **Option D:** The client data do not include dysuria, frequency, or urgency, symptoms of urinary tract infections, which would necessitate assessing the client's urine.

13. Which of the following positions would best aid breathing for a patient with acute pulmonary edema?

- A. Lying flat in bed
- B. Left side-lying position
- C. High Fowler's position
- D. Semi-Fowler's position

Correct Answer: C. High Fowler's position

High Fowler's position facilitates breathing by reducing venous return. Lying flat and side-lying positions worsen breathing and increase the heart's workload.

- **Option A:** Lying flat in bed would make the patient feel like he is "drowning".
- **Option C:** Side-lying position worsens breathing and increases the heart's workload.
- **Option D:** Semi-Fowler's may not be enough to improve the patient's breathing.

14. While assessing a newborn with cleft lip, the nurse would be alert that which of the following will most likely be compromised?

- A. Sucking ability
- B. Respiratory status
- C. Locomotion
- D. GI function

Correct Answer: A. Sucking ability

Because of the defect, the child will be unable to form the mouth adequately around the nipple, thereby requiring special devices to allow for feeding and sucking gratification.

- **Option B:** Respiratory status may be compromised if the child is fed improperly or during the postoperative period
- **Option C:** Locomotion would be a problem for the older infant because of the use of restraints.
- **Option D:** GI functioning is not compromised in the child with a cleft lip. One of the most immediate concerns after birth is feeding. While most babies with cleft lips can breast-feed, a cleft palate may make sucking difficult.

15. Important teaching for women in their childbearing years who are receiving antipsychotic medications includes which of the following?

- A. Increased incidence of dysmenorrhea while taking the drug.

- B. Occurrence of incomplete libido due to medication adverse effects.
- C. Continuing previous use of contraception during periods of amenorrhea.
- D. Instruction that amenorrhea is irreversible.

Correct Answer: C. Continuing previous use of contraception during periods of amenorrhea

Women may experience amenorrhea, which is reversible while taking antipsychotics. Amenorrhea doesn't indicate cessation of ovulation thus, the client can still be pregnant. Antipsychotic-induced menstrual dysfunction has prevalence rates of approximately 45% for oligomenorrhoea/amenorrhoea and 19% for galactorrhoea (Kinon 2003; Wieck 2003). An illness-related underfunction of the hypothalamic-pituitary-gonadal axis in women with schizophrenia may also contribute to menstrual irregularities. This review will focus on amenorrhoea. In an extensive study conducted in India, the prevalence of amenorrhoea in women on risperidone was 60%.

- **Option A:** Other adverse effects can affect women of reproductive age, who have an increased risk of experiencing endocrinological, metabolic and neurological adverse effects from antipsychotic medication (Seeman 2009). Menstrual dysfunction such as amenorrhoea (absence of menstruation) and oligomenorrhoea (infrequent or light menstruation) has multiple causes which can include developmental problems with reproductive organs, thyroid disease, stress, excessive weight loss, and hyperprolactinemia (high levels of prolactin production).
- **Option B:** Antipsychotic-induced menstrual dysfunction, if not addressed, not only affects compliance with treatment in women suffering from schizophrenia or similar illnesses but also is a major cause of distress. Amenorrhoea can have physical (for example, bone mineral density changes) and psychological consequences that affect well-being (Haddad 2004).
- **Option D:** Typical antipsychotic medications and some of the novel antipsychotics frequently cause an elevation of plasma prolactin levels. Among the several side reactions related to hyperprolactinemia, are menstrual disorders such as amenorrhea or oligomenorrhoea which have not been adequately evaluated.

16. A high school student returns to school following a 3-week absence due to mononucleosis. The school nurse knows it will be important for the client:

- A. To complete antiviral medication for 7-14 days
- B. To avoid contact sports for 1–2 months
- C. To have a snack twice a day to prevent hypoglycemia
- D. To continue antibiotic therapy for 6 months

Correct Answer: B. To avoid contact sports for 1–2 months

- **Option B:** Mononucleosis is an infectious disease that is caused by the Epstein-Barr virus. The client recovering from mononucleosis should avoid contact sports and other activities that could result in injury or rupture of the spleen.
- **Options A and D:** Antibiotics and antivirals are not usually indicated for mononucleosis. Treatment is focused on relieving symptoms such as pain relief, hydration, and rest.
- **Option C:** Hypoglycemia is not associated with mononucleosis.

17. What is the primary function of ligaments in the musculoskeletal system?

- A. Connecting muscles to bones
- B. Connecting bones to bones
- C. Facilitating muscle contractions
- D. Providing cushioning between bones

- **Option A:** Connecting muscles to bones is the function of tendons.
- **Option C:** Facilitating muscle contractions is the function of muscle fibers.
- **Option D:** Providing cushioning between bones is the function of cartilage.

18. The nurse recognizes that urinary elimination changes may occur even in healthy older adults because of which of the following?

- A. The bladder distends and its capacity increases.
- B. Older adults ignore the need to void.
- C. Urine becomes more concentrated.
- D. The amount of urine retained after voiding increases.

Correct Answer: D. The amount of urine retained after voiding increases

The capacity of the bladder may decrease with age but the muscle is weaker and can cause urine to be retained. Muscle changes and changes in the reproductive system can affect bladder control. As the volume of urine held by the bladder increases, so too does the pressure therein. Wall pressure of 5 to 15 mm Hg creates a sensation of bladder fullness while 30 mm Hg and beyond is painful. The sensation of increasing bladder fullness is conveyed to the spinal cord via the pudendal and hypogastric nerves on both A-delta and C nerve fibers.

- **Option A:** The bladder wall changes. The elastic tissue becomes tough and the bladder becomes less stretchy. The bladder cannot hold as much urine as before. The urethra can become blocked. In women, this can be due to weakened muscles that cause the bladder or vagina to fall out of position (prolapse). In men, the urethra can become blocked by an enlarged prostate gland.
- **Option B:** Older adults don't ignore the urge to void and may have difficulty getting to the toilet in time. Bladder capacity changes throughout one's life. In children, an approximation of bladder volume can be calculated with the formula: (years of age + 2) x 30 mL. By adulthood, the average volume that a functional bladder can comfortably hold is between 300 and 400 mL.
- **Option C:** The kidney becomes less able to concentrate urine with age. Urination or micturition primarily functions in the excretion of metabolic products and toxic wastes. The urinary tract also serves as a storage vessel of the waste filtered from the kidneys. Urine stored in the bladder is released from the bladder through the urethra upon a complex network of neurological function.

19. A cyanotic client with an unknown diagnosis is admitted to the E.R. In relation to oxygen, the first nursing action would be to:

- A. Wait until the client's lab work is done.
- B. Not administer oxygen unless ordered by the physician.
- C. Administer oxygen at 2 L flow per minute.

D. Administer oxygen at 10 L flow per minute and check the client's nail beds.

Correct Answer: C. Administer oxygen at 2 L flow per minute.

Administer oxygen at 2 L/minute and no more, for if the client is emphysemic and receives too high a level of oxygen, he will develop CO₂ narcosis and the respiratory system will cease to function. With prolonged oxygen therapy there is an increase in blood oxygen level, which suppresses peripheral chemoreceptors; depresses ventilator drive and increase in PCO₂. High blood oxygen level may also disrupt the ventilation: perfusion balance (V/Q) and cause an increase in dead space to tidal volume ratio and increase in PCO₂.

- **Option A:** This is the 'gold standard' monitor of ventilation. Arterial blood gases are needed to obtain accurate data, in particular, evidence of hypoventilation (raised PaCO₂) as a reason for hypoxemia. Arterial blood gases may also give an indication of the metabolic effects of clinically important hypoxemia.
- **Option B:** Although history taking and clinical examination may clarify the diagnosis, oxygen at 40%–60% should be continued until blood gas results are available unless the patient is drowsy or is known to have had previous episodes of hypercapnic respiratory failure.
- **Option D:** Low intravascular volume either due to acute blood loss as in trauma can result in poor oxygen transport and tissue hypoxia. So, these patients should be given high concentration oxygen to maintain oxygen saturation above 90% until arrival at an emergency department. This can be achieved in most cases by the use of approximately 40%–60% oxygen via a medium concentration mask at a flow rate of 4–10 l/min.

20. Katherine is a young Unit Manager of the Pediatric Ward. Most of her staff nurses are senior to her, very articulate, confident, and sometimes aggressive. Katherine feels uncomfortable believing that she is the scapegoat of everything that goes wrong in her department. Which of the following is the best action that she must take?

- A. Identify the source of the conflict and understand the points of friction.
- B. Disregard what she feels and continues to work independently.
- C. Seek help from the Director of Nursing.
- D. Quit her job and look for another employment.

Correct Answer: A. Identify the source of the conflict and understand the points of friction

This involves a problem-solving approach, which addresses the root cause of the problem. Seek to understand the underlying emotions of the employees in conflict. Employers can manage workplace conflict by creating an organizational culture designed to preclude conflict as much as possible and by dealing promptly and equitably with conflicts that employees cannot resolve among themselves.

- **Option B:** Do not ignore conflict, and do not avoid taking steps to prevent it. Unresolved issues of interpersonal tension and conflict can create emotional stress for employees, politicize the workplace and divert attention from the organization's mission.
- **Option C:** Before escalating the conflict to the Director of Nursing, the unit manager should first try to deescalate the problem. If a manager has mechanisms in place to resolve conflict at its early stages, employees will generally see their employer as fair in their dealings with them and will likely be more satisfied with their jobs.

- **Option D:** If the manager does not act, conflicts will escalate into larger problems, discrimination and harassment complaints may increase, and the employer's reputation could be damaged. When employees mistrust management or perceive the organization as acting unfairly, turnover may increase. This can lead to recruiting and training expenses for new hires and the costs attributable to slippage of performance until new employees become fully proficient in their jobs.

21. ACEs participate in the renin-angiotensin-aldosterone system to have which of the following physiologic effects?

- A. Inhibit conversion of angiotensin II to angiotensin I.
- B. Vasoconstriction and sodium depletion.
- C. Promote sodium and water retention.
- D. Stimulate vasodilation and inhibit sodium depletion.

Correct Answer: C. Promote sodium and water retention.

Angiotensin is a potent vasoconstrictor that stimulates the release of aldosterone. Aldosterone release promotes sodium and water retention. The renin–angiotensin–aldosterone system (RAAS) is a critical regulator of blood volume and systemic vascular resistance. While the baroreceptor reflex responds in a short-term manner to decreased arterial pressure, the RAAS is responsible for more chronic alterations. It is composed of three major compounds: renin, angiotensin II, and aldosterone.

- **Option A:** The conversion of angiotensin I to II is not inhibited. The conversion of angiotensin I to angiotensin II is catalyzed by an enzyme called angiotensin-converting enzyme (ACE). ACE is found primarily in the vascular endothelium of the lungs and kidneys. After angiotensin I is converted to angiotensin II, it has effects on the kidney, adrenal cortex, arterioles, and brain by binding to angiotensin II type I (AT) and type II (AT) receptors.
- **Option B:** Aldosterone promotes sodium retention, not depletion. Aldosterone is a steroid hormone that causes an increase in sodium reabsorption and potassium excretion at the distal tubule and collecting duct of the nephron. Aldosterone works by stimulating the insertion of luminal Na channels and basolateral Na-K ATPase proteins. The net effect is an increased level of sodium reabsorption.
- **Option D:** The effect of angiotensin II on vasoconstriction takes place in systemic arterioles. Here, angiotensin II binds to G protein-coupled receptors, leading to a secondary messenger cascade that results in potent arteriolar vasoconstriction. This acts to increase total peripheral resistance, causing an increase in blood pressure.

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

- A. Ankle clonus is noted.
- B. The blood pressure decreases.
- C. Seizures do not occur.
- D. Scotomas are present.

Correct Answer: C. Seizures do not occur.

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

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

23. The parents of a young man with schizophrenia express feelings of responsibility and guilt for their son's problems. How can the nurse best educate the family?

- A. Acknowledge the parent's responsibility.
- B. Explain the biological nature of schizophrenia.
- C. Refer the family to a support group.
- D. Teach the parents various ways they must change.

Correct Answer: B. Explain the biological nature of schizophrenia.

The parents are feeling responsible and this inappropriate self-blame can be limited by supplying them with the facts about the biological basis of schizophrenia. Schizophrenia is a psychiatric disorder, which is characterized by slow functional deterioration and episodes of relapse or acute exacerbation of psychotic symptoms. The mean age of onset in early adulthood, deterioration in patients' activities of daily living and ability to sustain employment, and the propensity of the disorder to affect insight leave many patients requiring assistance and care for an extended period of time.

- **Option A:** Acknowledging the patient's responsibility is neither accurate nor helpful to the parents and would only reinforce their feelings of guilt. Caregivers of patients with childhood-onset chronic psychiatric disorders such as autism spectrum disorders, who are usually the parents, realize at an early stage that there will be a responsibility for them to care for their child for the rest of their lives in most cases. They, therefore, tend to adapt accordingly as the child grows up and experience a comparatively slow change to their lives and expectations regarding their ill child.
- **Option C:** Support groups are useful; however, the nurse needs to handle the parents' self-blame directly instead of making a referral for this problem. Patients with schizophrenia can often have a normal childhood and adolescence before suddenly, unexpectedly, and often dramatically becoming ill. Because of the age of onset, care responsibilities are suddenly thrust upon mostly parents, even before they have come to terms with the shock of the sudden, dramatic onset of the illness. It often comes at a time when they would expect their child to gain independence and when they themselves are at an age when retirement could have been considered. The lowering of expectation for the future of their child, along with the new, long-term care responsibilities, tends to weigh heavily on these parents, requiring a dramatic adjustment to their lives and subjecting them to unique symptoms and behaviors, which become increasingly difficult to manage, especially for people of their age.

- **Option D:** Teaching the parents various ways to change would reinforce the parental assumption of blame; although parents can learn about schizophrenia and what is helpful and not helpful, the approach suggested in this option implies the parents' behavior is at fault. Caring for family members with schizophrenia subjects caregivers to mostly negative experiences, which in turn negatively impact the caregivers themselves. These negative aspects experienced by patients' relatives as a consequence of their caregiving role are collectively known as 'burden'. Attempts have been made in the literature to better define 'burden' as the existence of serious psychosocial and emotional problems, difficulties or negative events, stressful situations or significant life changes that influence the family member of an ill relative.

24. A nurse is supervising a diverse group of elderly clients aged 75-90 years in a residential home setting. Many of these clients have varied health conditions, including vision and hearing impairments, limited mobility, and chronic illnesses that require medication. The nurse is assessing factors that could contribute to sensory deprivation in these clients. Which of the following reasons is most likely to increase the risk of sensory deprivation in this elderly group?

- A. Increased sensitivity to the side effects of medications.
- B. Decreased visual, auditory, and gustatory abilities.
- C. Isolation from their families and familiar surroundings.
- D. Decrease musculoskeletal function and mobility.

Correct Answer: B. Decreased visual, auditory, and gustatory abilities.

Gradual loss of sight, hearing, and taste interferes with normal functioning.

- **Option A:** The side effects of medications do not usually affect the senses in the elderly.
- **Option C:** Isolation is not the reason for developing sensory deprivation.
- **Option D:** Decrease in mobility and functioning does not cause sensory deprivation.

25. The nurse is teaching the client with polycythemia vera about prevention of complications of the disease. Which of the following statements by the client indicates a need for further teaching?

- A. "I will drink 500mL of fluid or less each day."
- B. "I will wear support hose when I am up."
- C. "I will use an electric razor for shaving."
- D. "I will eat foods low in iron."

Correct Answer: A. "I will drink 500mL of fluid or less each day."

The client with polycythemia vera is at risk for thrombus formation. Hydrating the client with at least 3L of fluid per day is important in preventing clot formation, so the statement to drink less than 500mL is incorrect.

- **Option B:** Wearing a support hose promotes venous return.

- **Option C:** The electric razor prevents bleeding due to injury.
- **Option D:** A diet low in iron is essential to preventing further red cell formation.

26. Lisa, a client with altered urinary function, is under the care of nurse Tine. Which intervention is appropriate to include when developing a plan of care for Lisa who is experiencing urinary dribbling?

- A. Inserting an indwelling Foley catheter.
- B. Having the client perform Kegel exercises.
- C. Keeping the skin clean and dry.
- D. Using pads or diapers on the client.

Correct Answer: B. Having the client perform Kegel exercises.

Kegel exercises, which help strengthen the muscles in the perineal area, are used to maintain urinary continence. To perform these exercises, the client tightens pelvic floor muscles for 4 seconds 10 times at least 20 times each day, stopping and starting the urinary flow.

- **Option A:** Inserting an indwelling Foley catheter increases the risk for infection and should be avoided. Begin bladder retraining per protocol when appropriate (fluids between certain hours, digital stimulation of trigger area, contraction of abdominal muscles, Credé's maneuver).
- **Option C:** Proper perineal hygiene decreases the risk of skin irritation or breakdown and the development of ascending infection. The nurse should encourage the client to develop a toileting schedule based on normal urinary habits. However, suggesting bathroom use every 8 hours may be too long an interval to wait.
- **Option D:** Pads or diapers should be used only as a resort. Refer to the urinary continence specialist as indicated. Collaboration with specialists is helpful for developing an individual plan of care to meet a patient's specific needs using the latest techniques, continence products.

27. Clinical manifestations of acute glomerulonephritis include which of the following?

- A. Chills and flank pain
- B. Oliguria and generalized edema
- C. Hematuria and proteinuria
- D. Dysuria and hypotension

Correct Answer: C. Hematuria and proteinuria

Hematuria and proteinuria indicate acute glomerulonephritis. These findings result from increased permeability of the glomerular membrane due to the antigen-antibody reaction. Generalized edema is seen most often in nephrosis. The most common presenting symptom is gross hematuria as it occurs in 30 to 50% of cases with acute PSGN; patients often describe their urine as smoky, tea-colored, cola-colored, or rusty. The hematuria can be described as postpharyngitic (hematuria seen after weeks of infection).

- **Option A:** Approximately 50% of children with PSGN are asymptomatic and are discovered accidentally during routine urine analysis. The classic triad of glomerulonephritis includes

hematuria, edema, and hypertension. Typically, patients give a history of a recent streptococcal infection such as pharyngitis, tonsillitis, or impetigo.

- **Option B:** The incidence of edema is seen in about 65-90% of the cases. Puffiness of the eyelids (periorbital edema) is typical for the nephritic syndrome. It is most prominent in the morning and tends to resolve at the end of the day. Generalized edema is also a common feature.
- **Option D:** Renal involvement is common and is transient with recovery in 1-2 weeks. Less than half of the patients experience oliguria. Depending on the severity of renal involvement, signs, and symptoms suggestive of anuric renal failure or life-threatening acid-base imbalance, electrolyte abnormalities (especially hyperkalemia), and fluid overload would require RRT. About 60-80% of the patients experience high blood pressure which typically resolves in 10 days.

28. Which of the following tasks should be included in the immediate postoperative management of a client who has undergone gastric resection?

- A. Monitoring gastric pH to detect complications.
- B. Assessing for bowel sounds.
- C. Providing nutritional support.
- D. Monitoring for symptoms of hemorrhage.

Correct Answer: D. Monitoring for symptoms of hemorrhage.

The client should be monitored closely for signs and symptoms of hemorrhage, such as bright red blood in the nasogastric tube suction, tachycardia, or a drop in blood pressure. Identify signs and symptoms requiring medical evaluation such as persistent nausea and vomiting or abdominal fullness; weight loss; diarrhea; foul-smelling fatty or tarry stools; bloody or coffee-ground vomitus or presence of bile, fever. Instruct the patient to report changes in pain characteristics.

- **Option A:** Gastric pH may be monitored to evaluate the need for histamine-2 receptor antagonists. Caution the patient to read labels and avoid products containing ASA, ibuprofen. This can cause gastric irritation and bleeding. Review medication purpose, dosage, and schedule, and possible side effects.
- **Option B:** Bowel sounds may not return for up to 72 hours postoperatively. Auscultate for resumption of bowel sounds and note passage of flatus. Peristalsis can be expected to return about the third postoperative day, signaling readiness to resume oral intake.
- **Option C:** Nutritional needs should be addressed soon after surgery. Monitor tolerance to fluid and food intake, noting abdominal distension, reports of increased pain, cramping, nausea, and vomiting. Avoid milk and high-carbohydrate foods in the diet because this may trigger dumping syndrome.

29. A nurse is providing instructions to a client receiving baclofen (Lioresal). Which of the following would be included in the teaching plan?

- A. Limit fluid intake.
- B. Hold the medication if diarrhea occurs.
- C. Restrict alcohol intake.
- D. Notify the physician if weakness occurs.

Correct Answer: C. Restrict alcohol intake.

Baclofen is a skeletal muscle relaxant. The client should be cautioned against the use of alcohol and other central nervous system depressants because baclofen potentiates the depressant activity of these agents.

- **Option A:** Limiting fluid intake is not necessary, but the client should be warned that urinary retention occurs.
- **Option B:** Constipation rather than diarrhea is a side effect.
- **Option D:** Weakness is related to a CNS effect that is prevalent during the early phase of the treatment and diminishes with continued medication use.

30. What statement indicates the client needs further education regarding skin grafting (allografting)?

- A. "Because the graft is my own skin, there is no chance it won't 'take.'"
- B. "For the first few days after surgery, the donor sites will be painful."
- C. "I will have some scarring in the area when the skin is removed for grafting."
- D. "I am still at risk for infection after the procedure."

Correct Answer: A. "Because the graft is my own skin, there is no chance it won't 'take.'"

Factors other than tissue type, such as circulation and infection, influence whether and how well a graft will work. The client should be prepared for the possibility that not all grafting procedures will be successful. Graft survival depends on the diffusion of nutrients and oxygen from the wound bed known as imbibition. Inosculation then follows when the blood vessels of the graft and from the wound bed grow together to make end-to-end contact. Lastly, neovascularization occurs when new blood vessels grow from the wound bed into the graft.

- **Option B:** The donor sites will be painful after the surgery. Silicone gel sheets, along with pressure dressings, have shown a dramatic decrease in pain, pruritis, and scar thickness six months after burn injury.
- **Option C:** There can be scarring in the area where the skin is removed for grafting. Burn scars are a common occurrence after skin grafting and can cause anxiety, depression, pain, itching, altered pigmentation, temperature intolerance, and decreased range of motion secondary to scar contracture. Scar formation is propagated by deficiencies in the biosynthetic and tissue degradation pathway during wound healing.
- **Option D:** The client is still at risk for infection. Early failure of graft survival is attributable to seroma and hematoma formation, which lifts the graft off the wound bed, preventing imbibition. Other factors that lead to graft failure include shearing forces, edematous tissue, and infected tissue.

31. A client has just been diagnosed with terminal cancer and is being transferred to home hospice care. The client's daughter tells the nurse, "I don't know what to say to my mother if she asks me if she's going to die." Which responses by the nurse would be appropriate? Select all that apply.

- A. "Tell your mother not to worry. She still has some time left."

- B. "Let's talk about your mother's illness and how it will progress."
- C. "You sound like you have some questions about your mother dying. Let's talk about that."
- D. "Don't worry, hospice will take care of your mother."
- E. "Tell me how you're feeling about your mother dying."

Correct Answer: B, C, & E.

Talking about death is an uncomfortable situation. Conveying information clearly and openly can alleviate fears and strengthen the individual's sense of control. Encouraging verbalization of feelings helps build a therapeutic relationship based on trust and reduces anxiety. Advising the daughter not to worry, or having her tell her mother that, ignores her feelings and discourages further communication.

- **Option A:** The nurse needs to recognize and understand these events as a time during which an individual or family member incorporates his or her strength to go on to the next stage of grief.
- **Option B:** Support the client and significant others share mutual fears, concerns, plans, and hopes for each other. Keeping secrets won't do any help during this time. These times of stress can be used as an opportunity for growth and family development.
- **Option C:** Communicate therapeutically with the client and family members and allow them to verbalize feelings. Sharing feelings with a healthcare provider may help the client and significant others find significance in the experience of loss.
- **Option D:** Acknowledge the client's and significant other's need to review the loss experience. In this way, the client and family members integrate the event into their experience.
- **Option E:** Review and point out strengths and progress to date. Reviewing the client's progress is very helpful and provides perspective in the whole process.

32. A 65 years old client is in the first stage of Alzheimer's disease. Nurse Patricia should plan to focus this client's care on:

- A. Offering nourishing finger foods to help maintain the client's nutritional status.
- B. Providing emotional support and individual counseling.
- C. Monitoring the client to prevent minor illnesses from turning into major problems.
- D. Suggesting new activities for the client and family to do together.

Correct Answer: B. Providing emotional support and individual counseling.

Clients in the first stage of Alzheimer's disease are aware that something is happening to them and may become overwhelmed and frightened. Therefore, nursing care typically focuses on providing emotional support and individual counseling. Identify possible support systems and ability to participate in social activities. Community resources are available for clients and families dealing with stages of AD that provide information and assistance.

- **Option A:** During this stage, offering nourishing finger foods helps clients to feed themselves and maintain adequate nutrition. Offer vegetables, fruits, whole grains, low-fat dairy products, and lean protein foods. Some fat is essential for health — but not all fats are equal. Go light on fats that are bad for heart health, such as butter, solid shortening, lard and fatty cuts of meats.
- **Option C:** The other options are appropriate during the second stage of Alzheimer's disease when the client needs continuous monitoring to prevent minor illnesses from progressing into major problems and when maintaining adequate nutrition may become a challenge.

- **Option D:** Instruct the family to utilize distraction techniques, such as soothing music, going for a walk, or looking at picture albums if the patient has delusions. Distraction may be effective to calm the patient if stressful situations occur. Instruct the family to avoid having the patient watch violent TV shows. The patient cannot make a distinction between reality from fiction, and witnessing violent acts on the screen may be frightening to the patient.

33. The client has an order for a trough to be drawn on the client receiving Vancomycin. The nurse is aware that the nurse should contact the lab for them to collect the blood:

- A. 15 minutes after the infusion
- B. 30 minutes before the infusion
- C. 1 hour after the infusion
- D. 2 hours after the infusion

Correct Answer: B. 30 minutes before the infusion

A trough level should be drawn 30 minutes before the third or fourth dose. Draw trough specimens immediately before (?30 min) the next dose. Do not draw specimens until a steady state is achieved (ie, before the fourth dose). Draw peak specimens 1-2 hours after completion of intravenous dosage.

- **Option A:** Vancomycin is a glycopeptide antibiotic first isolated in 1953. It is a naturally occurring antimicrobial synthesized by soil bacterium *Amycolatopsis Orientalis*. Generic vancomycin became available and approved for use in 1958 and quickly became a common antibiotic in treating rapidly growing penicillin-resistant *Staphylococcus* species.
- **Option C:** The emergence of pseudomembranous enterocolitis, coupled with the spread of methicillin-resistant *Staphylococcus aureus* (MRSA), led to a resurgence in the use of vancomycin. It is used to treat serious, life-threatening infections by gram-positive bacteria that are resistant to less-toxic agents.
- **Option D:** General indications for measuring vancomycin trough levels include risk of nephrotoxicity and inadequate therapeutic response. Monitor at regular intervals. Specifically, trough levels should be measured in patients at risk for nephrotoxicity.

34. The nurse is checking the client's central venous pressure. The nurse should place the zero of the manometer at the:

- A. Phlebostatic axis
- B. PMI
- C. Erb's point
- D. Tail of Spence

Correct Answer: A. Phlebostatic axis

The phlebostatic axis is located at the fifth intercostal space midaxillary line and is the correct placement of the manometer. Phlebostatic axis is a point located by drawing an imaginary line from the fourth intercostal space at the sternum and finding its intersection with an imaginary line drawn down the center of the chest below the axillae.

- **Option B:** The PMI or point of maximal impulse is located at the fifth intercostal space midclavicular line. The point of maximal impulse, known as PMI, is the location at which the cardiac impulse can be best palpated on the chest wall. Frequently, this is at the fifth intercostal space at the midclavicular line. When dilated cardiomyopathy is present, this can be shifted laterally.
- **Option C:** Erb's point is the point at which you can hear the valves close simultaneously. "Erb's point" is also a term used in head and neck surgery to describe the point on the posterior border of the sternocleidomastoid muscle where the four superficial branches of the cervical plexus—the greater auricular, lesser occipital, transverse cervical, and supraclavicular nerves—emerge from behind the muscle.
- **Option D:** The Tail of Spence (the upper outer quadrant) is the area where most breast cancers are located and has nothing to do with the placement of a manometer. The tail of Spence (Spence's tail, axillary process, axillary tail) is an extension of the tissue of the breast that extends into the axilla. It is actually an extension of the upper lateral quadrant of the breast. It passes into the axilla through an opening in the deep fascia called foramen of Langer.

35. A 75-year-old male patient, a retired bartender with a history of mild alcohol consumption over the years, presents to the clinic with worsening symptoms of osteoarthritis in his hands and lower back. His primary care physician has prescribed acetaminophen as part of his pain management regimen. Given his medical history and the medication prescribed, the nurse plans her assessments. Which finding should the nurse prioritize when monitoring the patient?

- A. Blood pressure and heart rate
- B. Liver function tests
- C. Blood glucose levels
- D. Kidney function tests

Correct Answer: B. Liver function tests.

Acetaminophen is metabolized in the liver. Overdose or prolonged use, especially when combined with other factors such as alcohol consumption, can lead to hepatotoxicity or liver damage. Monitoring liver function is vital to ensure the patient is not experiencing adverse effects from the medication. Given the patient's history of alcohol consumption and the known hepatotoxic effects of acetaminophen, especially in overdose or prolonged use, liver function tests should be prioritized to ensure the patient's safety.

- **Options A:** While it's always important to monitor vital signs, especially in the elderly, acetaminophen does not have a direct significant effect on blood pressure and heart rate. Though they are essential parameters to monitor in general clinical care, they are not the primary concern with acetaminophen use.
- **Option C:** Acetaminophen doesn't have a direct impact on blood glucose levels. Monitoring blood glucose would be essential for diabetic patients or when medications known to affect glucose metabolism are prescribed.
- **Option D:** While many medications, especially NSAIDs, can affect kidney function, acetaminophen is primarily metabolized in the liver. However, as with all drugs, it's essential to monitor kidney function periodically, but it isn't the primary concern with acetaminophen use.