

Kevin's Review - 85 NCLEX Practice Questions

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

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

Correct Answer: A. Dilate the bronchioles

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

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

2. When assessing the lower extremities for arterial function, which intervention should the nurse perform?

- A. Assessing the medial malleoli for pitting edema.
- B. Performing Allen's test.
- C. Assessing the Homans' sign.
- D. Palpating the pedal pulses.

Correct Answer: D. Palpating the pedal pulses.

Palpating the client's pedal pulses assists in determining if arterial blood supply to the lower extremities is sufficient. Finding a pedal pulse is part of the trauma patient assessment and performed before and after lower extremity splint application as well as long backboard immobilization. Assessing a pedal pulse is part of the ongoing assessment for a patient on a backboard or a lower extremity splint.

- **Option A:** Assessing the medial malleoli for pitting edema is appropriate for assessing the venous function of the lower extremity. The lower extremity examination should focus on the medial malleolus, the bony portion of the tibia, and the dorsum of the foot. Pitting edema also occurs in the early stages of lymphedema because of an influx of protein-rich fluid into the interstitium, before fibrosis of the subcutaneous tissue; therefore, its presence should not exclude the diagnosis of lymphedema.

- **Option B:** Allen's test is used to evaluate arterial blood flow before inserting an arterial line in an upper extremity or obtaining arterial blood gases. The Allen test is a first-line standard test used to assess the arterial blood supply of the hand. This test is performed whenever intravascular access to the radial artery is planned or for selecting patients for radial artery harvesting, such as for coronary artery bypass grafting or for forearm flap elevation.
- **Option C:** Homans' sign is used to evaluate the possibility of deep vein thrombosis. Homan's sign test also called dorsiflexion sign test is a physical examination procedure that is used to test for Deep Vein Thrombosis (DVT). A positive Homan's A positive Homan's sign in the presence of other clinical signs may be a quick indicator of DVT.

3. Two student nurses are assigned to a client with lung cancer who has received oxycodone (Roxicodone) 10 mg orally for pain. During the assessment, which finding should the student nurses report immediately?

- A. Decrease in pain level from 6 to 2 (on a scale of 10)
- B. Heart rate of 90 to 100 beats/min
- C. Request by the client that the room door be closed
- D. Respiratory rate of 8 to 10 breaths/min

Correct Answer: D. Respiratory rate of 8 to 10 breaths/min

A drop in respiratory rate indicates respiratory depression, which also puts the client at risk for respiratory acidosis. Signs and symptoms of an oxycodone overdose include bradycardia, hypotension, miosis, respiratory depression, somnolence, muscle flaccidity, cold and clammy skin, and death.

- **Option A:** Oxycodone is an opioid agonist prescription medication. The oxycodone immediate-release formulation is FDA-approved for the management of acute or chronic moderate to severe pain, for which other treatments do not suffice and for which the use of opioid medication is appropriate.
- **Option B:** A heart rate of 100/min is slightly higher than normal, therefore this should still be reported to the RN. Patients taking oxycodone require monitoring for the presence of constipation, pain relief, other side effects, and appropriate usage. Their blood pressure, heart rate, and respiratory rate should also be monitored, especially for the first 24 to 72 hours after initiating therapy or increasing dosage.
- **Option C:** The student nurses should still inform the RN of the client's wishes. Due to the high misuse potential and possibly fatal results of an oxycodone overdose, prescriptions should be written for the lowest therapeutic dose and only for the period the patient is expected to be in pain. Close follow-up should be arranged.

4. The nurse is caring for residents in a long-term care setting for the elderly. Which of the following activities based on Erickson's theory will be most effective in meeting the growth and development needs of a person in this age group?

- A. Boardgame
- B. Mentor other elderly clients
- C. Reminiscence groups

D. Regularly scheduled social activities

Correct Answer: C. Reminiscence groups

According to Erikson's theory, older adults need to find and accept the meaningfulness of their lives, or they may become depressed, angry, and fear death. Reminiscing contributes to successful adaptation by maintaining self-esteem, reaffirming identity, and working through loss.

- **Option A:** Playing board games is an activity that is appropriate for school-age children where there is an equal share of efforts and tasks to reach a common goal. In addition to teaching them about teamwork, patience, and how to win and lose gracefully, board games can actually benefit kids' brains and language development.
- **Option B:** Mentoring is an activity for individuals who are in their middle adulthood where it involves finding one's purpose and contributing to the development of others.
- **Option D:** Attending social activities is an activity that benefits individuals who are in their adolescent years where these kinds of events play a role in creating and shaping their identity.

5. In a day treatment program, a manic client is creating considerable chaos, behaving in a dominating and manipulative way. Which nursing intervention is most appropriate?

- A. Allow the peer group to intervene.
- B. Describe acceptable behavior and set realistic limits with the client.
- C. Recommend that the client is hospitalized for treatment.
- D. Tell the client that his behavior is inappropriate.

Correct Answer: B. Describe acceptable behavior and set realistic limits with the client.

In this situation, it would be appropriate for the nurse to suggest alternative behaviors in place of unacceptable ones to help the client gain self-control. Maintain a consistent approach, employ consistent expectations, and provide a structured environment. Clear and consistent limits and expectations minimize the potential for the client's manipulation of staff.

- **Option A:** The peer group is not responsible for monitoring the client's behavior. Decrease environmental stimuli (e.g., by providing a calming environment or assigning a private room). Helps decrease escalation of anxiety and manic symptoms.
- **Option C:** The client's behavior does not warrant hospitalization. Redirect agitation and potentially violent behaviors with physical outlets in an area of low stimulation (e.g., punching bag). Can help to relieve pent-up hostility and relieve muscle tension.
- **Option D:** The client is told only what is unacceptable and is not given any alternatives. Remain neutral as possible; Do not argue with the client. The client can use inconsistencies and value judgments as justification for arguing and escalating mania.

6. A nurse in the emergency department is observing a 4-year-old child for signs of increased intracranial pressure after a fall from a bicycle, resulting in head trauma. Which of the following signs or symptoms would be cause for concern?

- A. Bulging anterior fontanel

- B. Repeated vomiting
- C. Signs of sleepiness at 10 PM
- D. Inability to read short words from a distance of 18 inches

Correct Answer: B. Repeated vomiting

Increased pressure caused by bleeding or swelling within the skull can damage delicate brain tissue and may become life-threatening. Repeated vomiting can be an early sign of pressure as the vomiting center within the medulla is stimulated.

- **Option A:** The anterior fontanel is closed in a 4-year-old child. The average closure time of the anterior fontanelle ranges from 13 to 24 months. Infants of African descent statically have larger fontanelles that range from 1.4 to 4.7 cm, and in terms of sex, the fontanelles of male infants will close sooner compared to female infants.
- **Option C:** Evidence of sleepiness at 10 PM is normal for a four-year-old. Young toddlers have a sleep schedule supplemented by two naps a day. Toddler sleep problems are compounded by separation anxiety and a fear of missing out, which translates to stalling techniques and stubbornness at bedtime.
- **Option D:** The average 4-year-old child cannot read yet, so this too is normal. At 4, many children just aren't ready to sit still and focus on a book for long. Others may learn the mechanics of reading but aren't cognitively ready to comprehend the words.

7. Alfred was newly diagnosed with anxiety disorder. The physician prescribed buspirone (BuSpar). The nurse is aware that the teaching instructions for newly prescribed buspirone should include which of the following?

- A. A warning about the drug's delayed therapeutic effect, which is from 14 to 30 days.
- B. A warning about the incidence of neuroleptic malignant syndrome (NMS).
- C. A reminder of the need to schedule blood work in 1 week to check blood levels of the drug.
- D. A warning that immediate sedation can occur with a resultant drop in pulse.

Correct Answer: A. A warning about the drug's delayed therapeutic effect, which is from 14 to 30 days.

The client should be informed that the drug's therapeutic effect might not be reached for 14 to 30 days. The client must be instructed to continue taking the drug as directed. Unlike benzodiazepines and barbiturates, there is no associated risk of physical dependence or withdrawal with buspirone use due to the lack of effects on GABA receptors. However, buspirone has little efficacy as an acute anxiolytic as clinical effect typically takes 2 to 4 weeks to achieve.[1] Buspirone is FDA approved for the short and long-term treatment of GAD, as well as short-term symptomatic relief of anxiety. It is as effective as benzodiazepine treatment for GAD.

- **Option B:** NMS hasn't been reported with this drug, but tachycardia is frequently reported. Patients should receive a warning about the possibility of CNS depression. While rarer, patients should also be informed of the potential for akathisia (likely due to central dopamine antagonism) and serotonin syndrome.
- **Option C:** Blood level checks aren't necessary. Offer frequent follow-up after initiating treatment to assess for therapeutic and adverse effects. Encourage patients to stay consistent with their medication schedule and whether they take it with food. As mentioned before, a therapeutic effect typically takes 2 to 4 weeks to take effect. Often, many of the adverse effects will lessen over time,

as well. However, the patient should have close monitoring for signs and symptoms of anaphylaxis, akathisia, and serotonin syndrome.

- **Option D:** Relative to other anxiolytics, buspirone has low toxicity and potential for abuse. There have been no deaths reported from a buspirone overdose alone. In pharmacological trials, healthy male patients were given up to 375 mg per day and developed nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. While buspirone overdose typically resolves with complete recovery, high suspicion of additional medication overdose should be maintained and investigated.

8. A nurse is caring for a Chinese client who is hospitalized due to pneumonia. Based on their culture, which of the following is believed to be the cause of the illness?

- A. An illness is cast by an enemy.
- B. An illness is a result of punishment for sins.
- C. An illness may be attributed to overexertion.
- D. An illness may be given by someone who did not want it.

Correct Answer: C. An illness may be attributed to overexertion.

Illness for Chinese people may be attributed to prolonged sitting or lying or to overexertion. Health is maintained through a balance between “yin” (cold) and “yang” (hot) forces. A lack of “chi” (energy) causes illness. The body is viewed as a gift and must be valued through proper care.

- **Option A:** When there is disharmony and imbalance of the functional entities, the cardinal functions cannot be not well-performed and as a result, the body becomes ill. Illness then is ultimately viewed as arising from an imbalance of qi and yin-yang, rather than a purely physical phenomenon.
- **Option B:** When a person is ill, he or she will manifest different disease symptoms. Given that everything has Wu Xing, a pattern of disharmony can be identified by a trained doctor. Because all the functional entities are interconnected, accurately pinpointing patterns of illness is considered to be one of the most challenging aspects for aspiring acupuncturists.
- **Option D:** As such, illness can be identified as to how the functional entities are imbalanced. At the most basic level, this is measured as there is an excess (vacuity) or deficiency (stagnation) in one of the entities.

9. When teaching a group of adolescents about male hormone production, which of the following would the nurse include as being produced by the Leydig cells?

- A. Follicle-stimulating hormone
- B. Testosterone
- C. Luteinizing hormone
- D. Gonadotropin-releasing hormone

Correct Answer: B. Testosterone

Testosterone is produced by the Leydig cells in the seminiferous tubules. The Leydig cells make and secrete testosterone, in response to luteinizing hormone from the pituitary. This process does not start until puberty when LH stimulates the Leydig cells to produce testosterone. FSH stimulates the Sertoli cells to secrete androgen-binding protein into the lumen of the seminiferous tubules.

- **Option A:** FSH is made by the pituitary gland, a small gland located underneath the brain. FSH plays an important role in sexual development and functioning. In women, FSH helps control the menstrual cycle and stimulates the growth of eggs in the ovaries.
- **Option C:** Luteinizing hormone (LH) is produced and released in the anterior pituitary gland. This hormone is considered a gonadotropic hormone because of its role in controlling the function of ovaries in females and testes in males, which are known as the gonads.
- **Option D:** The hypothalamus is responsible for releasing gonadotropin-releasing hormone.

10. A mother of a term neonate asks what the thick, white, cheesy coating is on his skin. Which correctly describes this finding?

- A. Lanugo
- B. Milia
- C. Nevus flammeus
- D. Vernix

Correct Answer: D. Vernix.

- **Option D:** Vernix caseosa or vernix is the waxy or cheese-like white substance found coating the skin of newborn human babies. It is produced by dedicated cells and is thought to have some protective roles during fetal development and for a few hours after birth.

11. A nurse is caring for a client with Wernicke-Korsakoff syndrome. The physician asks the nurse to teach the client to consume thiamine-rich food. The nurse instructs the client to increase the intake of which food items?

- A. Chicken
- B. Milk
- C. Beef
- D. Broccoli

Correct Answer: C. Beef

Food sources of thiamin include beef, liver, nuts, oats, oranges, pork, eggs, seeds, legumes, peas, and yeast. In meat, the liver has the highest amount of thiamine. Whereas three ounces of beefsteak gives 7% of the daily value of thiamine, one serving of beef liver will give about 10%. One serving of cooked salmon gives 18% of the daily value of thiamine.

- **Option A:** Poultry contains niacin. Chicken meat, particularly chicken breast, is an excellent source of protein as well as niacin. A three-ounce serving of skinless breast meat provides 10.3 mg. Niacin is an essential nutrient that we mainly need to get from foods. The body may also convert some tryptophan, one of the body's amino acids, into a nutrient.

- **Option B:** Milk contains vitamins A, D, and B2. Milk contains the fat-soluble vitamins A, D, E, and K. The content level of fat-soluble vitamins in dairy products depends on the fat content of the product. Milk contains the water-soluble vitamins thiamin (vitamin B1), riboflavin (vitamin B2), niacin (vitamin B3), pantothenic acid (vitamin B5), vitamin B6 (pyridoxine), vitamin B12 (cobalamin), vitamin C, and folate. Milk is a good source of thiamin, riboflavin, and vitamin B12.
- **Option D:** Broccoli contains folic acid, vitamins C, E, and K. Broccoli is a good source of fiber and protein and contains iron, potassium, calcium, selenium, and magnesium as well as the vitamins A, C, E, K, and a good array of B vitamins including folic acid.

12. You are preparing to change the linens on the bed of a client who has a draining sacral wound infected by MRSA. Which PPE items will you plan to use. Select all that apply

- A. N95 respirator
- B. Surgical Mask
- C. Gloves
- D. Goggles
- E. Gown

Correct Answer: C & E

A gown and gloves should be used when coming in contact with linens that may be decontaminated by the client's wound secretions.

- **Options A, B, and D:** The other items are not necessary because transmission by splashes, droplets, or airborne means will not occur when the bed is changed.

13. A client 12 weeks' pregnant came to the emergency department with abdominal cramping and moderate vaginal bleeding. Speculum examination reveals 2 to 3 cm cervical dilation. The nurse would document these findings as which of the following?

- A. Threatened abortion
- B. Imminent abortion
- C. Complete abortion
- D. Missed abortion

Correct Answer: B. Imminent abortion

Cramping and vaginal bleeding coupled with cervical dilation signify that termination of the pregnancy is inevitable and cannot be prevented. Thus, the nurse would document an imminent abortion.

- **Option A:** In a threatened abortion, cramping and vaginal bleeding are present, but there is no cervical dilation. The symptoms may subside or progress to abortion.
- **Option C:** In a complete abortion all the products of conception are expelled.
- **Option D:** A missed abortion is early fetal intrauterine death without expulsion of the products of conception.

14. Ruby is receiving thyroid replacement therapy, develops the flu, and forgets to take her thyroid replacement medicine. The nurse understands that skipping this medication will put the client at risk for developing which of the following life-threatening complications?

- A. Exophthalmos
- B. Thyroid storm
- C. Myxedema coma
- D. Tibial myxedema

Correct Answer: C. Myxedema coma

Myxedema coma, severe hypothyroidism, is a life-threatening condition that may develop if thyroid replacement medication isn't taken.

- **Option A:** Exophthalmos, protrusion of the eyeballs, is seen with hyperthyroidism. If a person's immune system attacks the thyroid gland, it may react by producing extra hormones. The autoimmune antibodies can attack the muscles and soft tissue surrounding the eyes, which can cause them to protrude from the sockets.
- **Option B:** Thyroid storm is life-threatening but is caused by severe hyperthyroidism. It is also referred to as thyrotoxic crisis, an acute, life-threatening hypermetabolic state induced by excessive release of thyroid hormones.
- **Option D:** Tibial myxedema, peripheral mucinous edema involving the lower leg, is associated with hypothyroidism but isn't life-threatening

15. A nurse is administering an IV bolus of cimetidine (Tagamet). Which of the following should the nurse monitor closely follow the administration?

- A. Respiratory rate
- B. Skin turgor
- C. Blood pressure
- D. Temperature

Correct Answer: C. Blood pressure

Rapid intravenous administration of Cimetidine causes hypotension due to arterial vasodilation. It is recommended to be injected slowly over a period of not less than 5 minutes.

- **Options A, B, & D:** These are not related to this medication.

16. Bismuth subsalicylate (Pepto-Bismol), as an absorbent, has which of the following mechanisms of action?

- A. Decreased GI motility.
- B. Decreased gastric secretions.

- C. Increased fluid absorption.
- D. Binding to diarrhea-causing bacteria for excretion.

Correct Answer: D. Binding to diarrhea-causing bacteria for excretion.

Absorbent antidiarrheal medications bind to diarrhea-causing bacteria to form a nonabsorbable complex, which is then excreted in the stool. Bismuth subsalicylate (BSS) exhibits many of its properties due to its formulation as an insoluble salt of salicylic acid and trivalent bismuth. The mechanism of action through which BSS works is complex.

- **Option A:** In the stomach, BSS hydrolyzes into two compounds, bismuth, and salicylic acid. The salicylate compound is almost completely absorbed into the bloodstream, while bismuth salt is minimally absorbed.
- **Option B:** The bismuth that remains in the gastrointestinal tract forms other bismuth salts. These bismuth salts contain bactericidal and antimicrobial activity, and prevent bacteria from binding and growing on the mucosal cells of the stomach. This is the mechanism by which BSS helps eradicate *H. pylori*.
- **Option C:** The prevention of bacterial binding to the mucosal cells provides many benefits, which include prevention of intestinal secretion, promotion of fluid absorption, reduction of inflammation, and promotion of the healing of any present ulcer in the stomach.

17. A 23-year-old client who has been admitted with a diagnosis of schizophrenia says to the nurse “Yes, it’s march, March is a little woman”. That’s literal you know”. These statements illustrate:

- A. Neologisms
- B. Echolalia
- C. Flight of ideas
- D. Loosening of association

Correct Answer: D. Loosening of association

Loose associations are thoughts that are presented without the logical connections usually necessary for the listener to interpret the message. A thought disturbance demonstrated by speech that is disconnected and fragmented, with the individual jumping from one idea to another unrelated or indirectly related idea. It is essentially equivalent to derailment.

- **Option A:** A new word that is coined especially by a person affected with schizophrenia and is meaningless except to the coiner, and is typically a combination of two existing words or a shortening or distortion of an existing word.
- **Option B:** Echolalia is a mechanical repetition of words and phrases uttered by another individual. It is often a symptom of a neurological or developmental disorder, particularly catatonic schizophrenia or autism.
- **Option C:** A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent. It is part of the DSM-5 criteria for Manic episodes.

18. The physician has ordered IV replacement of potassium for a patient with severe hypokalemia. The nurse would administer this:

- A. By rapid bolus
- B. Diluted in 100 cc over 1 hour
- C. Diluted in 10 cc over 10 minutes
- D. IV push

Correct Answer: B. Diluted in 100 cc over 1 hour

Potassium must be well diluted and given slowly because rapid administration will cause cardiac arrest. Intravenous KCl may be used as an alternative in these cases if the patient cannot tolerate oral KCl. Severe (less than 2.5 mEq/L) or symptomatic hypokalemia necessitates intravenous administration of KCl.

- **Option A:** Injectable KCl formulations have the potential to cause injection site complications (e.g., phlebitis, erythema, thrombosis, etc.). Also, rapid injection of KCl can precipitate mild hyperkalemia. If the necessary infusion rate for such cases is greater than 10 mEq/hour, the KCl should be administered through a central line and with cardiac monitoring.
- **Option C:** Patients treated with intravenous KCl may require more frequent checking, especially if the serum potassium level addressed is below 2.5 mEq/L. The use of continuous cardiac monitoring can aid in correlating symptoms with telling electrocardiogram (ECG) changes (e.g., peaked T waves in hyperkalemia, flattened T waves in hypokalemia, etc.).
- **Option D:** KCl toxicity is primarily a discussion of hyperkalemia. Like hypokalemia, the potentially fatal complication of hyperkalemia is cardiac arrhythmia. The risk for cardiac arrhythmia is significant at serum potassium levels greater than 6.0 to 6.5 mEq/L.

19. Nurse Kevin reviews the client's chart and notes that the physician has documented a diagnosis of paronychia. Based on this diagnosis, which of the following would the nurse expect to note during the assessment?

- A. Dry, rough patches and bumps around the hair follicles on the upper arms, legs, and buttocks
- B. Red shiny skin around the nail bed
- C. White silvery patches on the elbows
- D. Swelling of the skin near the parotid gland

Correct Answer: B. Red shiny skin around the nail bed

Paronychia, or infection around the nail, is characterized by red, shiny skin, often associated with painful swelling. These infections frequently result from trauma, picking at the nail, or disorders such as dermatitis. Often, these become secondarily infected with bacteria or fungus, which later involves the nail. Warm soaks three or four times a day may reduce pain and pressure; however, incision and drainage of the inflamed site frequently are required.

- **Option A:** A skin disorder that causes small, dry, rough patches and bumps around the hair follicles on the upper arms, legs, and buttocks is called keratosis pilaris.
- **Option C:** Silvery white patches that are seen on elbows, knees, and lower back is a characteristic of Plaque psoriasis, a common form of psoriasis.

- **Option D:** Swelling of the skin near the parotid gland is observed in patients with mumps.

20. After the nurse provides dietary restrictions to the parents of a child with celiac disease, which statement by the parents indicates effective teaching?

- A. "We'll follow these instructions until our child has completely grown and developed."
- B. "We'll follow these instructions until our child's symptoms disappear."
- C. "Our child must maintain these dietary restrictions until adulthood."
- D. "Our child must maintain these dietary restrictions lifelong."

Correct Answer: D. "Our child must maintain these dietary restrictions lifelong."

Celiac disease is an autoimmune reaction to a protein called gluten. A patient with celiac disease must maintain dietary restrictions lifelong to avoid recurrence of clinical manifestations of the disease. A gluten-free diet should be followed by avoiding barley, rye, wheat, oats, and triticale. Once the diagnosis of celiac disease is made, patients need regular follow up to ensure that they are compliant with a gluten-free diet and not developing any complications.

- **Option A:** It is recommended that all people diagnosed with celiac disease follow a strict gluten-free diet. This adherence is best done under the supervision of specialists, including a dietician. In general, symptoms improve on the gluten-free diet within days to weeks. Non-compliance can be unintentional in an individual who may be still ingesting gluten without realizing it.
- **Option B:** Currently, the only recommended treatment for celiac disease is the gluten-free diet. This makes a significant impact on the lives of people affected and can be challenging to maintain. There is continuous work on possible non-dietary therapies that enable people with celiac disease to tolerate gluten. One of the main focuses of the research in this area is immune modulators.
- **Option C:** The prognosis for patients with the correct diagnosis and treatment is good. Unfortunately, compliance with a gluten-free diet is very difficult and relapses are common. Some patients do not respond to a gluten-free diet or corticosteroids; they have a poor quality of life.

21. A nurse is caring for a client who has diarrhea for the past four days. When assessing a client, the nurse should expect which of the following findings? Select all that apply.

- A. Bradycardia
- B. Hypotension
- C. Fever
- D. Poor skin turgor
- E. Peripheral edema

Correct Answer: B, C, and D

Diarrhea is described as three or more loose or watery stools a day. Infection commonly causes acute diarrhea. Noninfectious etiologies are more common as the duration of diarrhea becomes chronic. Treatment and management are based on the duration and specific etiology. Rehydration therapy is an important aspect of the management of any patient with diarrhea. Prevention of infectious diarrhea

includes proper handwashing to prevent the spread of infection.

- **Option A:** Prolonged diarrhea is more likely to cause tachycardia than bradycardia. Diarrhea is the result of reduced water absorption by the bowel or increased water secretion. A majority of acute diarrheal cases are due to infectious etiology. Chronic diarrhea is commonly categorized into three groups; watery, fatty (malabsorption), or infectious.
 - **Option B:** Prolonged diarrhea leads to dehydration, which causes a decrease in blood pressure. In bacterial and viral diarrhea, the watery stool is the result of injury to the gut epithelium. Epithelial cells line the intestinal tract and facilitate the absorption of water, electrolytes, and other solutes. Infectious etiologies cause damage to the epithelial cells which leads to increased intestinal permeability. The damaged epithelial cells are unable to absorb water from the intestinal lumen leading to loose stool.
 - **Option C:** Prolonged diarrhea leads to dehydration, which causes fever. History should include the duration of symptoms, accompanying symptoms, travel history, and exposures to medications and food. It is important to ask about the stool frequency, type, volume, and presence of blood or mucus. Patients with diarrhea may also complain of abdominal pain or cramping, vomit, bloating, flatulence, fever, and bloody or mucoid stools.
- Option D: Prolonged diarrhea is more likely to cause a fluid deficit. An important aspect of diarrhea management is replenishing fluid and electrolyte loss. Patients should be encouraged to drink diluted fruit juice, Pedialyte or Gatorade. In more severe cases of diarrhea, IV fluid rehydration may become necessary.
- Option E: Peripheral edema results from a fluid overload. Important aspects of the physical exam include the patient's vital signs, volume status, and abdominal exam. Dry mucous membranes, poor skin turgor, and delayed capillary refill are signs of dehydration. A thorough history and physical exam are important to determine the proper diagnostic workup.

22. A female client is undergoing tests for multiple myeloma. Diagnostic study findings in multiple myeloma include:

- A. A decreased serum creatinine level
- B. A low serum protein level
- C. Hypocalcemia
- D. Bence Jones protein in the urine

Correct Answer: D. Bence Jones protein in the urine

- **Option D:** Bence-Jones protein is an antibody fragment called a light chain that is not detectable in the urine. A presence of Bence Jones may indicate excess light chain production of a single type of antibody by the bone marrow cells.
- **Option A:** The serum creatinine level may also be increased.
- **Option B:** Serum protein electrophoresis shows elevated globulin spike.
- **Option C:** Serum calcium levels are elevated because calcium is lost from the bone and reabsorbed in the serum.

23. Junnel, who is manic, but not yet on medication, comes to the drug treatment center. The nurse would not let this client join the group session because:

- A. The client is disruptive.
- B. The client is harmful to self.
- C. The client is harmful to others.
- D. The client needs to be on medication first.

Correct Answer: A. The client is disruptive.

Group activity provides too much stimulation, which the client will not be able to handle (harmful to self) and as a result will be disruptive to others. Decrease environmental stimuli (e.g., by providing a calming environment or assigning a private room). Helps decrease escalation of anxiety and manic symptoms.

- **Option B:** Frequently assess client's behavior for signs of increased agitation and hyperactivity. Early detection and intervention of escalating mania will prevent the possibility of harm to self or others, and decrease the need for seclusions.
- **Option C:** Redirect agitation and potentially violent behaviors with physical outlets in an area of low stimulation (e.g., punching bag). Can help to relieve pent-up hostility and relieve muscle tension. Remain neutral as possible; Do not argue with the client. The client can use inconsistencies and value judgments as justification for arguing and escalating mania.
- **Option D:** Chart, in nurse's notes, behaviors; interventions; what seemed to escalate agitation; what helped to calm agitation; when as-needed (PRN) medications were given and their effect; and what proved most helpful. Staff will begin to recognize potential signals for escalating manic behaviors and have a guideline for what might work best for the individual client.

24. A client is prescribed with guaifenesin (Mucinex). The nurse determines that the client understands the proper administration of this medication if the client states that he or she will:

- A. Limit oral fluid intake
- B. Take the medication with meals only
- C. Take an additional dose once fever and cough persist
- D. Drink extra fluids while taking this medication

Correct Answer: D. Drink extra fluids while taking this medication

Guaifenesin is an expectorant. Drink extra fluids to help loosen the congestion and lubricate the throat while taking this medication.

- **Option A:** Fluids are needed to loosen the secretions.
- **Option B:** The medication does not have to be taken with meals.
- **Option C:** Additional doses should not be taken without the prescription of the doctor.

25. A client with stomach cancer is admitted to the oncology unit after vomiting for 3 days. Physical assessment findings include irregular pulse, muscle twitching, and complaints of prickling sensations in the fingers and hands. Laboratory results include a potassium level of 2.9 mEq/L, a pH of 7.46, and a bicarbonate level of 29 mEq/L. The client is experiencing:

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

Correct Answer: A. Metabolic alkalosis

- The client is experiencing metabolic alkalosis caused by loss of hydrogen and chloride ions from excessive vomiting. This is shown by a pH of 7.46 and elevated bicarbonate level of 29 mEq/L.

26. While caring for a client with cervical cancer, the nurse notes that the radioactive implant is lying in the bed. The nurse should:

- A. Use tongs to pick up the implant and return it to a lead-lined container
- B. Place the implant in a biohazard bag and return it to the lab
- C. Give the client a pair of gloves and ask her to reinsert the implant
- D. Discard the implant in the commode and double-flush

Correct Answer: A. Use tongs to pick up the implant and return it to a lead-lined container

- Option A: The radioactive implant should be picked up with tongs and returned to the lead-lined container to avoid radiation exposure.
- Option B: Radioactive materials are placed in lead-lined containers, not plastic ones, and are returned to the radiation department, not the lab.
- Option C: The client should not touch the implant or try to reinsert it.
- Option D: The implant should not be placed in the commode for disposal.

27. A maternity nurse is preparing to care for a pregnant client in labor who will be delivering twins. The nurse monitors the fetal heart rates by placing the external fetal monitor:

- A. Over the fetus that is most anterior to the mother's abdomen.
- B. Over the fetus that is most posterior to the mother's abdomen.
- C. So that each fetal heart rate is monitored separately.
- D. So that one fetus is monitored for a 15-minute period followed by a 15 minute fetal monitoring period for the second fetus.

Correct Answer: C. So that each fetal heart rate is monitored separately.

In a client with a multifetal pregnancy, each fetal heart rate is monitored separately. Simultaneous monitoring of twins is preferable to non simultaneous monitoring to discriminate between their separate FHRs (ACOG, 1989). Synchronizing the internal clocks of both monitors will help produce accurate documentation. Otherwise, time increments should be documented on both monitor tracings for later comparison, to ensure that each twin has been monitored. If the monitor strips are synchronous, portable real-time ultrasound can be used to verify that both twins are being monitored independently

- **Option A:** Among the advantages of simultaneous twin monitoring is the increased likelihood that both twins are being monitored with potentially less nursing time.
- **Option B:** The nonstress test (NST) is the most widely used method of evaluating twins for any of the aforementioned risk factors. Normative data for simultaneous twin NSTs show synchrony or similarity in the tracings with incidences of 57.14% and 58% in twins monitored from 27 weeks until term.
- **Option D:** Synchrony is thought by some to occur because the first twin's movement produces a vibration and stimulates movement and FHR accelerations in the second twin. Recently, this idea was supported in a limited investigation of twins in which vibratory acoustic stimulation evoked an immediate transition from asynchronous to synchronous FHR tracings in all 16 tests carried out in the study (Sherer, Abramowicz, D'Amico, Caverly, & Woods, 1991).

28. A patient is admitted to the hospital with suspected polycythemia vera. Which of the following symptoms is consistent with the diagnosis? Select all that apply.

- A. Weight loss
- B. Increased clotting time
- C. Hypertension
- D. Headaches
- E. Polyphagia

Correct Answer: B, C, and D

Polycythemia vera is a condition in which the bone marrow produces too many red blood cells. This causes an increase in hematocrit and viscosity of the blood. Patients can experience headaches, dizziness, and visual disturbances. Cardiovascular effects include increased blood pressure and delayed clotting time.

- **Option A:** Weight loss is not a manifestation of polycythemia vera.
- **Option E:** Polyphagia or excessive hunger is a symptom of diabetes mellitus.

29. You are a charge nurse responsible for reviewing the nursing unit's refrigerator at a busy urban hospital that has recently experienced a power outage. The outage lasted for a short period, but you're ensuring that all medications are stored correctly post-outage. During your review, you find several medications, some of which are critical for patients with chronic conditions. Which of the following drugs, if found inside the fridge, should be removed and replaced due to incorrect storage?

- A. Nadolol (Corgard)
- B. Opened (in-use) Humulin N injection
- C. Urokinase (Kinlytic)
- D. Epoetin alfa IV (Epogen)
- E. Unopened vial of Glargine (Lantus)

F. Cyanocobalamin (Vitamin B12) injection

Correct Answer: A. Corgard

Nadolol (Corgard) is a beta-blocker used to treat high blood pressure and angina (chest pain). It does not require refrigeration and should be stored at room temperature (59 to 86 °F or 15 to 30°C), away from heat, moisture, and light. The other medications listed, such as Humulin N, Urokinase, Epoetin alfa, Glargine, and Cyanocobalamin, have specific storage requirements that may include refrigeration, especially once opened or in-use.

30. While in a skilled nursing facility, a male client contracted scabies, which is diagnosed the day after discharge. The client is living at her daughter's home, where six other persons are living. During her visit to the clinic, she asks a staff nurse, "What should my family do?" The most accurate response from the nurse is:

- A. "All family members will need to be treated."
- B. "If someone develops symptoms, tell him to see a physician right away."
- C. "Just be careful not to share linens and towels with family members."
- D. "After you're treated, family members won't be at risk for contracting scabies."

Correct Answer: A. "All family members will need to be treated."

When someone in a group of persons sharing a home contracts scabies, each individual in the home needs prompt treatment whether he's symptomatic or not. Scabies is a contagious skin condition caused by the mite *Sarcoptes scabiei* which burrows into the skin and causes severe itching. Scabies is transmitted by direct skin-to-skin contact or indirectly by contact with contaminated material (fomites).

- **Option B:** Skin-to-skin contact transmits the infectious organism therefore, family members and skin contact relationships create the highest risk. Scabies was declared a neglected skin disease by the World Health Organization (WHO) in 2009 and is a significant health concern in many developing countries.
- **Option C:** Towels and linens should be washed in hot water. The classic form of scabies may have a population of mites on an individual that range between 10 to 15 organisms. It typically takes ten minutes of skin-to-skin contact for mites to transmit to another human host, in cases of classic scabies. Transmission of the disease can also occur by fomite transmission via clothing or bed sheets.
- **Option D:** Scabies can be transmitted from one person to another before symptoms develop. Infested individuals require identification and prompt treatment because a misdiagnosis can lead to outbreaks, morbidity, and an increased economic burden. Adult female mites dig burrow tunnels 1 to 10 millimeters long within the superficial layers of the epidermis and lay 2 to 3 eggs daily. The mites die 30 to 60 days later, and the eggs hatch after approximately 2 to 3 weeks. It merits mentioning that not all treatment options can penetrate the eggs stored within the skin.

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

- A. Constipation
- B. Dumping syndrome

- C. Gastric spasm
- D. Intestinal spasms

Correct Answer: B. Dumping syndrome

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

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

32. A 40-year-old divorced mother of four school-age children is hospitalized with metastatic cancer of the ovary. The nurse finds the patient crying, and she tells the nurse that she does not know what will happen to her children when she dies. The most appropriate response by the nurse is

- A. "Why don't we talk about the options you have for the care of your children?"
- B. "Many patients with cancer live for a long time, so there is time to plan for your children."
- C. "For now you need to concentrate on getting well, not worry about your children."
- D. "Perhaps your ex-husband will take the children when you can't care for them."

Correct Answer: A. "Why don't we talk about the options you have for the care of your children?"

- **Option A:** This response expresses the nurse's willingness to listen and recognizes the patient's concern.
- **Options B and C:** The responses beginning "Many patients with cancer live for a long time" and "For now you need to concentrate on getting well" close off discussion of the topic and indicate that the nurse is uncomfortable with the topic. In addition, the patient with metastatic ovarian cancer may not have a long time to plan.
- **Option D:** Although it is possible that the patient's ex-husband will take the children, more assessment information is needed before making plans.

33. An 8-year-old admitted with an upper-respiratory infection has an order for O2 saturation via pulse oximeter. To ensure an accurate reading, the nurse

should:

- A. Place the probe on the child's abdomen
- B. Calibrate the oximeter at the beginning of each shift
- C. Apply the probe and wait 15 minutes before obtaining a reading
- D. Place the probe on the child's finger

Correct Answer: D. Place the probe on the child's finger

- Option D: The pulse oximeter should be placed on the child's finger or earlobe because blood flow to these areas is most accessible for measuring oxygen concentration.
- Option A: The probe cannot be secured to the abdomen.
- Option B: Pulse oximeter should be recalibrated before application.
- Option C: Reading from a pulse oximeter is obtained within seconds, not minutes.

34. A cromolyn sodium (Intal) inhaler is prescribed to a client with asthma. A nurse provides instructions regarding the side effects of this medication. The nurse tells the client to immediately report which of the following side effects?

- A. Sore throat
- B. Drowsiness
- C. Wheezing
- D. Hypotension

Correct Answer: C. Wheezing

Cromolyn Sodium (Intal) is used to prevent asthma attacks in people with bronchial asthma. Serious side effects associated with the use of this inhaler are wheezing, chest tightness, skin rash, hives, itching, swelling of the face, lips, throat, or tongue, and joint pain.

- **Options A & B:** These are expected side effects of Intal.
- **Option D:** Hypotension is not directly related to the medication.

35. Which laboratory result, obtained on a client 24 hours post-burn injury, will the nurse report to the physician immediately?

- A. Arterial pH, 7.32
- B. Hematocrit, 52%
- C. Serum potassium, 7.5 mmol/L (mEq/L)
- D. Serum sodium, 131 mmol/L (mEq/L)

Correct Answer: C. Serum potassium, 7.5 mmol/L (mEq/L)

The serum potassium level is changed to the degree that serious life-threatening responses could result. With such a rapid rise in the potassium level, the client is at high risk of experiencing severe cardiac dysrhythmias and death.

- **Option A:** Acid-base studies were carried out on 76 consecutive burn patients admitted within 36 hours of injury. Admission blood pH and base excess (BE) values all decreased in a linear relationship to the extent of the burn. Blood Pco-2 changes were unrelated to the extent of the burn. Significant acidosis developed within 2 hours of burn injury.
- **Option B:** The hematocrit (Hct) is the percentage of the volume of the whole blood that is made up of red blood cells. In burns, the patient has lost a lot of fluid from leaky blood vessels. There are more red cells than fluid so the hematocrit is high.
- **Option D:** Serum sodium is abnormal, but not to the same degree of severity, and would be expected in the emergent phase after a burn injury. Severe cutaneous injuries such as burn injuries and blast injuries result in the loss of both water and sodium. For burn patients, hypernatremia that occurs within a few days of injury may be associated with an increased risk of death.

36. A 72-year-old retired ballet dancer, with a long-standing history of osteoarthritis (OA) affecting her right hip, is admitted to the orthopedic ward for an upcoming total hip replacement surgery. Over the years, conservative treatments have become less effective, and her mobility has significantly declined, prompting the decision for surgical intervention. As the surgery date approaches, the nurse plans a preoperative intervention to optimize the patient's readiness for the procedure. Which preoperative nursing intervention should be implemented?

- A. Administering prophylactic antibiotics as prescribed
- B. Encouraging active range of motion exercises for the affected joint
- C. Applying cold packs to the affected joint to reduce inflammation
- D. Teaching the patient about postoperative pain management techniques

Correct Answer: A. Administering prophylactic antibiotics as prescribed.

Prophylactic antibiotics are often prescribed prior to certain surgeries, including joint replacements, to reduce the risk of postoperative infections. While this is an important measure, the decision and timing of antibiotic administration are usually very specific and directed by the surgical team or protocol, often closer to the time of the actual surgery.

- **Option B:** While exercise is crucial in the management of OA, encouraging active range of motion exercises immediately before a joint replacement surgery may not be the primary focus. The joint is already deteriorated, and the main goal of the surgery is to address this issue. However, exercises might be essential postoperatively to aid in rehabilitation.
- **Option C:** Cold therapy can help in reducing inflammation and alleviating pain. However, in the immediate preoperative phase, the focus is often on preparing the patient for surgery and managing any potential complications, rather than on symptom management which the surgery itself is aiming to address.
- **Option D:** Education about postoperative pain management is crucial before joint replacement surgeries. This ensures that the patient has realistic expectations, understands the methods of pain relief available, and can actively participate in their pain management after the surgery, leading to better outcomes and improved patient satisfaction. Teaching the patient about postoperative pain management techniques is important but is more appropriate for the postoperative period.

37. A client with dysthymic disorder reports to a nurse that his life is hopeless and will never improve in the future. How can the nurse best respond using a cognitive approach?

- A. Agree with the client's painful feelings.
- B. Challenge the accuracy of the client's belief.
- C. Deny that the situation is hopeless.
- D. Present a cheerful attitude.

Correct Answer: B. Challenge the accuracy of the client's belief

Use of cognitive techniques allows the nurse to help the client recognize that these negative beliefs may be distortions and that, by changing his thinking, he can adopt more positive beliefs that are realistic and hopeful. Assess individual signs of hopelessness. These aids focus attention on aspects of individual needs. These signs may include social withdrawal, decreased physical activity, and comments made by the patient that indicate despair and hopelessness.

- **Option A:** Express hope to the patient with realistic comments about the patient's strengths and resources. Patients may feel hopeless, but it is helpful to hear positive expressions from others. Allow the patient to express feelings and perceptions. The process of recognizing feelings that underlie and drive behaviors allows the patient to start taking control of their lives.
- **Option D:** Presenting a cheerful attitude is not consistent with a cognitive approach and would not be helpful in this situation. Assist the patient to determine aspects of life that are under his or her control. An individual's emotional state may interfere with problem-solving. Support may be required to identify areas that are under his or her control and to have clarity about options for taking control.
- **Option C:** Denying the client's feelings is belittling and may convey that the nurse does not understand the depth of the client's distress. Aid the patient to determine aspects of life events that are not within his or her ability to control. Discuss feelings related to this lack of control. The patient needs to recognize and resolve feelings related to inability to control certain life situations before acceptance can be achieved and hopefulness becomes possible.

38. The term "blue bloater" refers to which of the following conditions?

- A. Adult respiratory distress syndrome (ARDS)
- B. Asthma
- C. Chronic obstructive bronchitis
- D. Emphysema

Correct Answer: C. Chronic obstructive bronchitis

Clients with chronic obstructive bronchitis appear bloated; they have large barrel chests and peripheral edema, cyanotic nail beds, and, at times, circumoral cyanosis. People with chronic bronchitis are sometimes called "blue bloaters" because of their bluish-colored skin and lips. Blue bloaters often take deeper breaths but can't take in the right amount of oxygen.

- **Option A:** Clients with ARDS are acutely short of breath and frequently need intubation for mechanical ventilation and large amounts of oxygen. Clients with ARDS have acute symptoms and typically need large amounts of oxygen. Acute respiratory distress syndrome (ARDS) is a

life-threatening condition characterized by poor oxygenation and non-compliant or “stiff” lungs. The disorder is associated with capillary endothelial injury and diffuse alveolar damage. Once ARDS develops, patients usually have varying degrees of pulmonary artery vasoconstriction and may subsequently develop pulmonary hypertension.

- **Option B:** Clients with asthma don't exhibit characteristics of chronic disease. Asthma is a common disease and has a range of severity, from a very mild, occasional wheeze to acute, life-threatening airway closure. It usually presents in childhood and is associated with other features of atopy, such as eczema and hayfever. Asthma is a condition of acute, fully reversible airway inflammation, often following exposure to an environmental trigger.
- **Option D:** Clients with emphysema appear pink and cachectic (a state of ill health, malnutrition, and wasting). Emphysema comes on very gradually and is irreversible. People with emphysema are sometimes called “pink puffers” because they have difficulty catching their breath and their faces redden while gasping for air.

39. Which of the following groups of characteristics would the nurse expect to see in the client with schizophrenia?

- A. Loose associations, grandiose delusions, and auditory hallucinations
- B. Periods of hyperactivity and irritability alternating with depression
- C. Delusions of jealousy and persecution, paranoia, and mistrust
- D. Sadness, apathy, feelings of worthlessness, anorexia, and weight loss

Correct Answer: A. Loose associations, grandiose delusions, and auditory hallucinations

Loose associations, grandiose delusions, and auditory hallucinations are all characteristic of the classic schizophrenic client. These clients aren't able to care for their physical appearance. They frequently hear voices telling them to do something either to themselves or to others. Additionally, they verbally ramble from one topic to the next. In the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), Two or more of the following symptoms must be present for a significant portion of time during a one-month period: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms.

- **Option B:** Periods of hyperactivity and irritability alternating with depression are characteristic of bipolar or manic disease. The defining characteristics of mania are increased talkativeness, rapid speech, decreased the need for sleep (unlike depression or anxiety in which the need for sleep exists, but there is an inability to sleep), racing thoughts, distractibility, increase in goal-directed activity, and psychomotor agitation. Some other hallmarks of mania are an elevated or expansive mood, mood lability, impulsivity, irritability, and grandiosity.
- **Option C:** Delusions of jealousy and persecution, paranoia, and mistrust are characteristics of paranoid disorders. Often, these patients think that others have greatly and irreversibly injured them. They are hypervigilant for potential insults, slights, threats, and disloyalty and look for hidden meanings in remarks and actions. They closely scrutinize others for evidence to support their suspicions. For example, they may misinterpret an offer of help as implication that they are unable to do the task on their own. If they think that they have been insulted or injured in any way, they do not forgive the person who injured them. They tend to counterattack or to become angry in response to these perceived injuries. Because they distrust others, they feel a need to be autonomous and in control.
- **Option D:** Sadness, apathy, feelings of worthlessness, anorexia, and weight loss are characteristics of depression. Depression is a mood disorder that causes a persistent feeling of

sadness and loss of interest. The common features of all the depressive disorders are sadness, emptiness, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.

40. The client is about to start the treatment for juvenile rheumatoid arthritis. Before the administration of etanercept (Enbrel), it is important for the nurse to:

- A. Ask for an allergy to latex.
- B. Ask the client to postpone a vacation trip abroad.
- C. Tell the client to not miss due vaccination while on treatment.
- D. To avoid people with a recent injection of etanercept.

Correct Answer: A. Ask for an allergy to latex.

Etanercept, a tumor necrosis factor blocker is used to manage juvenile rheumatoid arthritis that is given by injection. Before using the medication, inform the physician or the nurse of any allergy to latex or natural dry rubber that can be found in the prefilled syringes or autoinjectors form of the medication.

- **Options B, C, and D:** These are not related to the medication.

41. According to the family systems theory, which of the following best describes the process of differentiation?

- A. Cooperative action among members of the family.
- B. Development of autonomy within the family.
- C. Incongruent messages wherein the recipient is a victim.
- D. Maintenance of system continuity or equilibrium.

Correct Answer: B. Development of autonomy within the family

Differentiation is the process of becoming an individual developing autonomy while staying in contact with the family system. "The ability to be in emotional contact with others yet still autonomous in one's own emotional functioning is the essence of the concept of differentiation." (Kerr & Bowen. 1988)
"Differentiation is a product of a way of thinking that translates into a way of being....Such changes are reflected in the ability to be in emotional contact with a difficult, emotionally charged problem and not feel compelled to preach about what others "should" do, not rush in to "fix" the problem and not pretend to be detached by emotionally insulating oneself." (Kerr & Bowen 1988).

- **Option A:** Cooperative action among family members does not refer to differentiation, although individuals who have a high level of differentiation would be able to accomplish cooperative action. Bowen's concept of 'differentiation of self' forms the basis of a systems understanding of maturity. The concept of differentiation can be confusing but, put simply, it refers to the ability to think as an individual while staying meaningfully connected to others. It describes the varying capacity each person has to balance their emotions and their intellect, and to balance their need to be attached with their need to be a separate self. Bowen proposed that the best way to grow a more solid self was in the relationships that make up our original families; running away from difficult family members would only add to the challenges in managing relationship upsets.
- **Option C:** Incongruent messages in which the recipient is a victim describe double-bind communication. In communication, sometimes people say things that are contradictory to their

non-verbal communication cues. When a person's words don't match what he or she is feeling or thinking, the communication is said to be incongruent.

- **Option D:** Maintenance of system continuity or equilibrium is homeostasis. It's not an easy theory to grasp, as it focuses on the big-picture patterns of a system rather than the narrower view of what causes difficulties for one individual. These ideas invite us to see the world through the lens of each family member rather than just from our own subjective experience; they don't allow room for simply seeing victims and villains in our relationship networks. Seeing the system takes people beyond blame to seeing the relationship forces that set people on their different paths. This way of seeing our life challenges avoids fault-finding and provides a unique path to maturing throughout our adult lives.

42. Norma asks for information about osteoarthritis. Which of the following statements about osteoarthritis is correct?

- A. Osteoarthritis is rarely debilitating.
- B. Osteoarthritis is a rare form of arthritis.
- C. Osteoarthritis is the most common form of arthritis.
- D. Osteoarthritis affects people over 60.

Correct Answer: C. Osteoarthritis is the most common form of arthritis

Osteoarthritis is the most common form of arthritis and can be extremely debilitating. It can afflict people of any age, although most are elderly.

- **Option A:** Osteoarthritis is an extremely debilitating disease. The cartilage within a joint begins to break down and the underlying bone begins to change.
- **Option B:** It is the most common form of arthritis. It affects over 32.5 million US adults.
- **Option D:** Osteoarthritis can affect people of any age, but are most common among the elderly. Women are more likely to develop OA than men, especially after the age of 50.

43. A nurse is reviewing the medical record of a male client to be admitted to the nursing unit and notes documentation of reticular skin lesions. The nurse expects that these lesions will appear to be:

- A. Ring-shaped
- B. Linear
- C. Shaped like an arc
- D. Net-like appearance

Correct Answer: D. Net-like appearance

Reticular skin lesions resemble a net in appearance.

- **Option A:** Annular lesions are ring-shaped.
- **Option B:** Linear lesions appear in a straight line.
- **Option C:** Arciform lesions are shaped like an arc.

44. When auscultating the apical pulse of a client who has atrial fibrillation, the nurse would expect to hear a rhythm that is characterized by:

- A. The presence of occasional coupled beats.
- B. Long pauses in an otherwise regular rhythm.
- C. A continuous and totally unpredictable irregularity.
- D. Slow but strong and regular beats.

Correct Answer: C. A continuous and totally unpredictable irregularity.

In atrial fibrillation, multiple ectopic foci stimulate the atria to contract. The AV node is unable to transmit all of these impulses to the ventricles, resulting in a pattern of highly irregular ventricular contractions. Due to its rhythm irregularity, blood flow through the heart becomes turbulent and has a high chance of forming a thrombus (blood clot), which can ultimately dislodge and cause a stroke. Atrial fibrillation is the leading cardiac cause of stroke.

- **Option A:** The most common sensation associated with PVCs is that of a skipped heartbeat followed by a fluttering sensation. Patients commonly present complaining of heart palpitations. The vast majority of patients are entirely asymptomatic as there are no associated symptoms with the palpitations.
- **Option B:** In the presence of a pause, one should exclude premature complexes with compensatory pause. If the ectopic beat failed to reset the sinus node, the premature complex would be followed by a compensatory pause, i.e. the R-R interval after the premature complex is longer than the R-R interval between normal sinus beats.
- **Option D:** Having bradycardia means that the heart beats very slowly. For most people, a heart rate of 60 to 100 beats a minute while at rest is considered normal. If the heart beats less than 60 times a minute, it is slower than normal. For some people, a slow heart rate does not cause any problems. It can be a sign of being very fit. Healthy young adults and athletes often have heart rates of less than 60 beats a minute.

45. A male client is asking the nurse a question regarding the Mantoux test for tuberculosis. The nurse should base her response on the fact that the:

- A. Area of redness is measured in 3 days and determines whether tuberculosis is present.
- B. Skin test doesn't differentiate between active and dormant tuberculosis infection.
- C. Presence of a wheal at the injection site in 2 days indicates active tuberculosis.
- D. Test stimulates a reddened response in some clients and requires a second test in 3 months.

Correct Answer: B. Skin test doesn't differentiate between active and dormant tuberculosis infection.

The Mantoux test doesn't differentiate between active and dormant infections. If a positive reaction occurs, a sputum smear and culture as well as a chest X-ray are necessary to provide more information. According to CDC, this test is performed using the 'Mantoux technique,' which is injecting 0.1 mL of a solution containing 5 units of tuberculin purified protein derivative into the inner surface of the forearm through the intradermal route. It should be administered two or more than 2 inches from the elbow, wrist, or any other injection site.

- **Option A:** Although the area of redness is measured in 3 days, a second test may be needed; neither test indicates that tuberculosis is active. It is a time-sensitive test. Tests that are read late are not accurate as they tend to under-estimate the size of the skin reaction. Therefore, the reliability of the test is compromised, and the results are doubtful. To avoid this, repeat testing is recommended if the reaction is not read on time.
- **Option C:** The presence of a wheal within 2 days doesn't indicate active tuberculosis. Type IV hypersensitivity reaction (delayed-type) to the injected tuberculin PPD antigen is seen and measured. The reaction starts at 5 to 6 hours, with a peak effect at 48 to 72 hours, after which it begins to subside. Therefore, the right time to read the test is after 48 to 72 hours of intradermal test placement.
- **Option D:** In the Mantoux test, an induration 5 to 9 mm in diameter indicates a borderline reaction; a larger induration indicates a positive reaction. Induration is the palpable, raised swelling, which is measured transversely by inspection and palpation.

46. The following are lipid abnormalities. Which of the following is a risk factor for the development of atherosclerosis and PVD?

- A. High levels of low-density lipid (LDL) cholesterol
- B. High levels of high-density lipid (HDL) cholesterol
- C. Low concentration triglycerides
- D. Low levels of LDL cholesterol.

Correct Answer: A. High levels of low-density lipid (LDL) cholesterol

An increase in LDL cholesterol concentration has been documented as a risk factor for the development of atherosclerosis. LDL cholesterol is not broken down into the liver but is deposited into the wall of the blood vessels. As the LDL particles leave the blood and enter the arterial intima, they accumulate by being trapped by proteoglycans and are modified. While the modifications of LDL are not elucidated, oxidative modification generating oxidized LDL appears to be an attractive candidate.

- **Option B:** High-density lipids are called the “good” cholesterol. They absorb cholesterol and carry it back to the liver. The liver then flushes it from the body. HDL is known for its anti-atherogenic and anti-inflammatory properties, thanks to its uptake and return of the cholesterol stored in the foam cells of atherosclerotic plaques to the liver. Thus, reducing the size of the plaque and its associated inflammation.
- **Option C:** Triglycerides are the type of fat found in the blood. When we eat, the body converts any calories it doesn't need to use right away into triglycerides. These are stored into fat cells. Later, hormones release triglycerides for energy between meals.
- **Option D:** Low levels of LDL or the “bad” cholesterol reduces the risk for atherosclerosis and PVD. Modified LDL is taken up by scavenger receptors (SR) such as SRA and CD36 resulting in foam cell formation since cellular cholesterol content does not regulate these SRs. Following endothelial dysfunction induced by LDL, smoking, diabetes, hypertension, among others, there is a deficiency of NO and prostacyclin and/or an increase in plasminogen activator inhibitor type 1 (PAI-1) and cell adhesion molecules (CAMs).

47. A nurse in the labor room is monitoring a client with dysfunctional labor for signs of maternal or fetal compromise. Which of the following assessment findings would alert the nurse to a compromise?

- A. Coordinated uterine contractions
- B. Meconium in the amniotic fluid
- C. Progressive changes in the cervix
- D. Maternal fatigue

Correct Answer: B. Meconium in the amniotic fluid

Signs of maternal or fetal compromise include passage of meconium, decreased movement felt by the mother, nonreassuring fetal heart rate, and fetal metabolic acidosis.

- **Option A:** Technically, effective uterine contractions include three factors: intensity, synchronization, and frequency of contractions. Most studies are based on single-lead recordings that can reflect the severity and frequency of uterine contractions. Therefore, uterine synchronization topography can be used to display labor progress in the labor room.
- **Option C:** A prolonged latent phase may result from oversedation or from entering labor early with a thickened or uneffaced cervix. It may be misdiagnosed in the face of frequent prodromal contractions.
- **Option D:** Maternal fatigue can occur with prolonged labor, but do not indicate maternal or fetal compromise. Fatigue is one of the most common complaints in pregnant women that often continues until delivery. Maternal fatigue prolongs the labor process and increases the rate of cesarean section. Studies on the pattern of uterine contractions have shown that the length of the fall time is longer in prolonged labors than in normal deliveries.

48. Oral steroids are prescribed on a taper in order to:

- A. Achieve optimal serum levels.
- B. Ensure drug reliability.
- C. Ensure compliance.
- D. Prevent steroid withdrawal syndrome.

Correct Answer: D. Prevent steroid withdrawal syndrome.

Steroids are tapered off in order to prevent a withdrawal syndrome. Tapering the dosage over 2 months or more may be necessary for patients on prolonged treatment (more than 1 year). Depending on the dosage, duration of therapy, and risk of systemic disease, decrease dosage by the equivalent of 2.5 to 5 mg prednisone every 3 to 7 days until a dosage of 5 mg of prednisone is reached.

- **Option A:** Optimal serum levels do not require tapering in order to be maintained. Before initiating long-term systemic corticosteroid therapy, a thorough history and physical examination should be performed to assess for risk factors or pre-existing conditions that may potentially be exacerbated by GC therapy, such as diabetes, dyslipidemia, CVD, GI disorders, affective disorders, or osteoporosis.
- **Option B:** Tapering has nothing to do with drug reliability. If the client takes prednisone for more than a few weeks, the adrenal glands will decrease the natural production of cortisol. If the client stops prednisone abruptly before production is restored, the lack of hormones can trigger an array of withdrawal symptoms.
- **Option C:** Compliance is not dependent on tapering. To avoid prednisone withdrawal, the drug should be gradually reduced in stages according to a specific schedule prescribed by the doctor.

An exception is if prednisone has been given over a very short period of time. Don't try to stop or taper prednisone without the doctor's knowledge or advice.

49. When evaluating a male client for complications of acute pancreatitis, the nurse would observe for:

- A. Increased intracranial pressure
- B. Decreased urine output
- C. Bradycardia
- D. Hypertension

Correct Answer: B. Decreased urine output

Acute pancreatitis can cause decreased urine output, which results from the renal failure that sometimes accompanies this condition. AKI develops late in the course of acute pancreatitis, usually after failure of other organs. Remarkably, the kidney was the first organ to fail in only 8.9% of patients with AKI, and only a minority of patients develop isolated AKI

- **Option A:** Intracranial pressure neither increases nor decreases in a client with pancreatitis. The causes of increased intracranial pressure (ICP) can be divided based on the intracerebral components causing elevated pressures. Generalized swelling of the brain or cerebral edema from a variety of causes such as trauma, ischemia, hyperammonemia, uremic encephalopathy, and hyponatremia.
- **Option C:** Tachycardia, not bradycardia, usually is associated with pulmonary or hypovolemic complications of pancreatitis. Tachycardia and mild hypotension may result from hypovolemia from sequestration of fluid in the pancreatic bed. About 60% of patients develop low-grade pyrexia from peripancreatic inflammation without evident infection.
- **Option D:** Hypotension can be caused by a hypovolemic complication, but hypertension usually isn't related to acute pancreatitis. Release into the systemic circulation of activated enzymes and proteases may cause endothelial damage leading to extravasation of fluids from the vascular space, hypovolemia, hypotension, increased abdominal pressure, intense kidney vasoconstriction, hypercoagulability, and fibrin deposition in the glomeruli.

50. A post-kidney transplant client went to the health care facility to ask the nurse regarding vaccinations while on tacrolimus (Prograf) a medication used to prevent organ rejection. Which of the following is an appropriate response of the nurse?

- A. "Do not skip due doses of vaccination for this can help in your treatment".
- B. "You can have live vaccinations even without the approval of the physician".
- C. "Influenza can happen anytime, so a flu vaccine is a must."
- D. "Do not receive any live vaccinations while on this treatment".

Correct Answer: D. "Do not receive any live vaccinations while on this treatment".

Tacrolimus may lower your body's resistance and the vaccine may not work as well or the client may get the infection the vaccine is meant to prevent.

- **Options A, B, and C:** Do not have any vaccination while on tacrolimus therapy since the medication can weaken the body's resistance and the vaccine might not work properly, or the client might get the infection the vaccine is meant to prevent.

51. Which of the following behaviors characterizes the PP mother in the taking in phase?

- A. Passive and dependent
- B. Striving for independence and autonomy
- C. Curious and interested in care of the baby
- D. Exhibiting maximum readiness for new learning

Correct Answer: A. Passive and dependent

During the taking in phase, which usually lasts 1-3 days, the mother is passive and dependent and expresses her own needs rather than the neonate's needs. The woman becomes dependent on her healthcare provider or support person with some of the daily tasks and decision-making. This dependence is mainly due to her physical discomfort from hemorrhoids or the after pains, from the uncertainty of how she could care for the newborn, and also from the extreme tiredness she feels that follows childbirth.

- **Option B:** The taking hold phase usually lasts from days 3-10 PP. During this stage, the mother strives for independence and autonomy. The woman starts to initiate actions on her own and makes decisions without relying on others. She starts to focus on the newborn instead of herself and begins to actively participate in newborn care. The woman still needs positive reinforcements despite the independence that she is already showing because she might still feel insecure about the care of her child.
- **Option C:** During the taking hold phase, demonstrate newborn care to the mother and watch her do a return demonstration of every procedure. Allow the woman to settle in gradually into her new role while still at the hospital or healthcare facility because making decisions about the child's welfare is a difficult part of motherhood.
- **Option D:** She also is most ready to learn. She is concerned about her ability to take care of her newborn. This phase is associated with a great deal of anxiety (especially by a new mother). She may have several mood swings. The mother might be involved in a lot of activity trying to accomplish tasks.

52. Your goal is to minimize David's risk of complications after a herniorrhaphy. You instruct the patient to:

- A. Avoid the use of pain medication.
- B. Cough and deep breath Q2H.
- C. Splint the incision if he can't avoid sneezing or coughing.
- D. Apply heat to scrotal swelling.

Correct Answer: C. Splint the incision if he can't avoid sneezing or coughing.

Teach the patient to avoid activities that increase intra-abdominal pressure such as coughing, sneezing, or straining with a bowel movement. Patients should be advised to avoid strenuous activities

for a few weeks. Typically, light work can be resumed after 1 week, heavier jobs after 6 weeks.

- **Option A:** Postoperative chronic pain is more frequent than was previously understood and has become one of the most important primary endpoints in hernia surgery. In published reports, the incidence of post herniorrhaphy pain has ranged from 0% to more than 30%. Chronic inguinodynia is defined as pain persisting more than 3 months post herniorrhaphy, after the process of wound healing is complete.
- **Option B:** Recurrence in Lichtenstein hernioplasty may be due to inaccurate execution of the technique (inadequate size or improper fixation of the mesh) or to an overlooked hernia at the primary operation. To avoid the latter, the patient should be asked to cough, and the region should be carefully examined for an indirect hernia, a direct hernia, a femoral hernia, or a combined hernia.
- **Option D:** After the procedure, the patient is asked to rest for a few hours. He or she may be discharged later the same day on a day-care basis. Early mobilization is the key to rapid convalescence. Patients can safely ambulate on the evening of the operation. If general or regional anesthesia is used, the patient may be hospitalized for a few days.

53. A client tells the nurse, "I think my baby likes to hear me talk to him." When discussing neonates and stimulation with sound, which of the following would the nurse include as a means to elicit the best response?

- A. High-pitched speech with tonal variations.
- B. Low-pitched speech with a sameness of tone.
- C. Cooing sounds rather than words.
- D. Repeated stimulation with loud sounds.

Correct Answer: A. High-pitched speech with tonal variations

Providing stimulation and speaking to neonates is important. Some authorities believe that speech is the most important type of sensory stimulation for a neonate. Neonates respond best to speech with tonal variations and a high-pitched voice. A neonate can hear all sound louder than about 55 decibels.

- **Option B:** Low pitched speech is less effective for neonates because they can hear all sounds louder than about 55 decibels.
- **Option C:** At about two months, the infant may start cooing and repeating vowel sounds. Imitate his cooing while also adding simple words and phrases over the first four to six months.
- **Option D:** A baby's hearing is very sensitive and can be easily damaged by loud sounds. It is recommended to keep sounds around the infant quieter than 60 decibels.

54. The newly hired nurse is in his first week on the job in the ED. He used to be a traveling nurse for 5 years. Which area in his present job is the most appropriate assignment for him?

- A. Fast-track clinic
- B. Pediatric medicine team
- C. Trauma team
- D. Triage

Correct Answer: A. Fast-track clinic

The ambulatory or fast-track clinic deals with relatively stable clients. The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.

- **Option B:** Few places are more hectic than a pediatric ward. Clearly, delegating important nursing tasks is the only plausible way for short-staffed emergency rooms to meet the challenges of providing quality patient care. All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety, and welfare of the public.
- **Option C:** This area should be filled with nurses who are experienced with hospital routines and policies and have the ability to locate equipment immediately. There is both individual accountability and organizational accountability for delegation. Organizational accountability for delegation relates to providing sufficient resources, including sufficient staffing with an appropriate staff mix.
- **Option D:** The RN delegates only those tasks for which he or she believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and procedures.

55. With regard to small-for-gestational-age (SGA) infants and intrauterine growth restriction (IUGR), nurses should be aware that:

- A. In the first trimester, diseases or abnormalities result in asymmetric IUGR.
- B. Infants with asymmetric IUGR have the potential for normal growth and development.
- C. In asymmetric IUGR, weight is slightly more than SGA, whereas length and head circumference are somewhat less than SGA.
- D. Symmetric IUGR occurs in the later stages of pregnancy.

Correct Answer: B. Infants with asymmetric IUGR have the potential for normal growth and development.

The infant with asymmetric IUGR has the potential for normal growth and development. SGA infants have reduced brain capacity. The asymmetric form occurs in the later stages of pregnancy.

- **Option A:** IUGR is either symmetric or asymmetric. The symmetric form occurs in the first trimester, as a result of disease or abnormalities.
- **Option C:** Weight is less than the 10th percentile, but the head circumference is greater than the 10th percentile (within normal limits).
- **Option D:** IUGR is either symmetric or asymmetric. The symmetric form occurs in the first trimester, as a result of disease or abnormalities.

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

- A. Fill out the client's menu and make sure she eats at least half of what is on her tray.
- B. Let the client eat her meals in private. Then engage her in social activities for at least 2 hours after each meal.

- C. Let the client choose her own food. If she eats everything she orders, then stay with her for 1 hour after each meal.
- D. Let the client eat food brought in by the family if she chooses, but she should keep a strict calorie count.

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

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

- **Option A:** She must then eat 100% of what she selected. During the early stages of treatment when patients are still new to recovery, they look to nurses to provide them with a highly structured environment, which sometimes involves nurses making food and behavioral decisions on their behalf. While this might not be an ongoing issue for primary care nurses, they may still be required to offer decisive advice on these areas. Here, it is imperative that nurses offer such advice with a clear message that patients have the power to make these decisions themselves.
- **Option B:** Remaining with the client for at least 1 hour after eating will prevent purging. As treatment progresses, patients eventually grow to appreciate nurses who act as role models and educate them on how to normalize their diet and involvement in social activities. Towards the end of treatment, nurses become more of a support system, encouraging the patient to move forward autonomously, while providing them with guidance on where to seek help if it is needed.
- **Option D:** Bulimic clients should only be allowed to eat food provided by the dietary department. From awareness of the eating disorder to recovery maintenance, the role of the primary care nurse evolves, but what doesn't change is the positive influence nurses can have on those with an eating disorder. With the skills of listening, empathy, adaptability, and communication, primary care nurses can assist in identifying at-risk individuals and optimizing the delivery of a multidisciplinary and holistic approach to care.

57. Which of the following stages is the carcinogen irreversible?

- A. Progression stage
- B. Initiation stage
- C. Regression stage
- D. Promotion stage

Correct Answer: A. Progression stage

Progression stage is the change of tumor from the preneoplastic state or low degree of malignancy to a fast-growing tumor that cannot be reversed. Tumor progression comprises the expression of the malignant phenotype and the tendency of malignant cells to acquire more aggressive characteristics over time. Also, metastasis may involve the ability of tumor cells to secrete proteases that allow invasion beyond the immediate primary tumor location. A prominent characteristic of the malignant phenotype is the propensity for genomic instability and uncontrolled growth.

- **Option B:** Initiation is the first step in the two-stage model of cancer development. Initiators cause irreversible changes to DNA that increase cancer risk. The early concept of tumor initiation indicated that the initial changes in chemical carcinogenesis are irreversible genetic damage. However, recent data from molecular studies of preneoplastic human lung and colon tissues implicate epigenetic changes as an early event in carcinogenesis.
- **Option C:** There is no regression stage in the development of cancer. Malignant conversion is the transformation of a preneoplastic cell into one that expresses the malignant phenotype. This process requires further genetic changes. The total dose of a tumor promoter is less significant than frequently repeated administrations, and if the tumor promoter is discontinued before malignant conversion has occurred, premalignant or benign lesions may regress.
- **Option D:** The promotion stage is considered to be a relatively lengthy and reversible process in which actively proliferating preneoplastic cells accumulate. Tumor promotion comprises the selective clonal expansion of initiated cells. Because the accumulation rate of mutations is proportional to the rate of cell division, or at least the rate at which stem cells are replaced, clonal expansion of initiated cells thus, produces a larger population of cells that are at risk of further genetic changes and malignant conversion.

58. 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.

59. Kyle is a client with an anxious, fearful personality who has difficulty accomplishing work assignments because of his fear of failure. He has been referred to the employee assistance program because of repeated absences from work and evidence of an alcohol problem. Which nursing diagnosis would be most appropriate?

- A. Ineffective coping
- B. Decisional conflict
- C. Disturbed thought process
- D. Risk for self-directed violence

Correct Answer: A. Ineffective coping

The client is experiencing difficulty in occupational functioning as well as problems with alcohol; therefore, he meets the criteria for the diagnosis of Ineffective coping. Work with the client on problem-solving skills using a situation that is bothering the client. Client might not know how to articulate the problem. Helping identify alternatives gives the client a sense of control. Evaluating the pros and cons of the alternatives facilitates choosing potential solutions.

- **Option B:** Keep goals very realistic and go in small steps. There are no overnight successes with people with personality disorders. It can take a long time to positively change ingrained, life-long, maladaptive habits; however, change is always possible.
- **Option C:** Identify behavioral limits and behaviors that are expected. Client needs a clear structure. Expect frequent testing of limits initially. Maintaining limits can enhance feelings of safety in the client.
- **Option D:** If the client becomes hostile or projects blame onto you or staff, project a neutral, calm demeanor, and avoid power struggles. Focus on the client's underlying feelings. Defuses tension and opens up productive interaction.

60. The patient who had a stroke needs to be fed. What instruction should you give to the nursing assistant who will feed the patient?

- A. Position the patient sitting up in bed before you feed her.
- B. Check the patient's gag and swallowing reflexes.

- C. Feed the patient quickly because there are three more waiting.
- D. Suction the patient's secretions between bites of food.

Correct Answer: A. Position the patient sitting up in bed before you feed her.

Positioning the patient in a sitting position decreases the risk of aspiration.

- **Option B:** The nursing assistant is not trained to assess gag or swallowing reflexes.
- **Option C:** The patient should not be rushed during feeding.
- **Option D:** A patient who needs to be suctioned between bites of food is not handling secretions and is at risk for aspiration. This patient should be assessed further before feeding.

61. Which of the following terms best describes the pain associated with appendicitis?

- A. Aching
- B. Fleeting
- C. Intermittent
- D. Steady

Correct Answer: D. Steady

The pain begins in the epigastrium or periumbilical region, then shifts to the right lower quadrant and becomes steady. The pain may be moderate to severe. Classically, appendicitis presents as an initial generalized or periumbilical abdominal pain that then localizes to the right lower quadrant. Initially, as the visceral afferent nerve fibers at T8 through T10 are stimulated, and this leads to vague centralized pain.

- **Option A:** Pain upon passive extension of the right leg with the patient in the left lateral decubitus position is known as psoas sign. This maneuver stretches the psoas major muscle, which can be irritated by an inflamed retrocecal appendix. Patients often flex the hip to shorten the psoas major muscle and relieve pain.
- **Option B:** As the appendix becomes more swollen and inflamed, it will irritate the lining of the abdominal wall, known as the peritoneum. This causes localized, sharp pain in the right lower part of the abdomen.
- **Option C:** As the appendix becomes more inflamed, and the adjacent parietal peritoneum is irritated, the pain becomes more localized to the right lower quadrant. The pain tends to be more constant and severe than the dull, aching pain that occurs when symptoms start.

62. The child with conduct disorder will likely demonstrate:

- A. Easy distractibility to external stimuli.
- B. Ritualistic behaviors
- C. Preference for inanimate objects.
- D. Serious violations of age related norms.

Correct Answer: D. Serious violations of age-related norms.

This is a disruptive disorder among children characterized by more serious violations of social standards such as aggression, vandalism, stealing, lying, and truancy. CD is characterized by a pattern of behaviors that demonstrates aggression and violation of rights of others and evolves over time. Conduct disorder is comorbid with many other psychiatric conditions including depression, ADHD, learning disorders and thus a thorough psychiatric evaluation is required to understand the psychopathology before initiating an appropriate treatment plan (American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013; Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC: American Psychiatric Association; 1994).

- **Option A:** This is characteristic of attention deficit disorder. The symptoms begin at a young age and usually include lack of attention, lack of concentration, disorganization, difficulty completing tasks, being forgetful, and losing things. These symptoms should be present before the age of 12, have lasted six months, and interfere with daily life activities in order to be labeled as 'ADHD'.
- **Option B:** Obsessive-compulsive disorder (OCD) is often a disabling condition consisting of bothersome intrusive thoughts that elicit a feeling of discomfort. To reduce the anxiety and distress associated with these thoughts, the patient may employ compulsions or rituals. These rituals may be personal and private, or they may involve others to participate; the rituals are to compensate for the ego-dystonic feelings of the obsessional thoughts and can cause a significant decline in function.
- **Option C:** These are noted among children with autistic disorders. Autism spectrum disorders (ASD) are a group of rapidly growing disabilities. They are characterized by repetitive patterns of behavior, interests, or activities, problems in social interactions. ASD is a complicated neurological disorder that is characterized by behavioral and psychological problems in children. These children become distressed when their surrounding environment is changed because their adaptive capabilities are minimal.

63. Nurse Lucy is planning to give preoperative teaching to a client who will be undergoing rhinoplasty. Which of the following should be included?

- A. Results of the surgery will be immediately noticeable postoperatively
- B. Normal saline nose drops will need to be administered preoperatively
- C. After surgery, nasal packing will be in place 8 to 10 days
- D. Aspirin-containing medications should not be taken 14 days before surgery

Correct Answer: D. Aspirin-containing medications should not be taken 14 days before surgery

Aspirin-containing medications should not be taken 14 days before surgery to decrease the risk of bleeding. Impaired coagulation may cause postoperative complications. Patients should be asked about a history of excessive bruising or bleeding, consumption of drugs, supplements, or vitamins that alter coagulation cascade or history of thrombotic events in the past. Any drug, vitamins, or supplement that impairs coagulation might have to be suspended preoperatively.

- **Option A:** Results would not be seen immediately, as swelling on the postoperative part will be prominent after surgery. Preoperative photos have to be taken for previous analysis and planning and for medico-legal purposes. Frontal, both profiles, and a basal view are the minimum requirements. They should be taken using a dark background with good lighting settings.
- **Option B:** There is no indication for normal saline nose drops after surgery. Closed rhinoplasty can be performed either with general anesthesia or local anesthesia and sedation, both with similar results in experienced hands. The patient is placed in the supine position, with a slight reverse

Trendelenburg, to minimize bleeding.

- **Option C:** Internal dressings or nasal packings remain in place for 1 to 7 days after the surgery. After mucosal incisions are closed with resorbable sutures, Silastic splints are placed and sutured to each side of the septum in order to provide septal support and enhance mucosal healing. Several strips of paper tape are distributed over the dorsum and a cast over it, which is removed 7 days postoperatively.

64. Which of the following methods of insulin administration would be used in the initial treatment of hyperglycemia in a client with diabetic ketoacidosis?

- A. Subcutaneous
- B. Intramuscular
- C. IV bolus only
- D. IV bolus, followed by continuous infusion

Correct Answer: D. IV bolus, followed by continuous infusion.

An IV bolus of insulin is given initially to control the hyperglycemia; followed by a continuous infusion, titrated to control blood glucose. Previous treatment protocols have recommended the administration of an initial bolus of 0.1 U/kg, followed by the infusion of 0.1 U/kg/h. A more recent prospective randomized trial demonstrated that a bolus is not necessary if patients are given hourly insulin infusion at 0.14 U/kg/hr.

- **Option A:** After the client is stabilized, subcutaneous insulin is given. Treatment of adult patients who have uncomplicated, mild diabetic ketoacidosis can be treated with subcutaneous insulin lispro hourly in a non-intensive care setting may be safe and cost-effective as opposed to treatment with intravenous regular insulin in the intensive care setting as shown in many studies.
- **Option B:** Insulin is never given intramuscularly. In one of these studies, the patients received subcutaneous insulin lispro at a dose of 0.3 U/kg initially, followed by 0.1 U/kg every hour until blood glucose was less than 250 mg/dl. Then insulin dose was decreased to 0.05 or 0.1 U/kg given every hour until the resolution of DKA.
- **Option C:** Intravenous insulin by continuous infusion is the standard of care. When the plasma glucose reaches 200-250 mg/dl, and if the patient still has an anion gap, then dextrose-containing fluids should be initiated, and the insulin infusion rate may need to be reduced.

65. When providing postoperative care for the child with a cleft palate, the nurse should position the child in which of the following positions?

- A. Supine
- B. Prone
- C. In an infant seat
- D. On the side

Correct Answer: B. Prone

Postoperatively children with cleft palate should be placed on their abdomens to facilitate drainage. A child who has had a cleft lip repair should be positioned on their back to keep them from rubbing their face in the bed. A child with only a cleft palate repair may sleep on their stomach.

- **Option A:** If the child is placed in the supine position, he or she may aspirate. The goal after surgery is to protect the new repair and stitches. For this reason, there will be some changes in the child's feeding, positioning, and activity for a short time.
- **Option C:** Using an infant seat does not facilitate drainage.
- **Option D:** Side-lying does not facilitate drainage as well as the prone position.

66. A pneumonectomy is a surgical procedure sometimes indicated for treatment of non-small-cell lung cancer. A pneumonectomy involves removal of:

- A. One lobe of a lung
- B. An entire lung field
- C. One or more segments of a lung lobe
- D. A small, wedge-shaped lung surface

Correct Answer: B. An entire lung field

- **Option B:** A pneumonectomy is the removal of an entire lung field indicated for the treatment of non-small cell lung cancer that has not spread outside of the lung tissue. It is performed on patients who will have adequate lung function in the unaffected lung.
- **Option D:** A wedge resection refers to the removal of a wedge-shaped section of lung tissue. It may be used to remove a tumor and a small amount of normal tissue around it/
- **Option A:** A lobectomy is the removal of one lobe.
- **Option C:** Removal of one or more segments of a lung lobe is called a partial lobectomy.

67. The physician has prescribed esomeprazole (Nexium) for a client with erosive gastritis. The nurse should administer the medication:

- A. 30 minutes before meals
- B. With each meal
- C. In a single dose at bedtime
- D. 30 minutes after meals

Correct Answer: A. 30 minutes before meals

Proton pump inhibitors reduce the production of acid in the stomach. Proton pump inhibitors work best when they are taken 30 minutes before the first meal of the day. Take each dose with a full glass (8 ounces) of water. Esomeprazole is usually given for 4 to 8 weeks only. The doctor may recommend a second course of treatment if the client needs additional healing time.

- **Option B:** It should be taken only once every day. Esomeprazole is used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions involving excessive stomach acid such as Zollinger-Ellison syndrome. Esomeprazole is also used to promote the healing of erosive esophagitis (damage to the esophagus caused by stomach acid).
- **Option C:** The medicine would not work on its best if taken at bedtime. Use exactly as directed on the label, or as prescribed by the doctor. Swallow the pill whole and do not crush, chew, break, or

open it. Esomeprazole is not for immediate relief of heartburn symptoms.

- **Option D:** Proton pump inhibitors are best taken before the first meal of the day to an empty stomach. Esomeprazole may also be given to prevent gastric ulcer caused by infection with *Helicobacter pylori* (*H. pylori*), or by the use of nonsteroidal anti-inflammatory drugs (NSAIDs).

68. Nurse Martinez is overseeing a group of nursing students during their orthopedic rotation. She presents a case of a 16-year-old male who had a minor bone fracture while playing soccer. As they discuss the recovery and healing processes, Nurse Martinez wants to ensure the students understand the composition of bones. She asks: “Regarding the composition of our bones, most of the mineral is in the form of calcium phosphate crystals known as what?”

- A. Synovial fluid
- B. Marrow
- C. Hydroxyapatite
- D. Proteoglycans

Correct Answer: C. Hydroxyapatite

Hydroxyapatite is a calcium phosphate crystal contained in normal bone. The lattice-like structure of hydroxyapatite crystals accounts for the bones to withstand compression.

- **Option A:** Synovial fluid forms a thin lubricating film covering the joint surfaces.
- **Option B:** Marrow, specifically bone marrow, is a semi-solid tissue which may be found within the spongy or cancellous portions of bones. It is responsible for producing blood cells.
- **Option D:** These are large molecules that are part of the matrix of cartilage. They help to provide the compressive strength of cartilage.

69. A pregnant patient asks the nurse if she can take castor oil for her constipation. How should the nurse respond?

- A. “Yes, it produces no adverse effect.”
- B. “No, it can initiate premature uterine contractions.”
- C. “No, it can promote sodium retention.”
- D. “No, it can lead to increased absorption of fat-soluble vitamins.”

Correct Answer: B. “No, it can initiate premature uterine contractions.”

Castor oil can initiate premature uterine contractions in pregnant women. It also can produce other adverse effects, but it does not promote sodium retention.

- **Option A:** Castor oil is a harsh stimulant laxative that relieves constipation by forced bowel movements. Side effects may include nausea, stimulation of uterine activity, meconium-stained fluid, and amniotic fluid embolism.
- **Option C:** There is no evidence that suggests that castor oil can promote sodium retention.

- **Option D:** Castor oil is not known to increase absorption of fat-soluble vitamins, although laxatives, in general, may decrease absorption if intestinal motility is increased.

70. Which intervention is most important to use to prevent infection by autocontamination in the burned client during the acute phase of recovery?

- A. Changing gloves between wound care on different parts of the client's body.
- B. Avoiding sharing equipment such as blood pressure cuffs between clients.
- C. Using the closed method of burn wound management.
- D. Using proper and consistent handwashing.

Correct Answer: A. Changing gloves between wound care on different parts of the client's body

Autocontamination is the transfer of microorganisms from one area to another area of the same client's body, causing infection of a previously uninfected area. Use gowns, gloves, masks, and strict aseptic techniques during direct wound care and provide sterile or freshly laundered bed linens or gowns.

- **Option B:** Although all techniques listed can help reduce the risk of infection, only changing gloves between carrying out wound care on different parts of the client's body can prevent autocontamination. Depending on the type or extent of wounds and the choice of wound treatment (open versus closed), isolation may range from a simple wound and/or skin to complete or reverse to reduce the risk of cross-contamination and exposure to multiple bacterial flora.
- **Option C:** Prevent skin-to-skin surface contact (wrap each burned finger or toe separately; do not allow burned ear to touch scalp). This identifies the presence of healing (granulation tissue) and provides for early detection of burn-wound infection. Infection in a partial-thickness burn may cause conversion of burn to full-thickness injury.
- **Option D:** Emphasize and model good handwashing techniques for all individuals coming in contact with the patient. This prevents cross-contamination and reduces the risk of acquired infection.

71. Nurse Walter should expect a 3-year-old child to be able to perform which action?

- A. Ride a tricycle
- B. Tie the shoelaces
- C. Roller-skates
- D. Jump rope

Correct Answer: A. Ride a tricycle

At age 3, gross motor development and refinement in eye-hand coordination enable a child to ride a tricycle. Most 3-year-olds are able to walk a line, balance on a low balance beam, skip or gallop, and walk backward. They can usually pedal a tricycle, catch a large ball, and jump with two feet.

- **Option B:** The fine motor skills required to tie shoelaces develop around age 5. By age 3, kids can usually wash and dry their hands, dress themselves with a little assistance, and turn pages in a book. Most preschoolers can hold a writing instrument with their fingers, not their fists.

- **Option C:** The gross motor skills required for roller-skating develop around age 5. Most children by age 3 develop more large muscle movements (gross motor skills). These generally include running, climbing, jumping in place, kicking a ball, and bending over easily.
- **Option D:** The gross motor skills required for jumping rope develop around age 5. Give the child time outdoors. Let them run and play. Climbing in and out of boxes is a favorite game. Remember to watch them closely when outside—they can move pretty fast when they want to.

72. A patient is taking insulin glargine injection daily. The nurse instructed the client that the onset of action will likely happen?

- A. 2-4 hours after administration
- B. 4-12 hours after administration
- C. 6-12 hours after administration
- D. 18-24 hours after administration

Correct Answer: A. 2-4 hours after administration

Insulin glargine is a long-acting insulin with an onset of 2-4 hours, no peak, and its duration of action is 24 hours.

73. Mr. Thompson, a 58-year-old winery owner, has been admitted to the hospital with a severe gout flare-up. As part of his discharge plan, Nurse Ramirez has been tasked with providing self-care instructions to Mr. Thompson to help manage his gout symptoms and prevent future flare-ups. Given his lifestyle and newly prescribed medication, which self-care instructions should Nurse Ramirez include? Select all that apply.

- A. "Apply cold packs to the affected joints during flare-ups."
- B. "Limit alcohol consumption to reduce the risk of gout flare-ups."
- C. "Engage in regular physical activity to maintain a healthy weight."
- D. "Avoid dehydration by drinking at least 8 glasses of water per day."
- E. "Take colchicine on an empty stomach for optimal absorption."

Correct Answers: A, B, C, and D.

- **Option A:** Cold packs can help reduce inflammation and provide relief from pain during gout flare-ups.
- **Option B:** Excessive alcohol consumption, especially beer, can increase uric acid levels and trigger gout attacks.
- **Option C:** Maintaining a healthy weight can help reduce the risk of gout attacks. Regular physical activity can assist in weight management.
- **Option D:** Adequate hydration can help in the excretion of uric acid through urine, thereby reducing the risk of gout flare-ups.
- **Option E:** Taking colchicine on an empty stomach may increase the risk of gastrointestinal side effects like nausea, vomiting, and diarrhea. It's generally better to take colchicine with food to

reduce potential stomach upset.

74. Which of the following assessment findings is seen in a client diagnosed with borderline personality disorder?

- A. Abrasions in various healing stages.
- B. Intermittent episodes of hypertension.
- C. Alternating tachycardia and bradycardia.
- D. Mild state of euphoria with disorientation.

Correct Answer: A. Abrasions in various healing stages.

Clients with borderline personality disorder tend to self-mutilate and have abrasions in various stages of healing. Unfortunately, self-mutilation is a common behavior, particularly among those with BPD. One study found that, among college students (not necessarily with BPD), attachment issues (insecure attachment, childhood separation, and emotional neglect) along with sexual abuse and dissociation, were significant risk factors for self-injury, and that the risk factors were gender-specific.

- **Option B:** Under conditions of stress, people with BPD may experience changes in thinking, including paranoid thoughts (for example, thoughts that others may be trying to cause them harm), or dissociation (feeling spaced out, numb, or like they're not really in their body).
- **Option C:** BPD is associated with a tendency to engage in risky and impulsive behaviors, such as going on shopping sprees, drinking excessive amounts of alcohol or abusing drugs, engaging in promiscuous or risky sex, or binge eating. Also, people with BPD are more prone to engage in self-harming behaviors, such as cutting or burning and attempting suicide.
- **Option D:** Emotional instability is a key feature of BPD. Individuals feel like they're on an emotional roller coaster with quick mood shifts (i.e., going from feeling OK to feeling extremely down or blue within a few minutes). Mood changes can last from minutes to days and are often intense. Anger, anxiety, and overwhelming emptiness are common as well.

75. A client in the family planning clinic asks the nurse about the most likely time for her to conceive. The nurse explains that conception is most likely to occur when:

- A. Estrogen levels are low.
- B. Luteinizing hormone is high.
- C. The endometrial lining is thin.
- D. The progesterone level is low.

Correct Answer: B. Luteinizing hormone is high.

Luteinizing hormone released by the pituitary is responsible for ovulation. At about day 14, the continued increase in estrogen stimulates the release of luteinizing hormone from the anterior pituitary. The LH surge is responsible for ovulation, or the release of the dominant follicle in preparation for conception, which occurs within the next 10–12 hours after the LH levels peak.

- **Option A:** Estrogen levels are high at the beginning of ovulation. At about day 14 in the menstrual cycle, a sudden surge in luteinizing hormone causes the ovary to release its egg. The egg begins

its five-day travel through a narrow, hollow structure called the fallopian tube to the uterus. As the egg is traveling through the fallopian tube, the level of progesterone, another hormone, rises, which helps prepare the uterine lining for pregnancy.

- **Option C:** The endometrial lining is thick, not thin. The blastocyst then attaches itself to the lining of the uterus (the endometrium). This attachment process is called implantation. Release of the hormones estrogen and progesterone causes the endometrium to thicken, which provides the nutrients the blastocyst needs to grow and eventually develop into a baby.
- **Option D:** The progesterone levels are high, not low. As cells continue to divide — some developing into the baby, others forming the nourishment and oxygen supply structure called the placenta — hormones are released that signal the body that a baby is growing inside the uterus. These hormones also signal the uterus to maintain its lining rather than shedding it.

76. How are critical thinking skills and critical thinking attitudes similar? Both are:

- A. Influences on the nurse's problem solving and decision making.
- B. Like feelings rather than cognitive activities.
- C. Cognitive activities rather than feelings.
- D. Applicable in all aspects of a person's life.

Correct Answer: A. Influences on the nurse's problem solving and decision making.

Cognitive skills are used in complex thinking processes, such as problem-solving and decision making. Critical thinking attitudes determine how a person uses her cognitive skills. Critical thinking attitudes are traits of the mind, such as independent thinking, intellectual curiosity, intellectual humility, and fair-mindedness, to name a few. Critical thinking skills refer to the cognitive activities used in complex thinking processes. A few examples of these skills involve recognizing the need for more information, recognizing gaps in one's own knowledge, and separating relevant information from irrelevant data. Critical thinking, which consists of intellectual skills and attitudes, can be used in all aspects of life.

- **Option B:** Critical Thinking is, in short, self-directed, self-disciplined, self-monitored, and self-corrective thinking. It presupposes assent to rigorous standards of excellence and mindful command of their use. It entails effective communication and problem-solving abilities and a commitment to overcome our native egocentrism and sociocentrism.
- **Option C:** Critical Thinking is a domain-general thinking skill. The ability to think clearly and rationally is important whenever one chooses to do. But critical thinking skills are not restricted to a particular subject area. Being able to think well and solve problems systematically is an asset for any career.
- **Option D:** A critical thinking attitude is related to the motivation to try to reason well, but it can also motivate an attempt to use various strategies to overcome personal limitations. Additionally, a person with a critical thinking attitude should often rely on the expertise of others rather than trying to assess all arguments on her own because expertise is often required to properly evaluate an argument.

77. Alexander has hypotonic FVE; which of the following findings would the nurse expect to assess in the patient?

- A. Poor skin turgor and increased thirst

- B. Weight gain and thirst
- C. Interstitial edema and hypertension
- D. Hypotension and pitting edema

Correct Answer: B. Weight gain and thirst

Weight gain and thirst are symptoms of hypotonic FVE; other symptoms include the excretion of dilute urine, non-pitting edema, dysrhythmias, and hyponatremia. Monitor for peripheral edema, pulmonary edema, or hepatomegaly. It is important to consider underlying cardiac dysfunction or renal failure and adjust volumes of administration accordingly. These patients might require a lower maintenance fluid rate than expected for their body weight.

- **Option A:** Severe cases of dehydration might present with flaccid or tented skin; Eyeballs might also appear sunken back into orbital cavities. Classically find cool and clammy skin found in hypovolemic shock due to peripheral vasoconstriction causing hypoperfusion of skin, especially at the extremities (i.e., hands or feet)
- **Option C:** Peripheral edema can be a sign of volume overload or third spacing of intravascular fluid. Appreciate a distended jugular vein in volume overload state; Can also be found in patients with congestive heart failure who are euvolemic but not pumping blood appropriately
- **Option D:** Falling blood pressure is an ominous finding in the setting of tachycardia, indicating that the cardiovascular system can no longer compensate adequately for hypovolemia. Conversely, elevated blood pressures can be seen in hypervolemia.

78. The nurse is conducting a postoperative assessment of a client on the first day after renal surgery. Which of the following findings would be most important for the nurse to report to the physician?

- A. Temperature, 99.8°F
- B. Urine output, 20 ml/hour
- C. Absence of bowel sounds
- D. A 2x2 inch area of serosanguineous drainage on the flank dressing.

Correct Answer: B. Urine output, 20 ml/hour.

The decrease in urinary output may indicate inadequate renal perfusion and should be reported immediately. Urine output of 30 ml/hour or greater is considered acceptable. There is a possibility that the kidney could become damaged during the surgical procedure. Every attempt will be made to minimize this risk.

- **Option A:** A slight elevation in temperature is expected after surgery. An infection can delay the healing process or cause scarring or other problems. If the wound from the surgical incision becomes infected, it will be treated with antibiotics. Antibiotics are powerful medicines that fight bacterial infections.
- **Option C:** Peristalsis returns gradually, usually the second or third day after surgery. Bowel sounds will be absent until then. The surgery involves the same level of risk for the donor as any other major surgery. The majority of complications following surgery are minor and may cause a longer hospitalization.
- **Option D:** A small amount of serosanguineous drainage is to be expected. The client will be encouraged to move around as soon as he can after surgery. This will stimulate blood circulation to

help prevent blood clots.

79. After teaching a pregnant woman who is in labor about the purpose of the episiotomy, which of the following purposes stated by the client would indicate to the nurse that the teaching was effective?

- A. Shortens the second stage of labor.
- B. Enlarges the pelvic inlet.
- C. Prevents perineal edema.
- D. Ensures quick placenta delivery.

Correct Answer: A. Shortens the second stage of labor

An episiotomy serves several purposes. It shortens the second stage of labor, substitutes a clean surgical incision for a tear, and decreases undue stretching of perineal muscles. An episiotomy helps prevent tearing of the rectum but it does not necessarily relieve pressure on the rectum. Tearing may still occur.

- **Option B:** The pelvic inlet or superior aperture of the pelvis is a planar surface that defines the boundary between the pelvic cavity and the abdominal cavity. It is not involved during an episiotomy.
- **Option C:** To prevent perineal edema, ice packs may be applied in the first 24 hours after birth to decrease swelling and pain.
- **Option D:** Placenta delivery may be sped up by either pulling the cord gently with one hand while pressing and kneading the uterus with the other, or exerting downward pressure on the top of the uterus, asking the woman to push at the appropriate time.

80. Johnette is reviewing her lessons in Pharmacology. She is aware that the general classification of drugs belonging to the opioid category is analgesic and:

- A. Tranquilizing
- B. Hallucinogenic
- C. Stimulant
- D. Depressant

Correct Answer: D. Depressant

Opiates are both analgesics and CNS depressants because they decrease the effect of neurotransmitters that are excitatory or stimulating. Opioids act both presynaptically and postsynaptically to produce an analgesic effect. Presynaptically, opioids block calcium channels on nociceptive afferent nerves to inhibit the release of neurotransmitters such as substance P and glutamate, which contribute to nociception. Postsynaptically, opioids open potassium channels, which hyperpolarize cell membranes, increasing the required action potential to generate nociceptive transmission. The mu, kappa, and delta-opioid receptors mediate analgesia spinal and supraspinal.

- **Option A:** Although an opiate can provide a tranquilizing effect; the general category would be that of a depressant. Tranquilizer, also spelled Tranquillizer, a drug that is used to reduce anxiety, fear,

tension, agitation, and related states of mental disturbance. Tranquilizers fall into two main classes, major and minor. Major tranquilizers, which are also known as antipsychotic agents, or neuroleptics, are so called because they are used to treat major states of mental disturbance in schizophrenics and other psychotic patients. By contrast, minor tranquilizers, which are also known as antianxiety agents, or anxiolytics, are used to treat milder states of anxiety and tension in healthy individuals or people with less serious mental disorders.

- **Option B:** Hallucinogens are a diverse group of drugs that alter a person's awareness of their surroundings as well as their own thoughts and feelings. They are commonly split into two categories: classic hallucinogens (such as LSD) and dissociative drugs (such as PCP). Both types of hallucinogens can cause hallucinations or sensations and images that seem real though they are not. Additionally, dissociative drugs can cause users to feel out of control or disconnected from their body and environment.
- **Option C:** Stimulant is a category that does not apply to opiates. Stimulants are a class of drugs that speed up the messages between the brain and the body. They can make a person feel more awake, alert, confident or energetic. Large doses of stimulants can cause over-stimulation, causing anxiety, panic, seizures, headaches, stomach cramps, aggression, and paranoia. Long-term use of strong stimulants can also cause a number of adverse effects. Stimulants include caffeine, nicotine, amphetamines, and cocaine.

81. You are preparing a child for IV conscious sedation before the repair of a facial laceration. What information should you report immediately to the physician?

- A. The child suddenly pulls out the IV
- B. The parent is not sure regarding the child's tetanus immunization status
- C. The parent wants information about the IV conscious sedation
- D. The parent's refusal of the administration of the IV sedation

Correct Answer: D. The parent's refusal of the administration of the IV sedation.

The refusal of the parents is an absolute contraindication; therefore the physician must be notified. But the autonomy of parents is very obviously different from the autonomy of patients to make decisions for themselves. While adult patients are generally thought to have an absolute right to refuse medical treatment for themselves, we don't usually think that parents can refuse all medical treatment for their children.

- **Option A:** The RN can reestablish the IV access. Parents' views might, at least in some circumstances, influence whether or not treatment would be in a child's best interests. Nurses and doctors are able to administer fluid directly into the veins using IV therapy. IV therapy is a relatively simple process that can be performed by nurses, but there are serious complications associated with it.
- **Option B:** Tetanus status can be addressed later. Tetanus immunization is part of the DTaP (diphtheria, tetanus, and acellular pertussis) vaccinations. Kids usually get: a series of four doses of DTaP vaccine before 2 years of age. another dose at 4–6 years of age.
- **Option C:** The RN can provide information about conscious sedation. Identifying teachable moments in clinical practice is an effective way to increase workplace learning with all nurses playing a role, not just nurse educators.

82. Exchange of gases takes place in which of the following organs?

- A. Kidney
- B. Lungs
- C. Liver
- D. Heart

Correct Answer: B. Lungs

Gas exchange is the transport of oxygen from the lungs to the bloodstream and the expulsion of carbon dioxide from the bloodstream to the lungs. It transpires in the lungs between the alveoli and a network of tiny blood vessels called capillaries, which are located in the walls of the alveoli.

- **Option A:** The renal system consists of the kidney, ureters, and urethra. The overall function of the system filters approximately 200 liters of fluid a day from renal blood flow which allows for toxins, metabolic waste products, and excess ions to be excreted while keeping essential substances in the blood. The kidney regulates plasma osmolarity by modulating the amount of water, solutes, and electrolytes in the blood. It ensures long-term acid-base balance and also produces erythropoietin which stimulates the production of red blood cells.
- **Option C:** The liver is a critical organ in the human body that is responsible for an array of functions that help support metabolism, immunity, digestion, detoxification, vitamin storage among other functions. It comprises around 2% of an adult's body weight. The liver is a unique organ due to its dual blood supply from the portal vein (approximately 75%) and the hepatic artery (approximately 25%).
- **Option D:** The heart is a muscular organ situated in the center of the chest behind the sternum. It consists of four chambers: the two upper chambers are called the right and left atria, and the two lower chambers are called the right and left ventricles. The right atrium and ventricle together are often called the right heart, and the left atrium and left ventricle together functionally form the left heart.

83. A postpartum nurse is providing instructions to the mother of a newborn infant with hyperbilirubinemia who is being breastfed. The nurse provides which most appropriate instructions to the mother?

- A. Switch to bottle-feeding the baby for 2 weeks
- B. Stop the breastfeedings and switch to bottle-feeding permanently
- C. Feed the newborn infant less frequently
- D. Continue to breast-feed every 2-4 hours

Correct Answer: D. Continue to breastfeed every 2-4 hours.

Hyperbilirubinemia is caused by the accumulation of excess bilirubin in the blood serum. The skin and sclera of the eyes of the newborn may appear noticeably yellow as a result of breakdown of fetal red blood cells.

- **Option D:** Breastfeeding should be initiated within 2 hours after birth and every 2-4 hours thereafter. Early feeding of newborns with hyperbilirubinemia promotes intestinal movement and excretion of meconium which ultimately helps prevent indirect bilirubin buildup. The other options are not necessary.

84. A 57-year-old librarian with a recent diagnosis of osteoarthritis (OA) in her hands and knees attends a joint protection workshop at a local community health center. During the session, she is introduced to various strategies to minimize joint stress and prevent the exacerbation of symptoms. At the end of the teaching session, the nurse checks for the patient's understanding of the provided instructions. Which statement by the patient indicates a need for further teaching?

- A. "I will use assistive devices to reduce joint stress when performing tasks."
- B. "I will alternate periods of activity with rest to prevent overuse of my joints."
- C. "I will engage in high-impact exercises to strengthen my joints."
- D. "I will maintain a healthy weight to reduce stress on my joints."

Correct Answer: C. "I will engage in high-impact exercises to strengthen my joints."

This statement indicates a misunderstanding. High-impact exercises can exacerbate symptoms of OA and place additional stress on already compromised joints. It's more appropriate to engage in low-impact exercises, such as swimming or walking, to maintain joint function and muscle strength without causing further damage.

- **Option A:** This statement is accurate. Using assistive devices, like jar openers, can be beneficial in reducing strain on joints, especially those in the hands. These tools can help make tasks easier and prevent unnecessary stress and pain.
- **Option B:** This statement is also correct. Alternating between activity and rest can help manage symptoms of OA. It's essential to balance activity to prevent overexertion and allow joints to recover.
- **Option D:** This is a correct understanding. Maintaining a healthy weight can significantly reduce stress, especially on weight-bearing joints like the knees and hips. This can decrease pain and potentially slow the progression of OA.

85. The client with non-Hodgkin's lymphoma is receiving Idarubicin (Idamycin). Which of the following would indicate to the nurse that the client is experiencing an adverse effect related to the medication?

- A. Dysrhythmia
- B. Weight loss
- C. Nausea and vomiting
- D. Peripheral neuropathy

Correct Answer: A. Dysrhythmia

Idarubicin (Idamycin) and Daunorubicin (Daunoxome) may cause cardiotoxicity (such as dysrhythmia, fatigue, shortness of breath), cardiomyopathy, and ECG changes.

- **Option B:** Weight gain, not weight loss is a side effect.
- **Option C:** This is a usual side effect that can last for 2-3 days.
- **Option D:** This is not a side effect related to this medication.