Kevin's Review - 35 NCLEX Practice Questions

1. A 68-year-old male patient was admitted to the cardiac unit following a recent myocardial infarction. The patient has a history of chronic venous insufficiency in both lower extremities. The nurse is preparing to provide a bed bath to the patient. The charge nurse advises the nurse to use long, firm strokes from the distal to the proximal areas when washing the patient's extremities. The primary reason for this technique is to:

A. Facilitate thorough examination and skin assessment.

B. Prevent musculoskeletal injuries for the nurse during the procedure.

C. Enhance venous blood return and reduce the risk of venous stasis.

D. Induce vasoconstriction, thereby augmenting peripheral circulation.

E. Stimulate the lymphatic system and reduce potential edema.

F. Offer therapeutic touch, which can calm the patient.

Correct Answer: C. Increases venous blood return.

Massaging or washing the extremities from distal to proximal areas promotes venous blood return towards the heart, which is especially important for patients with venous insufficiency. This technique counteracts the effects of gravity and can reduce the risk of venous stasis, which can be particularly beneficial in patients with compromised circulation like the one in this scenario. While some of the other choices have valid reasons within different contexts, the most direct and primary reason for this technique in this clinical scenario is to enhance venous return.

2. Glenda has cholelithiasis (gallstones). You expect her to complain of:

A. Pain in the right upper quadrant, radiating to the shoulder.

B. Pain in the right lower quadrant, with rebound tenderness.

C. Pain in the left upper quadrant, with shortness of breath.

D. Pain in the left lower quadrant, with mild cramping.

Correct Answer: A. Pain in the right upper quadrant, radiating to the shoulder.

The gallbladder is located in the RUQ and a frequent sign of gallstones is pain radiating to the shoulder. Patients with gallstone disease typically present with symptoms of biliary colic (intermittent episodes of constant, sharp, right upper quadrant (RUQ) abdominal pain often associated with nausea and vomiting), normal physical examination findings, and normal laboratory test results.

- **Option B:** Clinical symptoms and signs suggestive of appendicitis include a history of central abdominal pain migrating to the right lower quadrant (RLQ), anorexia, fever, and nausea/vomiting. On examination, RLQ tenderness, along with "classical" signs of peritoneal irritation (e.g., rebound tenderness, guarding, rigidity, referred pain), may be present.
- **Option C:** LUQ pain can originate from the chest, abdomen, diaphragm/peritoneum, or from general 'medical' causes. Note that intra-abdominal organs may not localize pain accurately and diaphragmatic pain can be referred to the shoulder tip.
- **Option D:** Crampy pain may be due to gas, indigestion, inflammation, or infection, or it may result from menstrual cramps, endometriosis, or pelvic inflammatory disease in women. Severe pain that comes in waves may be caused by kidney stones. Trauma to the body wall, hernias, and shingles

can also cause left lower quadrant pain.

3. Clients who are suspicious primarily use projection for which purpose:

A. Deny reality.

B. To deal with feelings and thoughts that are not acceptable.

C. To show resentment towards others.

D. Manipulate others.

Correct Answer: B. To deal with feelings and thoughts that are not acceptable.

Projection is a defense mechanism where one attributes one's feelings and inadequacies to others to reduce anxiety. Projection is a defense mechanism that involves taking our own unacceptable qualities or feelings and ascribing them to other people.

- **Option A:** This is not true in all instances of projection. Denial is an outright refusal to admit or recognize that something has occurred or is currently occurring. People living with drug or alcohol addiction often deny that they have a problem, while victims of traumatic events may deny that the event ever occurred.
- **Option C:** For example, if you have a strong dislike for someone, you might instead believe that they do not like you. Projection works by allowing the expression of the desire or impulse, but in a way that the ego cannot recognize, therefore reducing anxiety.
- **Option D:** This focuses on the self rather than others. Manipulation is using others for one's own advantage as a self defense mechanism. Manipulating others to try and get people to do what is desired for personal gain usually backfires eventually.

4. A 20-year-old male client was brought to the emergency department with a gunshot wound to the chest. In obtaining a history of the incident to determine possible injuries, the nurse should ask which of the following?

A. "How long ago did the incident occur?"

B. "What was the initial first aid done?"

C. "Where did the incident happen?"

D. "What direction did the bullet enter into the body?"

Correct Answer: D. "What direction did the bullet enter into the body?"

The entry point and direction of the bullet will predict the injuries of the client. In gunshot wounds, due to the high-intensity kinetic energy of the bullet, the pathway is often unpredictable in nature as well as the internal organs that may be affected. The most common organs injured are the small and large bowel at 50% and 40%, respectively.

- **Option A:** Personnel such as paramedics, police officers, or fire rescue who may have arrived at the scene of the injury may be utilized as sources of essential history regarding the etiology of the injury. This is especially important if the patient has altered mental status and is unable to relay the history of the incident.
- **Option B:** In penetrating abdominal injury due to a gunshot wound, initial treatment can be paramount for the prognosis and survival of the victim. The most important task for the initial

assessment is to assess the airway, breathing, and circulation of the patient and stop the bleeding.

- **Option C:** The other information is not as useful in determining which diagnostic studies and care are needed immediately. It is beneficial to gather information regarding the events surrounding the injury, including the environment, people involved, allergies, medications, and past medical history of the patient. Information about the caliber of the weapon, the number of shots heard, and any other extenuating circumstances may provide additional valuable information.

5. The nurse is performing colostomy irrigation on a male client. During the irrigation, the client begins to complain of abdominal cramps. What is the appropriate nursing action?

A. Notify the physician

B. Stop the irrigation temporarily

C. Increase the height of the irrigation

D. Medicate for pain and resume the irrigation

Correct Answer: B. Stop the irrigation temporarily.

If cramping occurs during colostomy irrigation, the irrigation flow is stopped temporarily and the client is allowed to rest. Cramping may occur from an infusion that is too rapid or is causing too much pressure. Have the colostomy patient sit on or near the toilet for about 15 to 20 minutes so the initial colostomy returns can drain into the toilet. (If the patient is on bed rest, allow the colostomy to drain into the bedpan.)

- **Option A:** The physician does not need to be notified. Unless contraindicated or otherwise ordered by the physician, it is best to establish a routine of daily irrigation in accordance with the patient's former bowel habits.
- **Option C:** Increasing the height of the irrigation will cause further discomfort. Hold the enema can approximately 12 inches above the bed and allow the solution to flow in slowly to avoid painful cramps usually caused by too rapid flow.
- **Option D:** Medicating the client for pain is not the appropriate action in this situation. If cramping occurs, slow down the flow rate and ask the patient to deep breathe until cramps subside. Cramping during irrigation may indicate that the flow is too fast or the water is too cold.

6. During shift report, the nurse learns that an older female client is unable to maintain continence after she senses the urge to void and becomes incontinent on the way to the bathroom. Which nursing diagnosis is most appropriate?

A. Stress urinary incontinence

B. Reflex urinary incontinence

C. Functional urinary incontinence

D. Urge urinary incontinence

Correct Answer: D. Urge urinary incontinence

The key phrase is "the urge to void" option one occurs when the client coughs, sneezes, or jars the body, resulting in accidental loss of urine. If one feels a strong urge to urinate even when the bladder

isn't full, the incontinence might be related to overactive bladder, sometimes called urge incontinence. This condition occurs in both men and women and involves an overwhelming urge to urinate immediately, frequently followed by loss of urine before the client can reach a bathroom. Even if one never has an accident, urgency and urinary frequency can interfere with work and a social life because of the need to keep running to the bathroom.

- **Option A:** Stress Urinary Incontinence (SUI) is when urine leaks out with sudden pressure on the bladder and urethra, causing the sphincter muscles to open briefly. With mild SUI, pressure may be from sudden forceful activities, like exercise, sneezing, laughing, or coughing.
- **Option B:** Reflex urinary incontinence occurs with involuntary loss of urine at somewhat predictable intervals when a specific bladder volume is reached. Reflex incontinence occurs when the bladder muscle contracts and urine leaks (often in large amounts) without any warning or urge. This can happen as a result of damage to the nerves that normally warn the brain that the bladder is filling.
- **Option C:** Functional urinary continence is the involuntary loss of urine related to impaired function. If the urinary tract is functioning properly but other illnesses or disabilities are preventing one from staying dry, the client might have what is known as functional incontinence. For example, if an illness rendered the client unaware or unconcerned about the need to find a toilet, the client would become incontinent. Medications, dementia, or mental illness can decrease awareness of the need to find a toilet.

7. The nurse is caring for a pregnant client. The client asks how the doctor could tell she was pregnant 'just by looking inside.' The nurse tells her the most likely explanation is that she had a positive Chadwick's sign, which is a

A. Bluish coloration of the cervix and vaginal walls

B. Pronounced softening of the cervix

C. Clot of very thick mucous that obstructs the cervical canal

D. Slight rotation of the uterus to the right

Correct Answer: A. Bluish coloration of the cervix and vaginal walls.

Chadwick sign is an early sign of pregnancy that is characterized by the bluish-purple coloration of the cervix and vaginal walls which occurs during the 4th week of pregnancy. It is caused by vasocongestion.

- **Option B:** Softening of the cervix is called the Goodell's sign. In medicine, Goodell's sign is an indication of pregnancy. It is a significant softening of the vaginal portion of the cervix from increased vascularization. This vascularization is a result of hypertrophy and engorgement of the vessels below the growing uterus. This sign occurs at approximately four weeks' gestation.
- **Option C:** An increase in vaginal discharge happens during the late third trimester. This thick mucous plug obstructs the cervical canal to prevent bacteria from entering the uterus. Towards the end of pregnancy, the amount of discharge increases further. In the last week or so of pregnancy, it may contain streaks of sticky, jelly-like pink mucus.
- **Option D:** With ascent from the pelvis, the uterus is slightly rotating to the right due to the presence of the rectosigmoid colon to the left side. This is called dextro-rotation.

8. For a client who is taking aspirin, which laboratory value should be reported to the physician?

A. Potassium 3.6 mEq/L

B. Hematocrit 41%

C. PT 14 seconds

D. BUN 20 mg/dL

Correct Answer: C. PT 14 seconds

When a client takes aspirin, monitor for increases in PT (normal range 11.0-12.5 seconds in 85%-100%). Also, monitor for possible decreases in potassium (normal range 3.5-5.0 mEq/L). If bleeding signs are noted, hematocrit should be monitored (normal range male 42%-52%, female 37%-47%). An elevated BUN could be seen if the client is having chronic gastrointestinal bleeding (normal range 10-20 mg/dL).

- **Option A:** Severity is categorized as mild when the serum potassium level is 3 to 3.4 mmol/L, moderate when the serum potassium level is 2.5 to 3 mmol/L, and severe when the serum potassium level is less than 2.5 mmol/L. Values obtained from plasma and serum may differ.
- **Option B:** HCT calculation is by dividing the lengths of the packed RBC layer by the length of total cells and plasma. As it is a ratio, it doesn't have any unit. Multiplying the ratio by 100 gives the accurate value, which is the accepted reporting style for HCT. A normal adult male shows an HCT of 40% to 54% and female shows 36% to 48%.
- **Option D:** BUN and creatinine levels that are within the ranges established by the laboratory performing the test suggest that the kidneys are functioning as they should. Increased BUN and creatinine levels may mean that the kidneys are not working as they should. This healthcare practitioner will consider other factors, such as the medical history and physical exam, to determine what condition, if any, may be affecting the kidneys.

9. The parents express apprehensions on their ability to care for their maladaptive child. The nurse identifies what nursing diagnosis:

A. Hopelessness

B. Altered parenting role

C. Altered family process

D. Ineffective coping

Correct Answer: B. Altered parenting role

Altered parenting role refers to the inability to create an environment that promotes optimum growth and development of the child. This is reflected in the parent's inability to care for the child. Provide an opportunity for parents to express their feelings, personal needs, and goals; avoid making judgmental remarks or comparing them to other parents. Supports parents in meeting their own needs.

- **Option A:** This refers to the lack of choices or inability to mobilize one's resources. Hopelessness can result when someone is going through difficult times or unpleasant experiences. A person may feel overwhelmed, trapped, or insecure, or may have a lot of self-doubts due to multiple stresses and losses. He or she might think that challenges are unconquerable or that there are no solutions to the problems and may not be able to mobilize the energy needed to act on his or her own behalf.

- **Option C:** Refers to change in family relationship and function. Altered family processes can be related to the impact that an ill family member can have on the family system. An illness, hospitalization, surgery, previous diagnoses, coping styles, culture can all place tremendous stress on a family and greatly interfere with keeping a family strong and united.
- **Option D:** Ineffective coping is the inability to form a valid appraisal of the stressor or inability to use available resources. Considering healthy ways to cope and getting the appropriate care and support can put problems in perspective and help stressful feelings and symptoms subside. Nurses, together with the patients, need to recognize stress accordingly to come up with the most effective yet proper strategies that work best for every patient.

10. A murmur is heard at the second left intercostal space along the left sternal border. Which valve area is this?

A. Aortic

B. Mitral

C. Pulmonic

D. Tricuspid

Correct Answer: C. Pulmonic

Abnormalities of the pulmonic valve are auscultated at the second left intercostal space along the left sternal border. Murmurs of the cardiac system develop due to alterations in blood flow or mechanical operation. Murmurs develop from a multitude of mechanisms. Typical cases include low blood viscosity from anemia, septal defects, failure of the ductus arteriosus to close in newborns, excessive hydrostatic pressure on cardiac valves causing valve failure, hypertrophic obstructive cardiomyopathy, and valvular specific pathologies.

- **Option A:** Aortic valve abnormalities are heard at the second intercostal space, to the right of the sternum. Aortic regurgitation, also known as aortic insufficiency, is a decrescendo blowing diastolic murmur heard best at the left lower sternal border, heard when blood flows retrograde into the left ventricle. This is most commonly seen in aortic root dilation and as sequelae of aortic stenosis.
- **Option B:** Mitral valve abnormalities are heard at the fifth intercostal space in the midclavicular line. Mitral stenosis is a diastolic murmur, best heard at the left 5th midclavicular line. It is associated with infective endocarditis and chronic rheumatic heart disease. Mitral regurgitation is a systolic murmur, best heard at the left 5th midclavicular line with possible radiation to the left axilla. It is commonly associated with infective endocarditis, rheumatic heart disease, congenital anomalies, and inferior wall myocardial infarctions.
- **Option D:** Tricuspid valve abnormalities are heard at the third and fourth intercostal spaces along the sternal border. Tricuspid stenosis is best heard at the lower left sternal border. Typical causes include infective endocarditis, seen in intravenous drug users, and carcinoid syndrome. Prolonged tricuspid stenosis may lead to right atrial enlargement and arrhythmias. Tricuspid regurgitation is systolic, auscultated at the lower left sternal border. It is also associated with intravenous drug users and carcinoid syndrome.

11. A nurse is preparing to care for a female client with esophageal varices who just had a Sengstaken-Blakemore tube inserted. The nurse gathers supplies, knowing that which of the following items must be kept at the bedside at all times?

A. An obturator

B. Kelly clamp

C. An irrigation set

D. A pair of scissors

Correct Answer: D. A pair of scissors

When the client has a Sengstaken-Blakemore tube, a pair of scissors must be kept at the client's bedside at all times. The client needs to be observed for sudden respiratory distress, which occurs if the gastric balloon ruptures and the entire tube moves upward. If this occurs, the nurse immediately cuts all balloon lumens and removes the tube. Sengstaken-Blakemore tube placement is indicated for unstable patients with uncontrolled hemorrhage. Sengstaken-Blakemore tube placements can temporarily control the hemorrhage.

- **Option A:** An obturator is kept at the bedside of a client with a tracheostomy. This is a piece of rigid plastic, silicone, or metal that fits inside the outer cannula when a tracheostomy tube is being inserted. It helps guide the tracheostomy tube into place, causing less damage to the tissues.
- **Option B:** A Kelly clamp is kept at the bedside of a client with a tracheostomy. Clinicians must be prepared in case of emergency as the medical condition of a patient with tracheostomy and/or mechanical ventilation may change quickly. Emergency equipment is necessary at the bedside as well as during the transportation.
- **Option C:** An irrigation set may be kept at the bedside, but it is not the priority item. Airway protection remains the foremost focus. If the patient is requiring a Sengstaken-Blakemore tube placement, they have likely already been intubated for airway protection, but if not, endotracheal intubation should be performed prior to placement. Following intubation, the patient should be placed in the supine position with the head of the bed elevated to 45 degrees.

12. Which of the following is being used when the mother of a hospitalized child calls the student nurse and states, "You idiot, you have no idea how to care for my sick child"?

A. Displacement

B. Projection

C. Repression

D. Psychosis

Correct Answer: B. Projection

The mother is using projection, the defense mechanism used when a person attributes his or her own undesirable traits to another.

- **Option A:** Displacement is the transfer of emotion onto an unrelated object, such as when the mother would kick a chair or bang the door shut.
- **Option C:** Repression is the submerging of painful ideas into the unconscious. Repression is an unconscious mechanism employed by the ego to keep disturbing or threatening thoughts from becoming conscious.
- **Option D:** Psychosis is a state of being out of touch with reality. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty

understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear).

13. Prior to administering chlorpromazine (Thorazine) to an agitated client, the nurse should:

A. Assess skin color and sclera

B. Assess the radial pulse

C. Take the client's blood pressure

D. Ask the client to void

Correct Answer: C. Take the client's blood pressure

Because chlorpromazine (Thorazine) can cause a significant hypotensive effect (and possible client injury), the nurse must assess the client's blood pressure (lying, sitting, and standing) before administering this drug. When administered as intramuscular or intravenous injections, it may cause hypotension and headache. Prolonged use of chlorpromazine may cause corneal deposits and lens opacity. It may prolong the QT interval.

- **Option A:** If the client had taken the drug previously, the nurse would also need to assess the skin color and sclera for signs of jaundice, a possible drug side effect; however, based on the information given here, there is no evidence that the client has received chlorpromazine before.
- **Option B:** The hepatic P450 enzyme CYP2D6 metabolizes the drug, and its half-life is approximately 30 hours. It gets excreted from the body via urine and in bile. Studies have shown the correlation between chlorpromazine's therapeutic level and the improvement of the psychiatric symptoms. Researchers have noted that the patients receiving chronic treatment with chlorpromazine have lower plasma levels as compared to the patients acutely treated on an oral dose of chlorpromazine.
- **Option D:** Although the drug can cause urine retention, asking the client to avoid will not alter this anticholinergic effect. Chlorpromazine is a low-potency antipsychotic that mainly causes non-neurologic side effects. It is highly lipid-soluble and stored in body fats, thus very slow to be removed from the body. Being a low-potency typical antipsychotic, it primarily causes dry mouth, dizziness, urine retention, blurred vision, and constipation by blocking the muscarinic receptors. There is a risk of angle-closure glaucoma in the elderly. It also causes sedation due to the blockade of histamine H1 receptors.

14. After the nurse has explained the purpose of and schedule for chemotherapy to a 23-year-old patient who recently received a diagnosis of acute leukemia, the patient asks the nurse to repeat the information. Based on this assessment, which nursing diagnosis is most likely for the patient?

A. Risk for ineffective health maintenance related to anxiety about new leukemia diagnosis

B. Knowledge deficit: chemotherapy related to a lack of interest in learning about treatment

C. Risk for ineffective adherence to treatment related to denial of need for chemotherapy

D. Acute confusion related to infiltration of leukemia cells into the central nervous system

Correct Answer: A. Risk for ineffective health maintenance related to anxiety about new leukemia diagnosis

- **Option A:** The patient who has a new cancer diagnosis is likely to have high anxiety, which may impact learning and require that the nurse repeat and reinforce information.
- **Options B and C:** The patient asks for the information to be repeated, indicating that lack of interest in learning and denial are not etiologic factors.
- **Option D:** The patient's history of a recent diagnosis suggests that infiltration of the leukemia is not a likely cause of the confusion.

15. Barbiturates are usually not given for pain relief during active labor for which of the following reasons?

A. The neonatal effects include hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days.

B. These drugs readily cross the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection.

C. They rapidly transfer across the placenta, and the lack of an antagonist makes them generally inappropriate during labor.

D. Adverse reactions may include maternal hypotension, allergic or toxic reaction, or partial or total respiratory failure.

Correct Answer: C. They rapidly transfer across the placenta, and the lack of an antagonist makes them generally inappropriate during labor.

Barbiturates are rapidly transferred across the placental barrier, and the lack of an antagonist makes them generally inappropriate during active labor.

- **Option A:** Neonatal side effects of barbiturates include central nervous system depression, prolonged drowsiness, delayed establishment of feeding (e.g. due to poor sucking reflex or poor sucking pressure). Tranquilizers are associated with neonatal effects such as hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days.
- **Option B:** Narcotic analgesic readily crosses the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection.
- **Option D:** Regional anesthesia is associated with adverse reactions such as maternal hypotension, allergic or toxic reaction, or partial or total respiratory failure.

16. A client is admitted to the hospital with benign prostatic hyperplasia, the nurse most relevant assessment would be:

A. Flank pain radiating in the groin

B. Distention of the lower abdomen

C. Perineal edema

D. Urethral discharge

Correct Answer: B. Distention of the lower abdomen

This indicates that the bladder is distended with urine, therefore palpable. In the elective setting, the examination should include abdominal examination (looking for a palpable bladder/loin pain) and examination of external genitalia (meatal stenosis or phimosis). Benign prostatic hyperplasia (BPH) refers to the nonmalignant growth or hyperplasia of prostate tissue and is a common cause of lower urinary tract symptoms in men.

- **Option A:** Flank pain is a vague symptom associated with urinary system infections. Lower urinary tract symptoms can be divided into storage (frequency, nocturia, urgency) and voiding symptoms (stream, straining, hesitancy, prolonged micturition) and can help establish other causes of urinary symptoms such as urinary tract infections/overactive bladder, in addition to determining the site affected (bladder vs. prostate).
- **Option C:** BPH only occurs in older men. Disease prevalence has been shown to increase with advancing age. Indeed the histological prevalence of BPH at autopsy is as high as 50% to 60% for males in their 60's, increasing to 80% to 90% of those over 70 years of age.
- **Option D:** Urethral discharge is not a manifestation of BPH. Men with BPH are likely to report predominant symptoms of nocturia, poor stream, hesitancy, or prolonged micturition. The examination should then conclude with a digital rectal examination making a note in particular of the size, shape (how many lobes), and consistency (smooth/hard/nodular) of the prostate (BPH is characterized by a smooth enlarged prostate).

17. A pediatric client with asthma has just received omalizumab (Xolair). The nurse determines that the client might be suffering a life-threatening effect in which of the following?

A. Headache and dizziness

B. Nausea and vomiting

C. Swelling of the tongue

D. Joint pain

Correct Answer: C. Swelling of the lips

Omalizumab (Xolair) Xolair is an anti-inflammatory that is used to treat moderate to severe asthma that is caused by allergies. An anaphylactic reaction may happen such as flushing, rash, wheezing, or swelling of the face, lips, or tongue.

- **Options A, B, & D:** These are some of the side effects but will not alert the nurse for an anaphylactic reaction.

18. Which of the following organisms is the most common cause of urinary tract infection (UTI) in children?

A. Klebsiella

B. Staphylococcus

C. Escherichia coli

D. Pseudomonas

Correct Answer: C. Escherichia coli

E. coli is the most common organism associated with the development of UTI. Escherichia coli is the most common organism in uncomplicated UTI by a large margin. Pathogenic bacteria ascend from the perineum, causing the UTI. Women have shorter urethras than men and therefore are far more susceptible to UTI. Very few uncomplicated UTIs are caused by blood-borne bacteria.

- **Option A:** E.coli causes the vast majority of UTIs but other organisms of importance include proteus, klebsiella, and enterococcus. The diagnosis of UTI is made from the clinical history (symptoms) and urinalysis with confirmation by a urine culture, but the proper collection of the urine sample is important.
- **Option B:** Staphylococcus aureus is a major bacterial human pathogen that causes a wide variety of clinical manifestations. Infections are common both in community-acquired as well as hospital-acquired settings and treatment remains challenging to manage due to the emergence of multi-drug resistant strains such as MRSA (Methicillin-Resistant Staphylococcus aureus).
- **Option D:** Although Klebsiella, Staphylococcus, and Pseudomonas species may cause UTIs, the incidence of UTIs related to each is less than that for E. coli. Pseudomonas aeruginosa is commonly found in the environment, particularly in freshwater. It is commonly an opportunistic pathogen and is also an important cause of nosocomial infections like ventilator-associated pneumonia, catheter-associated urinary tract infections, and others.

19. A 16-year old patient with cystic fibrosis is admitted with increased shortness of breath and possible pneumonia. Which nursing activity is most important to include in the patient's care?

A. Perform postural drainage and chest physiotherapy every 4 hours.

B. Allow the patient to decide whether she needs aerosolized medications.

C. Place the patient in a private room to decrease the risk of further infection.

D. Plan activities to allow at least 8 hours of uninterrupted sleep.

Correct Answer: A. Perform postural drainage and chest physiotherapy every 4 hours.

Airway clearance techniques are critical for patients with cystic fibrosis and should take priority over other activities. The Cystic Fibrosis Transmembrane Conductance Regulator defect causes mucus to become dehydrated. Secretions in cystic fibrosis are generally thick, sticky, and more difficult to clear. Frequent airway clearance is a mainstay in the treatment of acute exacerbations, as well as an integral part of health maintenance in cystic fibrosis.

- **Option B:** Although allowing more independent decision-making is important for adolescents, the physiologic need for an improved respiratory function takes precedence at this time. Collaborate with the client and staff to ensure that the schedule for therapy is amenable to all and does not interfere with meals, rest times, or medications.
- **Option C:** A private room may be desirable for the patient but is not necessary. Ensure that clients with CF are not cohorted. The cohorting of clients with CF is not recommended based on published CF Infection Control Consensus Guidelines.
- **Option D:** With increased shortness of breath, it will be more important that the patient has frequent respiratory treatments than 8 hours of sleep. Infection, inflammation, and mucous plugging will cause an increase in the respiratory effort to compensate for airway obstruction. As moving air into and out of the lungs becomes more difficult, the breathing pattern alters to include the use of accessory muscles and retractions.

20. The nurse is caring for the client with a 5-year-old diagnosis of plumbism. Which information in the health history is most likely related to the development of plumbism?

A. The client has traveled out of the country in the last 6 months.

B. The client's parents are skilled stained-glass artists.

C. The client lives in a house built in one.

D. The client has several brothers and sisters.

Correct Answer: B. The client's parents are skilled stained-glass artists.

Plumbism is lead poisoning. One factor associated with the consumption of lead is eating from pottery made in Central America or Mexico that is unfired. The child lives in a house built after 1976 (this is when lead was taken out of paint), and the parents make stained glass as a hobby. Stained glass is put together with lead, which can drop on the work area, where the child can consume the lead beads.

- **Option A:** Traveling out of the country does not increase the risk of plumbism. Because lead is not biodegradable, it demonstrates remarkable environmental persistence. Despite the fact that the amount of lead in paint intended for use in or on residential buildings, furniture, or children's toys in the United States has been restricted to 0.06% since 1978 and was further reduced to 0.009% in 2008, lead-based paint continues to be a major source of lead exposure in young children.
- **Option C:** The house was built after the lead was removed with the paint. Several million young children in the United States live in older homes in which lead-based paint was previously used, and as this old paint ages, it peels, flakes, and crumbles into dust that settles on the interior surfaces of homes and in the soil surrounding the exterior of the home. The dust and soil containing these tiny paint particles inevitably make their way into children's mouths as a result of normal childhood exploratory hand-to-mouth behavior.
- **Option D:** Having several siblings is unrelated to the stem. A variety of occupations and hobbies may expose adults to lead, and working parents may inadvertently bring lead home where they can expose their children second-hand. Some of the highest risk occupations and hobbies include metal welding, battery manufacturing, and recycling, shipbuilding and shipbreaking, firing range use or instruction as well as bullet salvaging, lead smelting and refining, painting and construction work, and pipefitting and plumbing.

21. A male client who has been treated for chronic renal failure (CRF) is ready for discharge. Nurse Billy should reinforce which dietary instruction?

A. "Be sure to eat meat at every meal."

B. "Monitor your fruit intake, and eat plenty of bananas."

C. "Increase your carbohydrate intake."

D. "Drink plenty of fluids, and use a salt substitute."

Correct Answer: C. "Increase your carbohydrate intake."

In a client with CRF, unrestricted intake of sodium, protein, potassium, and fluid may lead to a dangerous accumulation of electrolytes and protein metabolic products, such as amino acids and ammonia. Therefore, the client must limit intake of sodium; meat, which is high in protein; bananas, which are high in potassium; and fluid, because the failing kidneys can't secrete adequate urine.

- **Option A:** The amount of protein the client should have depended on his body size, activity level, and health concerns. Some doctors recommend that people with kidney disease limit protein or change their source of protein. This is because a diet very high in protein can make the kidneys work harder and may cause more damage.
- **Option B:** Healthy sources of carbohydrates include fruits and vegetables. Unhealthy sources of carbohydrates include sugar, honey, hard candies, soft drinks, and other sugary drinks. Some carbohydrates are high in potassium and phosphorus, which the client may need to limit depending on his stage of kidney disease.
- **Option D:** Sodium (salt) is a mineral found in almost all foods. Too much sodium can make the client thirsty, which can lead to swelling and raise blood pressure. This can damage the kidneys more and make the heart work harder. Salt substitutes are high in potassium and should be avoided. Extra carbohydrates are needed to prevent protein catabolism.

22. A nurse is providing health teachings regarding antiplatelet medications. Which of the following is not true regarding the use of this medication?

A. Antiplatelet medication inhibits the aggregation of platelets in the clotting process, thereby prolonging bleeding time.

B. Antiplatelet medications cannot be used with anticoagulants.

C. Take the medication with food to prevent gastrointestinal upset.

D. A routine bleeding time is monitored during the therapy.

Correct Answer: B. Antiplatelet medications cannot be used with anticoagulants.

Antiplatelet and anticoagulant therapies are effective in keeping a clot from forming or stopping the growth of one.

- **Option A:** Antiplatelet medication inhibits the aggregation of platelets in the clotting process, thereby prolonging bleeding time.
- **Option C:** These medications are taken with food to prevent gastrointestinal side effects such as stomach pain, nausea, and diarrhea.
- **Option D:** Bleeding time is monitored to determine the effectiveness of the medication.

23. Nurse Trixie is preparing to perform tracheostomy care. Prior to the beginning of the procedure, the nurse performs which action?

A. Tells the client to raise two fingers to indicate pain or distress.

B. Changes twill tape holding the tracheostomy and place.

C. Cleans the incision site.

D. Check the tightness of the ties and knot.

Correct Answer: A. Tells the client to raise two fingers to indicate pain or distress.

Prior to starting the procedure, it is important to develop a means of communication by which the client can express pain or discomfort. Tracheostomy is a procedure where an artificial airway is established surgically or percutaneously in the cervical trachea. The term “tracheostomy” has evolved to refer to both the procedure as well as the clinical condition of having a tracheostomy tube. With the increasing

number of patients with tracheostomy, safe caring requires knowledge and competencies in dealing with routine care, weaning, decannulation, as well as tracheostomy-related emergencies.

- **Option B:** The twill tape is not changed until after performing tracheostomy care. Remove any sutures or ties attached to the tracheostomy tube and patient. When doing this, the assistant must stabilize the flange at all times to prevent premature removal.
- **Option C:** Cleaning the incision should be done after cleaning the inner cannula. Inspect the stoma for signs of infection, presence of granulation tissue, bleeding, wound breakdown, and adequacy of a tract. Clean the area with moist gauze (with normal saline or hydrogen peroxide) followed by dry gauze while ensuring no foreign body enters the airway. Stay sutures, if present, may be used gently to pull up the trachea to provide exposure.
- **Option D:** Checking the tightness of the ties and knot is done after applying new twill tape. Make sure the trach ties are not too tight and should be able to pass an index finger in between the trach ties and neck.

24. A client whose husband just left her has a recurrence of anorexia nervosa. Nurse Vic caring for her realizes that this exacerbation of anorexia nervosa results from the client's effort to:

A. Manipulate her husband.

B. Gain control of one part of her life.

C. Commit suicide.

D. Live up to her mother's expectations.

Correct Answer: B. Gain control of one part of her life

By refusing to eat, a client with anorexia nervosa is unconsciously attempting to gain control over the only part of her life she feels she can control. Assist the patient to confront changes associated with puberty and sexual fears. Provide sex education as necessary. Encourage personal development program, preferably in a group setting. Provide information about the proper application of makeup and grooming. Learning about methods to enhance personal appearance may be helpful to a long-range sense of self-esteem and image. Feedback from others can promote feelings of self-worth.

- **Option A:** This eating disorder doesn't represent an attempt to manipulate others or live up to their expectations (although anorexia nervosa has a high incidence in families that emphasize achievement). Assist the patient to assume control in areas other than dieting and weight loss such as management of their own daily activities, work, and leisure choices. Feelings of personal ineffectiveness, low self-esteem, and perfectionism are often part of the problem. The patient feels helpless to change and requires assistance to problem-solve methods of control in life situations.
- **Option C:** The client isn't attempting to commit suicide through starvation; rather, by refusing to eat, she is expressing feelings of despair, worthlessness, and hopelessness. Help the patient formulate goals for self (not related to eating) and create a manageable plan to reach those goals, one at a time, progressing from simple to more complex. Patients need to recognize the ability to control other areas in life and may need to learn problem-solving skills to achieve this control. Setting realistic goals fosters success.
- **Option D:** Encourage patients to take charge of their own lives in a more healthful way by making their own decisions and accepting self as she or he is at this moment (including inadequacies and strengths). Patient often does not know what she or he may want for themselves. Parents (mother) often make decisions for the patient. Patient may also believe she or he has to be the best in

everything and holds self-responsible for being perfect.

25. Nurses agree to be advocates for their patients. The practice of advocacy calls for the nurse to:

A. Seek out the nursing supervisor in conflicting situations.

B. Work to understand the law as it applies to the client's clinical condition.

C. Assess the client's point of view and prepare to articulate this point of view.

D. Document all clinical changes in the medical record in a timely manner.

Correct Answer: C. Assess the client's point of view and prepare to articulate this point of view.

Nurses strengthen their ability to advocate for a client when nurses are able to identify personal values and then accurately identify the values of the client and articulate the client's point of view. Nurse advocates support the patient's best interests while respecting the family's important role. They attend healthcare team meetings with the patient and family to clarify any communication problems and ensure information from the healthcare team is complete and correct.

- **Option A:** Throughout the treatment process, the nurse follows the progress of the patient and acts accordingly with the patient's best interests in mind. The care provided by a nurse extends beyond the administration of medications and other therapies. They are responsible for the holistic care of patients, which encompasses the psychosocial, developmental, cultural, and spiritual needs of the individual.
- **Option B:** Nurses are also responsible for ensuring that patients are able to understand their health, illnesses, medications, and treatments to the best of their ability. This is of the essence when patients are discharged from the hospital and need to take control of their own treatments.
- **Option D:** A nurse is directly involved in the decision-making process for the treatment of patients. It is important that they are able to think critically when assessing patient signs and identifying potential problems so that they can make the appropriate recommendations and actions.

26. A patient is scheduled for a magnetic resonance imaging (MRI) scan for suspected lung cancer. Which of the following is a contraindication to the study for this patient?

A. The patient is allergic to shellfish.

B. The patient has a pacemaker.

C. The patient suffers from claustrophobia.

D. The patient takes antipsychotic medication.

Correct Answer: B. The patient has a pacemaker

The implanted pacemaker will interfere with the magnetic fields of the MRI scanner and may be deactivated by them. Patients with cardiac implantable electronic devices or CIED are at risk for inappropriate device therapy, device heating/movement, and arrhythmia during MRI. These patients must be scheduled in a CIED blocked slot or scheduled with electrophysiology nurse or technician support. But nowadays MRI conditional cardiac implantable electronic devices are widely available.

- **Option A:** Shellfish/iodine allergy is not a contraindication because the contrast used in MRI scanning is not iodine-based. MRI contrast agents are gadolinium chelates with different stability, viscosity, and osmolality. Gadolinium is a relatively very safe contrast; however, it rarely might cause allergic reactions in patients.
- **Options C:** Open MRI scanners and anti-anxiety medications are available for patients with claustrophobia. Claustrophobic patients might refuse to complete the MRI scan and need sedation. These patients need to be well informed about the MRI scan procedure. The recommendation is that a physician has a discussion with them about the details in advance. Using Larger and opener MRI systems might be helpful in claustrophobic patients.
- **Option D:** Psychiatric medication is not a contraindication to MRI scanning. MRI helps in high-resolution investigations of soft tissues without the use of ionizing radiation. This safe modality currently becomes the imaging technique of choice for diagnosing musculoskeletal, neurologic, and cardiovascular disease. However, there are restrictions and contraindications caused by MRI magnetic fields, machine structure, and gadolinium contrast agents.

27. The nurse is caring for a hospitalized client who has chronic renal failure. Which of the following nursing diagnoses are most appropriate for this client? Select all that apply.

A. Excess Fluid Volume

B. Imbalanced Nutrition; Less than Body Requirements

C. Activity Intolerance

D. Impaired Gas Exchange

E. Pain.

Correct Answer: A, B, C, & E.

Appropriate nursing diagnoses for clients with chronic renal failure include excess fluid volume related to fluid and sodium retention; imbalanced nutrition, less than body requirements related to anorexia, nausea, and vomiting; and activity intolerance related to fatigue.

- **Option A:** Renal disorder impairs glomerular filtration that results in fluid overload. With fluid volume excess, hydrostatic pressure is higher than the usual pushing excess fluids into the interstitial spaces. Since fluids are not reabsorbed at the venous end, fluid volume overloads the lymph system and stays in the interstitial spaces.
- **Option B:** Due to restricted foods and prescribed dietary regimens, an individual experiencing renal problems cannot maintain ideal body weight and sufficient nutrition. At the same time, patients may experience anemia due to decreased erythropoietic factors that cause a decrease in the production of RBC causing anemia and fatigue.
- **Option C:** Assess the extent of weakness, fatigue, ability to participate in active and passive activities. This provides information about the impact of activities on fatigue and energy reserves.
- **Option D:** Gas exchange is not impaired in CRF. Instead, there is a dysfunction in renal tissue perfusion. For optimal cell functioning the kidney excrete potentially harmful nitrogenous products-urea, creatinine, and uric acid, but because of the loss of kidney excretory functions, there is impaired excretion of the nitrogenous waste product causing an increase in laboratory results of BUN, creatinine, and uric acid level.

- **Option E:** Pain is a discomfort that is caused by the stimulation of the nerve endings. Any trauma that the kidney experiences (by any causes or factors) is perceived by the body as a threat, the body releases cytokine and prostaglandin causing pain which is felt by the patient at his flank area.

28. A client has active TB. Which of the following symptoms will he exhibit?

A. Chest and lower back pain.

B. Chills, fever, night sweats, and hemoptysis.

C. Fever of more than 104*F and nausea.

D. Headache and photophobia.

Correct Answer: B. Chills, fever, night sweats, and hemoptysis

Typical signs and symptoms are chills, fever, night sweats, and hemoptysis. Constitutional symptoms like fever, weight loss, lymphadenopathy, and night sweats are commonly reported. Extrapulmonary tuberculosis can affect any organ and can have a varied presentation. In pulmonary tuberculosis, the most commonly reported symptom is a chronic cough. Cough most of the time is productive, sometimes mixed with blood.

- **Option A:** Chest pain may be present from coughing, but isn't usual. Secondary tuberculosis differs in clinical presentation from the primary progressive disease. In secondary disease, the tissue reaction and hypersensitivity is more severe, and patients usually form cavities in the upper portion of the lungs.
- **Option C:** Clients with TB typically have low-grade fevers, not higher than 102*F. A chronic cough, hemoptysis, weight loss, low-grade fever, and night sweats are some of the most common physical findings in pulmonary tuberculosis.
- **Option D:** Nausea, headache, and photophobia aren't usual TB symptoms. Pulmonary or systemic dissemination of the tubercles may be seen in active disease, and this may manifest as miliary tuberculosis characterized by millet-shaped lesions on chest x-ray. Disseminated tuberculosis may also be seen in the spine, the central nervous system, or the bowel.

29. The nurse is reviewing a list of components contained in the peritoneal dialysis solution with the client. The client asks the nurse about the purpose of the glucose contained in the solution. The nurse bases the response knowing that the glucose:

A. Prevents excess glucose from being removed from the client.

B. Decreases risk of peritonitis.

C. Prevents disequilibrium syndrome.

D. Increased osmotic pressure to produce ultrafiltration.

Correct Answer: D. Increases osmotic pressure to produce ultrafiltration.

Increasing the glucose concentration makes the solution increasingly more hypertonic. The more hypertonic the solution, the greater the osmotic pressure for ultrafiltration and thus the greater amount of fluid removed from the client during an exchange.

- **Option A:** Conventional PD solutions contain high levels of glucose (dextrose; 75.5–214 mmol/L) as a principal osmotic agent to achieve fluid removal (i.e. ultrafiltration across the peritoneal membrane).
- **Option B:** The appreciable peritoneal glucose absorption has been linked with adverse local peritoneal membrane effects and systemic metabolic effects. Glucose in PD solutions triggers protein glycosylation and activates the polyol and protein kinase C pathways.
- **Option C:** Systemic glucose absorption has also been associated with worsening hyperglycemia in diabetic patients, new?onset hyperglycemia in incident non?diabetic PD patients, visceral obesity and dyslipidemia, characterized by elevated levels of total cholesterol, triglyceride, very low?density lipoprotein (VLDL) and low?density lipoprotein (LDL).

30. The client says to the nurse "Pray for me" and entrusts her wedding ring to the nurse. The nurse knows that this may signal which of the following:

A. Anxiety

B. Suicidal ideation

C. Major depression

D. Hopelessness

Correct Answer: B. Suicidal ideation

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 A:** The client's statement is a verbal cue of suicidal ideation, not anxiety. 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.
- **Option C:** While suicide is common among clients with major depression, this occurs when their depression starts to lift. 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.
- **Option D:** Hopelessness indicates no alternatives available and may lead to suicide, the statement and nonverbal cue of the client indicate suicide. Haunted and dominated by hopelessness and helplessness. They are without hope and therefore cannot foresee things ever improving; they also view themselves as helpless in 2 ways: (1) they cannot help themselves, and all their efforts to liberate themselves from the sea of depression in which they are drowning are to no avail; and (2) no one else can help them.

31. The most appropriate time for the nurse to obtain a sputum specimen for culture is:

A. Early in the morning

B. After the patient eats a light breakfast

C. After aerosol therapy

D. After chest physiotherapy

Correct Answer: A. Early in the morning

Obtaining a sputum specimen early in this morning ensures an adequate supply of bacteria for culturing and decreases the risk of contamination from food or medication. A sputum culture is a test to detect and identify bacteria or fungi that infect the lungs or breathing passages. Sputum is a thick fluid produced in the lungs and in the adjacent airways. Normally, a fresh morning sample is preferred for the bacteriological examination of sputum.

- **Option B:** A sputum culture is a test that checks for bacteria or another type of organism that may be causing an infection in your lungs or the airways leading to the lungs. Sputum, also known as phlegm, is a thick type of mucus made in your lungs. If you have an infection or chronic illness affecting the lungs or airways, it can make you cough up sputum.
- **Option C:** Sputum is not the same as spit or saliva. Sputum contains cells from the immune system that help fight the bacteria, fungi, or other foreign substances in your lungs or airways. The thickness of sputum helps trap the foreign material. This allows cilia (tiny hairs) in the airways to push it through the mouth and be coughed out.
- **Option D:** A sputum culture is often done with another test called a Gram stain. A Gram stain is a test that checks for bacteria at the site of a suspected infection or in body fluids such as blood or urine. It can help identify the specific type of infection you may have.

32. A female patient who speaks a little English has emergency gallbladder surgery, during discharge preparation, which nursing action would best help this patient understand wound care instruction?

A. Asking frequently if the patient understands the instruction.

B. Asking an interpreter to replay the instructions to the patient.

C. Writing out the instructions and having a family member read them to the patient.

D. Demonstrating the procedure and having the patient return the demonstration.

Correct Answer: D. Demonstrating the procedure and having the patient return the demonstration

Demonstrating by the nurse with a return demonstration by the patient ensures that the patient can perform wound care correctly. One of the leading causes of medical errors in the United States is miscommunication between patients and providers. When patients with limited English proficiency (LEP) cannot adequately communicate their needs, they are less likely to comply with medical instructions and receive vital services.

- **Option A:** Patients may claim to understand discharge instruction when they do not. In-person translation services are preferred when complex medical information or end-of-life decisions are to be discussed. Studies show in-person professional interpretation increases patient satisfaction and

outcomes of care. Interpreters use visual cues to enhance communication. However, in-person interpreters can be costly and can limit the number of languages that can be adequately staffed.

- **Option B:** An interpreter of family members may communicate verbal or written instructions inaccurately. In some cases, patients prefer to use their family and friends as medical interpreters, but experts recommend against the practice because vital information may be lost.
- **Option C:** Internet-based apps for smartphones and tablets help medical professionals interpret information quickly so they can be used in emergency settings. Experts warn, however, that the one-sided nature of such applications can lead to missed or misconstrued information.

33. A 3-year-old child was brought to the pediatric clinic after the sudden onset of findings that include irritability, thick muffled voice, croaking on inspiration, hot to touch, sit leaning forward, tongue protruding, drooling, and suprasternal retractions. What should the nurse do first?

A. Prepare the child for X-ray of upper airways

B. Examine the child's throat

C. Collect a sputum specimen

D. Notify the healthcare provider of the child's status

Correct Answer: D. Notify the healthcare provider of the child's status

These findings suggest a medical emergency and may be due to epiglottitis. Any child with an acute onset of an inflammatory response in the mouth and throat should receive immediate care.

- **Option A:** If epiglottitis is seriously considered, no imaging studies are required. In less-clear cases, imaging studies are occasionally helpful in establishing the diagnosis or excluding epiglottitis.
- **Option B:** Examining the child's throat should not be attempted because it may compromise respiratory effort.
- **Option C:** There are no indications for the collection of sputum specimens.

34. The client has recently returned from having a thyroidectomy. The nurse should keep which of the following at the bedside?

A. A tracheostomy set

B. A padded tongue blade

C. An endotracheal tube

D. An airway

Correct Answer: A. A tracheotomy set

The client who has recently had a thyroidectomy is at risk for tracheal edema.

- **Option B:** A padded tongue blade is used for seizures and not for the client with tracheal edema.
- **Options C and D:** If the client experiences tracheal edema, the endotracheal tube or airway will not correct the problem.

35. A 66-year-old client has been complaining of sleeping more, increased urination, anorexia, weakness, irritability, depression, and bone pain that interferes with her going outdoors. Based on these assessment findings, the nurse would suspect which of the following disorders?

A. Diabetes mellitus

B. Diabetes insipidus

C. Hypoparathyroidism

D. Hyperparathyroidism

Correct Answer: D. Hyperparathyroidism

Hyperparathyroidism is most common in older women and is characterized by bone pain and weakness from excess parathyroid hormone (PTH). Clients also exhibit hypercalciuria-causing polyuria.

- **Option A:** Common symptoms of diabetes mellitus include polyuria, polydipsia, and polyphagia
- **Option B:** While clients with diabetes insipidus also have polyuria, they don't have bone pain and increased sleeping.
- **Option C:** Hypoparathyroidism is characterized by urinary frequency rather than polyuria.