

Kevin's Review - 85 NCLEX Practice Questions

1. The nurse is assisting the physician with the removal of a central venous catheter. To facilitate removal, the nurse should instruct the client to:

- A. Perform the Valsalva maneuver as the catheter is advanced
- B. Turn his head to the left side and hyperextend the neck
- C. Take slow, deep breaths as the catheter is removed
- D. Turn his head to the right while maintaining a sniffing position

Correct Answer: A. Perform the Valsalva maneuver as the catheter is advanced

The client who is having a central venous catheter removed should be told to hold his breath and bear down. This prevents air from entering the line.

- **Option B:** Although there are many steps in the process of CVC removal, essential elements of the procedure include (for internal jugular and subclavian CVCs), positioning of the patient in the head down (Trendelenburg) position, having the patient perform a Valsalva maneuver as the catheter is being withdrawn, application of pressure to the catheter-entry site as the catheter is being withdrawn, placement of an air-occlusive dressing over the site after removal, and a period of post-procedure monitoring.
- **Option C:** The patient is asked to take a deep breath, hold it, and bear down during the removal to avoid introduction of an air embolism. Breath-holding or Valsalva maneuver will increase intracardiac pressures. Immediate occlusion is required to prevent air embolism.
Option D: The patient's head should be placed in a supine position with the head of the bed flat to reduce the risk of air embolism. Risk for air embolism increases when the catheter insertion site is above heart level (e.g., in a sitting position), if the patient is hypovolemic or during spontaneous inspiration.

2. Which technique is considered the gold standard for diagnosing DVT?

- A. Ultrasound imaging
- B. Venography
- C. MRI
- D. Doppler flow study

Correct Answer: B. Venography

Proximal leg vein ultrasound, which when positive, indicates that the patient should be treated as having a DVT. If a patient scores 2 or above, either a proximal leg vein ultrasound scan should be done within 4 hours, and if the result is negative, a D-dimer test should be done. If imaging is not possible within 4 hours, a D-dimer test should be undertaken, and an interim 24-hour dose of a parenteral anticoagulant should be given. A proximal leg vein ultrasound scan should be carried out within 24 hours of being requested.

- **Option A:** Complex duplex ultrasound is the imaging modality of choice. There is non-compressible venous segment; loss of phasic flow on Valsalva maneuver; absent color flow if completely occlusive; lack of flow augmentation with calf squeeze; and increased flow in superficial veins.
- **Option C:** Vascular structures should always be interrogated during a routine assessment of the peripheries and pelvis. Incidental DVT has a prevalence of around 0.3% on routine outpatient knee

MRI

- **Option D:** Doppler flow is a type of ultrasound. It uses sound waves to measure the flow of blood through a blood vessel. The results are shown on a computer screen in lines called waveforms. It's sometimes called Doppler velocimetry. A Doppler flow study may be used during pregnancy to check the health of the unborn baby (fetus).

3. Cely is experiencing alcohol withdrawal exhibits tremors, diaphoresis, and hyperactivity. Blood pressure is 190/87 mmHg and pulse is 92 bpm. Which of the medications would the nurse expect to administer?

- A. naloxone (Narcan)
- B. benztropine (Cogentin)
- C. lorazepam (Ativan)
- D. haloperidol (Haldol)

Correct Answer: C. lorazepam (Ativan)

The nurse would most likely administer benzodiazepine, such as lorazepam (ativan) to the client who is experiencing symptoms: The client's experiences symptoms of withdrawal because of the rebound phenomenon when the sedation of the CNS from alcohol begins to decrease. Lorazepam binds to benzodiazepine receptors on the postsynaptic GABA-A ligand-gated chloride channel neuron at several sites within the central nervous system (CNS). It enhances the inhibitory effects of GABA, which increases the conductance of chloride ions into the cell. This shift in chloride ions results in hyperpolarization and stabilization of the cellular plasma membrane. Its inhibitory action in the amygdala helps with anxiety disorders, while its inhibitory action in the cerebral cortex helps in seizure disorders.

- **Option A:** Naloxone is indicated for the treatment of opioid toxicity, specifically to reverse respiratory depression from opioid use. It is useful in accidental or intentional overdose and acute or chronic toxicity. Common opioid overdoses treated with naloxone include heroin, fentanyl, carfentanil, hydrocodone, oxycodone, methadone, and others. Naloxone is a pure, competitive opioid antagonist with a high affinity for the mu-opioid receptor, allowing for reversal of the effects of opioids.
- **Option B:** Benztropine belongs to the synthetic class of muscarinic receptor antagonists (anticholinergic drug). Thus, it has a structure similar to that of diphenhydramine and atropine. However, it is long-acting so that its administration can be with less frequency than diphenhydramine. It also induces less CNS stimulation effect compared to that of trihexyphenidyl, making it a preferable drug of choice for geriatric patients.
- **Option D:** Haloperidol is a first-generation (typical) antipsychotic medication that is used widely around the world. Food and Drug Administration (FDA) approved the use of haloperidol is for schizophrenia, Tourette syndrome (control of tics and vocal utterances in adults and children), hyperactivity (which may present as impulsivity, difficulty maintaining attention, severe aggressivity, mood instability, and frustration intolerance), severe childhood behavioral problems (such as combative, explosive hyperexcitability), intractable hiccups. It is a typical antipsychotic because it works on positive symptoms of schizophrenia, such as hallucinations and delusions.

4. Which of the following laboratory tests must be monitored for pregnant patients receiving dexamethasone?

- A. Random blood sugar
- B. Serum Calcium
- C. Red blood cell count
- D. Uric acid

Correct Answer: A. Random blood sugar.

Elevation of blood glucose level is expected for patients receiving corticosteroid therapy such as dexamethasone so a routine check on the sugar level must be monitored.

- **Options B & D:** These are not related to the use of dexamethasone.
- **Option C:** Instead of Red blood cell count, White blood cell count must be monitored for any signs of infection, because corticosteroid suppresses the immune system.

5. A client is admitted to the psychiatric hospital with a diagnosis of catatonic schizophrenia. During the physical examination, the client's arm remains outstretched after the nurse obtains the pulse and blood pressure, and the nurse must reposition the arm. This client is exhibiting:

- A. Waxy flexibility
- B. Negativity
- C. Suggestibility
- D. Retardation

Correct Answer: A. Waxy flexibility

Waxy flexibility, the ability to assume and maintain awkward or uncomfortable positions for long periods, is characteristic of catatonic schizophrenia. Clients commonly remain in these awkward positions until someone repositions them. Catatonic patients may also display "waxy flexibility", meaning that they allow themselves to be moved into new positions, but do not move on their own. Most of the time, this is not an act or a show but rather a genuine and unpremeditated symptom of the illness that patients cannot help.

- **Option B:** Negativity, for example, is resistance to being moved or being asked to cooperate. This psychological phenomenon explains why bad first impressions can be so difficult to overcome and why past traumas can have such long lingering effects. In almost any interaction, we are more likely to notice negative things and later remember them more vividly.
- **Option C:** Clients with dependency problems may demonstrate suggestibility, a response pattern in which one easily agrees to the ideas and suggestions of others rather than making independent judgments. Suggestibility is the quality of being inclined to accept and act on the suggestions of others. One may fill in gaps in certain memories with false information given by another when recalling a scenario or moment. Suggestibility uses cues to distort recollection: when the subject has been persistently telling something about a past event, his or her memory of the event conforms to the repeated message.
- **Option D:** Retardation (slowed movement) also occurs in catatonic clients. Psychomotor retardation (PMR) is a possible feature of a melancholic depressive episode. It can include slowing of speech, thinking, and body movements. Speech may also be decreased in volume or inflection, and there may be increased pauses to the extreme of mutism, which is also a symptom of catatonia.

6. When being admitted to a mental health facility, a young female adult tells Nurse Mylene that the voices she hears frighten her. Nurse Mylene understands that the client tends to hallucinate more vividly:

- A. While watching TV
- B. During mealtime
- C. During group activities
- D. After going to bed

Correct Answer: D. After going to bed

Auditory hallucinations are most troublesome when environmental stimuli are diminished and there are few competing distractions. Be alert for signs of increasing fear, anxiety or agitation. Might herald hallucinatory activity, which can be very frightening to client, and client might act upon command hallucinations (harm self or others). Explore how the hallucinations are experienced by the client. Exploring the hallucinations and sharing the experience can help give the person a sense of power that he or she might be able to manage the hallucinatory voices.

- **Option A:** Help the client to identify the needs that might underlie the hallucination. What other ways can these needs be met? Hallucinations might reflect needs for anger, power, self-esteem, and sexuality. Help the client to identify times that the hallucinations are most prevalent and frightening. Helps both nurse and client identify situations and times that might be most anxiety-producing and threatening to the client.
- **Option B:** Stay with clients when they are starting to hallucinate and direct them to tell the “voices they hear” to go away. Repeat often in a matter-of-fact manner. The client can sometimes learn to push voices aside when given repeated instructions. especially within the framework of a trusting relationship.
- **Option C:** Decrease environmental stimuli when possible (low noise, minimal activity). Decrease the potential for anxiety that might trigger hallucinations. Helps calm the client. Work with the client to find which activities help reduce anxiety and distract the client from a hallucinatory material. Practice new skills with the client. If clients’ stress triggers hallucinatory activity, they might be more motivated to find ways to remove themselves from a stressful environment or try distraction techniques.

7. Nurse Cindy is caring for a client who has undergone a vaginal hysterectomy. The nurse avoids which of the following in the care of this client?

- A. Removal of antiembolism stockings twice daily
- B. Checking placement of pneumatic compression boots
- C. Elevating the knee gatch on the bed
- D. Assisting with range-of-motion leg exercises

Correct Answer: C. Elevating the knee gatch on the bed

- **Option C:** The nurse should avoid using the knee gatch in the bed, which inhibits venous return, thus placing the client more at risk for deep vein thrombosis or thrombophlebitis.

- **Options A, B, and D:** The client is at risk of deep vein thrombosis or thrombophlebitis after this surgery, as for any other major surgery. For this reason, the nurse implements measures that will prevent this complication. Range-of-motion exercises, anti-embolism stockings, and pneumatic compression boots are helpful.

8. Rosana is in the second stage of Alzheimer’s disease who appears to be in pain. Which question by Nurse Jenny would best elicit information about the pain?

- A. “Where is your pain located?”
- B. “Do you hurt? (pause) “Do you hurt?”
- C. “Can you describe your pain?”
- D. “Where do you hurt?”

Correct Answer: B. “Do you hurt? (pause) “Do you hurt?”

When speaking to a client with Alzheimer’s disease, the nurse should use close-ended questions. Those that the client can answer with “yes” or “no” whenever possible and avoid questions that require the client to make choices. Repeating the question aids comprehension. Alzheimer’s disease and other dementias gradually diminish a person’s ability to communicate. Communication with a person with Alzheimer’s requires patience, understanding, and good listening skills.

- **Option A:** Alzheimer’s, sometimes referred to as moderate Alzheimer’s, is typically the longest and can last for many years. As the disease progresses, the person will have greater difficulty communicating and will require more direct care. Ask yes or no questions. For example, “Would you like some coffee?” rather than “What would you like to drink?” Ask one question at a time.
- **Option C:** Engage the person in one-on-one conversation in a quiet space that has minimal distractions. Speak slowly and clearly. Give the person plenty of time to respond so he or she can think about what to say. Be patient and offer reassurance. It may encourage the person to explain his or her thoughts.
- **Option D:** Maintain eye contact. It shows you care about what he or she is saying. Offer clear, step-by-step instructions for tasks. Lengthy requests may be overwhelming. Avoid criticizing or correcting. Instead, listen and try to find the meaning in what the person says. Repeat what was said to clarify.

9. Which of the following actions would be least effective in maintaining a neutral thermal environment for the newborn?

- A. Place the infant under a radiant warmer after bathing.
- B. Covering the scale with a warmed blanket prior to weighing.
- C. Placing the crib close to the nursery window for family viewing.
- D. Covering the infant’s head with a knit stockinette.

Correct Answer: C. Placing the crib close to the nursery window for family viewing.

Heat loss by radiation occurs when the infant’s crib is placed too near cold walls or windows. Thus placing the newborn’s crib close to the viewing window would be least effective. Body heat is lost through evaporation during bathing.

- **Option A:** Placing the infant under the radiant warmer after bathing will assist the infant to be rewarmed.
- **Option B:** Covering the scale with a warmed blanket prior to weighing prevents heat loss through conduction.
- **Option D:** A knit cap prevents heat loss from the head, a large head, a large body surface area of the newborn's body.

10. Which criterion is needed for someone to give consent to a procedure?

- A. An appointed guardianship
- B. Unemancipated minor
- C. Minimum of 21 years or older
- D. An advocate for a child

Correct Answer: A. An appointed guardianship

A guardian has been appointed by a court and has full legal rights to choose management of care. A situation may arise in which a patient cannot make decisions independently but has not designated a decision-maker. In this instance, the hierarchy of decision-makers, which is determined by each state's laws, must be sought to determine the next legal surrogate decision-maker. If this is unsuccessful, a legal guardian may need to be appointed by the court.

- **Option B:** An exception to this rule is a legally emancipated child who may provide informed consent for himself. Some, but not all, examples of an emancipated minor include minors who are (1) under 18 and married, (2) serving in the military, (3) able to prove financial independence, or (4) mothers of children (married or not).
- **Option C:** Children (typically under 17) cannot provide informed consent. As such, parents must permit treatments or interventions. In this case, it is not termed "informed consent" but "informed permission." Legislation regarding minors and informed consent is state-based as well. It is important to understand the state laws.
- **Option D:** An advocate for the child is not legally appointed by the court. Several exceptions to the requirement for informed consent include (1) the patient is incapacitated, (2) life-threatening emergencies with inadequate time to obtain consent, and (3) voluntary waived consent. If the patient's ability to make decisions is questioned or unclear, an evaluation by a psychiatrist to determine competency may be requested.

11. The nurse administers a cleansing enema. The common position for this procedure is?

- A. Sims left lateral
- B. Dorsal Recumbent
- C. Supine
- D. Prone

Correct Answer: A. Sims left lateral

This position provides comfort to the patient and easy access to the natural curvature of the rectum. Enemas are rectal injections of fluid intended to cleanse or stimulate the emptying of the bowel. Enemas may also be prescribed to flush out the colon before certain diagnostic tests or surgeries. The bowel needs to be empty before these procedures to reduce infection risk and prevent stool from getting in the way.

- **Option B:** Position the patient on the left side, lying with the knees drawn to the abdomen. This eases the passage and flow of fluid into the rectum. Gravity and the anatomical structure of the sigmoid colon also suggest that this will aid enema distribution and retention. Dorsal recumbent is a position in which the patient lies on the back with the lower extremities moderately flexed and rotated outward. It is employed in the application of obstetrical forceps, repair of lesions following parturition, vaginal examination, and bimanual palpation.
- **Option C:** The supine position means lying horizontally with the face and torso facing up, as opposed to the prone position, which is face down. When used in surgical procedures, it allows access to the peritoneal, thoracic, and pericardial regions; as well as the head, neck, and extremities.
- **Option D:** Prone position is a body position in which the person lies flat with the chest down and the back up. In anatomical terms of location, the dorsal side is up, and the ventral side is down. The supine position is the 180° contrast.

12. While making a visit to the home of a postpartum woman 1 week after birth, the nurse should recognize that the woman would characteristically:

- A. Express a strong need to review the events and her behavior during the process of labor and birth.
- B. Exhibit a reduced attention span, limiting readiness to learn.
- C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn.
- D. Have reestablished her role as a spouse or partner.

Correct Answer: C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn.

One week after birth the woman should exhibit behaviors characteristic of the dependent-independent or taking-hold stage. She still has needs for nurturing and acceptance by others.

- **Option A:** Wanting to discuss the events of her labor and delivery are characteristics of the taking-in stage; this stage lasts from the first 24 hours until 2 days after delivery.
- **Option B:** A reduced attention span and limiting readiness to learn is also characteristic of the taking-in stage. 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 D:** Having reestablished her role as a spouse reflects the letting-go stage, which indicates that psychosocial recovery is complete.

13. Because cervical effacement and dilation are not progressing in a patient in labor, the doctor orders I.V. administration of oxytocin (Pitocin). Why should the nurse monitor the patient's fluid intake and output closely during oxytocin administration?

- A. Oxytocin causes water intoxication.
- B. Oxytocin causes excessive thirst.
- C. Oxytocin is toxic to the kidneys.
- D. Oxytocin has a diuretic effect.

Correct Answer: A. Oxytocin causes water intoxication.

The nurse should monitor fluid intake and output because prolonged oxytocin infusion may cause severe water intoxication, leading to seizures, coma, and death. In addition, oxytocin may cause water intoxication via an antidiuretic hormone-like activity when administered in excessive doses with electrolyte-free solution.

- **Option B:** Excessive thirst results from the work of labor and limited oral fluid intake—not oxytocin.
- **Option C:** Oxytocin, when given in rapid bolus, produces marked but short-lived hypotension and tachycardia. Sometimes, this abrupt and severe hemodynamic depression may need to be distinguished from placental abruption, myocardial infarction, or a pulmonary embolism in patients undergoing delivery.
- **Option D:** Oxytocin is known to possess antidiuretic properties. It can function physiologically as an antidiuretic hormone, mimicking the short-term action of vasopressin on water permeability, albeit with somewhat lower potency.

14. In clients with a cognitive impairment disorder, the phenomenon of increased confusion in the early evening hours is called:

- A. Aphasia
- B. Agnosia
- C. Sundowning
- D. Confabulation

Correct Answer: C. Sundowning

Sundowning is a common phenomenon that occurs after daylight hours in a client with a cognitive impairment disorder. The term “sundowning” refers to a state of confusion occurring in the late afternoon and spanning into the night. Sundowning can cause a variety of behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning can also lead to pacing or wandering. The other options are incorrect responses, although all may be seen in this client.

- **Option A:** Aphasia is a condition that robs you of the ability to communicate. It can affect your ability to speak, write and understand language, both verbal and written. Aphasia typically occurs suddenly after a stroke or a head injury. But it can also come on gradually from a slow-growing brain tumor or a disease that causes progressive, permanent damage (degenerative). The severity of aphasia depends on a number of conditions, including the cause and the extent of the brain damage.
- **Option B:** Agnosia is a rare disorder whereby a patient is unable to recognize and identify objects, persons, or sounds using one or more of their senses despite otherwise normally functioning senses. The deficit cannot be explained by memory, attention, language problems, or unfamiliarity to the stimuli. Usually, one of the sensory modalities is affected.

- **Option D:** Confabulation is a type of memory error in which gaps in a person's memory are unconsciously filled with fabricated, misinterpreted, or distorted information. When someone confabulates, they are confusing things they have imagined with real memories. A person who is confabulating is not lying. They are not making a conscious or intentional attempt to deceive. Rather, they are confident in the truth of their memories even when confronted with contradictory evidence.

15. The nurse is caring for a severely depressed client who has just been admitted to the in-client psychiatric unit. Which of the following is a priority of care?

- A. Nutrition
- B. Elimination
- C. Rest
- D. Safety

Correct Answer: D. Safety

Safety is a priority of care for the depressed client. Precautions to prevent suicide must be a part of the plan. Identify the level of suicide precautions needed. If there is a high-risk, does a hospitalization require it? Or if there is a low risk, will the client be safe to go home with supervision from a family member or a friend? A client with a high-risk will require constant supervision and a safe environment.

- **Option A:** Encourage small, high-calorie, and high-protein snacks and fluids frequently throughout the day and evening if weight loss is noted. Minimize weight loss, constipation, and dehydration. Encourage eating with others. Increases socialization, decreases focus on the food. Weigh the client weekly and observe the eating patterns of the client. Give the information needed for revising the intervention.
- **Option B:** Monitor intake and output, especially bowel movements. Most of the depressed clients are constipated. If this problem is not addressed, it can lead to fecal impaction. Encourage the intake of nonalcoholic and non-caffeinated fluids, 6 to 8 glasses a day. Fluids can help prevent constipation. Offer fiber-rich foods and periods of exercise. Roughage and exercise stimulate peristalsis and help evacuation of fecal material.
- **Option C:** Provide rest periods after activities. Fatigue can intensify feelings of depression. Encourage relaxation measures in the evening (e.g., drinking warm milk, back rub, or tepid bath). These measures induce sleep and relaxation. Encourage the client to get up and dress and to stay out of bed during the day. Minimizing sleep during the day increases the likelihood of sleep at night. Reduce environmental and physical stimulants in the evening; Provide decaffeinated coffee, soft music, soft lights, and quiet activities.

16. Which one of the following statements about hypothesis is most accurate?

- A. Hypotheses represent the main idea to be studied and are the foundations of research studies.
- B. Hypotheses help frame a test of the validity of a theory.
- C. Hypotheses provide the means to test nursing theory.
- D. A hypothesis can also be called a problem statement.

Correct Answer: B. Hypotheses help frame a test of the validity of a theory.

Although theories cannot be tested directly, hypotheses provide a bridge between theory and the real world. A hypothesis is a predetermined declaration regarding the research question in which the investigator(s) makes a precise, educated guess about a study outcome. This is sometimes called the alternative hypothesis and ultimately allows the researcher to take a stance based on experience or insight from medical literature.

- **Option A:** It is the research question that represents the main idea to be studied. Investigators conducting studies need research questions and hypotheses to guide analyses. Starting with broad research questions (RQs), investigators then identify a gap in current clinical practice or research.
- **Option C:** Theories cannot be tested directly. To test a hypothesis, researchers obtain data on a representative sample to determine whether to reject or fail to reject a null hypothesis. In most research studies, it is not feasible to obtain data for an entire population.
- **Option D:** The research question is also called the problem statement. Any research problem or statement is grounded in a better understanding of relationships between two or more variables. Research questions do not directly imply specific guesses or predictions; the researcher must formulate research hypotheses.

17. Mrs. Cruz, 80 years old is diagnosed with pneumonia. Which of the following symptoms may appear first?

- A. Altered mental status and dehydration
- B. Fever and chills
- C. Hemoptysis and Dyspnea
- D. Pleuritic chest pain and cough

Correct Answer: A. Altered mental status and dehydration

Elderly clients may first appear with only an altered mental status and dehydration due to a blunted immune response.

- **Option B:** Fever and chills are classic signs of pneumonia that may appear later in the elderly. The inflammatory response results in a proliferation of neutrophils. This can damage lung tissue, leading to fibrosis and pulmonary edema, which also impairs lung expansion.
- **Option C:** Hemoptysis is a late sign of pneumonia. Bleeding in the lungs may originate from bronchial arteries, pulmonary arteries, bronchial capillaries, and alveolar capillaries. Dyspnea may occur early, especially among the elderly. Swelling and mucus can make it harder to move air through the airways, making it harder to breathe. This leads to shortness of breath, difficulty of breathing, and feeling more tired than normal.
- **Option D:** Cough and pleuritic chest pain are the common symptoms of pneumonia. The air sacs may fill with fluid or pus, causing cough with phlegm or pus, fever, chills, and difficulty breathing.

18. A 76-year-old male client had a thromboembolic right stroke; his left arm is swollen. Which of the following conditions may cause swelling after a stroke?

- A. Elbow contracture secondary to spasticity.
- B. Loss of muscle contraction decreasing venous return.
- C. Deep vein thrombosis (DVT) due to immobility of the ipsilateral side.

D. Hypoalbuminemia due to protein escaping from an inflamed glomerulus.

Correct Answer: B. Loss of muscle contraction decreasing venous return

In clients with hemiplegia or hemiparesis, loss of muscle contraction decreases venous return and may cause swelling of the affected extremity.

- **Option A:** Contractures or bony calcifications may occur with a stroke, but don't appear with swelling.
- **Option C:** DVT may develop in clients with a stroke but is more likely to occur in the lower extremities.
- **Option D:** A stroke isn't linked to protein loss. Higher levels of protein were associated with a lower risk of stroke. According to a study, for every 20 grams of protein people ate per day, there is a 26 percent lower risk of stroke.

19. A nurse on the surgical floor is prioritizing care for clients after receiving the report from the previous shift. Which of the following patients should the nurse assess first?

- A. A 35-year-old patient admitted three hours ago for a gunshot wound, with a 1.5 cm area of dark drainage noted on the dressing.
- B. A 43-year-old patient who underwent a mastectomy two days ago, with 23 ml of serosanguinous fluid in the Jackson-Pratt drain.
- C. A 59-year-old patient with a history of a collapsed lung from an accident, with no drainage noted in the chest tube in the past eight hours.
- E. A 54-year-old patient with a total knee replacement two days ago, with moderate swelling at the surgical site.
- E. A 47-year-old patient who had a laparoscopic cholecystectomy yesterday, complaining of mild pain at the incision site.
- F. A 62-year-old patient who had an abdominal-perineal resection three days ago, now reporting chills.

Correct Answer: F. A 62-year-old patient who had an abdominal-perineal resection three days ago, now reporting chills.

The client is at risk for peritonitis; should be assessed for further symptoms and infection.

20. In which of the following disorders would the nurse expect to assess sacral edema in a bedridden client?

- A. Diabetes
- B. Pulmonary emboli
- C. Renal failure
- D. Right-sided heart failure

Correct Answer: D. Right-sided heart failure

The most accurate area on the body to assess dependent edema in a bed-ridden client is the sacral area. Sacral, or dependent, edema is secondary to right-sided heart failure. This is because the heart is

too weak to pump blood around the body properly, so the blood gathers in front of the heart. Because of this, and due to the increased blood pressure in the veins, fluid seeps out into the surrounding tissue. This may cause swelling in the legs or a build-up of fluid in the abdomen. If the person spends a lot of time lying down, the edema might show up on his or her back (called sacral edema).

- **Option A:** If there is a lack of the protein albumin in the blood, fluid can leak out of blood vessels more easily. Low protein in the blood can be caused by extreme malnutrition, as well as kidney and liver diseases which mean that the body loses too much or produces too little protein.
- **Option B:** Venous insufficiency can cause edema in the feet and ankles, because the veins are having trouble transporting enough blood all the way to the feet and back to the heart. This means that it gathers in the legs, and fluid is forced out of the blood vessels into the surrounding tissue. Edema can also be caused by varicose veins.
- **Option C:** Kidney disease could cause edema in the legs and around the eyes, because when the kidneys do not remove enough sodium and water from the body, the pressure in the blood vessels starts building up, which can lead to edema.

21. Dervid, an adolescent boy, was admitted for substance abuse and hallucinations. The client's mother asks Nurse Armando to talk with his husband when he arrives at the hospital. The mother says that she is afraid of what the father might say to the boy. The most appropriate nursing intervention would be to:

- A. Inform the mother that she and the father can work through this problem themselves.
- B. Refer the mother to the hospital social worker.
- C. Agree to talk with the mother and the father together.
- D. Suggest that the father and son work things out.

Correct Answer: C. Agree to talk with the mother and the father together.

By agreeing to talk with both parents, the nurse can provide emotional support and further assess and validate the family's needs. Observe family interactions and SO dynamics and level of support. Substance abuse is a family disease, and how the members act and react to the patient's behavior affects the course of the disease and how the patient sees himself. Many unconsciously become "enablers," helping the individual to cover up the consequences of the abuse.

- **Option A:** Review family history; explore roles of family members, circumstances involving drug use, strengths, areas for growth. Determines areas for focus, potential for change. Explore how the SO has coped with the patient's habit, (denial, repression, rationalization, hurt, loneliness, projection). The person who enables also suffers from the same feelings as the patient and uses ineffective methods for dealing with the situation, necessitating help in learning new and effective coping skills.
- **Option B:** Assess the current level of functioning of family members. Affects an individual's ability to cope with a situation. Determine the extent of enabling behaviors being evidenced by family members; explore with each individual and patient. Enabling is doing for the patient what he or she needs to do for self (rescuing). People want to be helpful and do not want to feel powerless to help their loved one stop substance use and change the behavior that is so destructive. However, the substance abuser often relies on others to cover up their own inability to cope with daily responsibilities.

- **Option D:** Identify and discuss sabotage behaviors of family members. Even though family member(s) may verbalize a desire for the individual to become substance-free, the reality of interactive dynamics is that they may unconsciously not want the individual to recover because this would affect the family member(s)' own role in the relationship. Additionally, they may receive sympathy and attention from others (secondary gain).

22. Which intervention is most important for the nurse to use to prevent infection by cross-contamination in the client who has open burn wounds?

- A. Handwashing on entering the client's room
- B. Encouraging the client to cough and deep breathe
- C. Administering the prescribed tetanus toxoid vaccine
- D. Changing gloves between cleansing different burn areas

Correct Answer: A. Handwashing on entering the client's room

Cross-contamination occurs when microorganisms from another person or the environment are transferred to the client. Handwashing with soap and water is the best way to get rid of germs in most situations. Emphasize and model good handwashing techniques for all individuals coming in contact with the patient.

- **Option B:** Although all the interventions listed above can help reduce the risk of infection, only handwashing can prevent cross-contamination. Airway obstruction and/or respiratory distress can occur very quickly or may be delayed, e.g., up to 48 hr after a burn.
- **Option C:** Tissue destruction and altered defense mechanisms increase the risk of developing tetanus or gas gangrene, especially in deep burns such as those caused by electricity.
- **Option D:** Serious complications often can be avoided by following strict aseptic techniques. Use of a mask, hat, gown, and sterile gloves, and drapes during placement of central venous catheters (CVCs) should be strictly implemented.

23. The nurse is preparing to teach a client about the prescribed spironolactone (Aldactone) to monitor for adverse effects of the drug. The nurse should instruct the client about which adverse effects? Select all that apply.

- A. Confusion.
- B. Fatigue.
- C. Hypertension.
- D. Leg cramps.
- E. Weakness.
- F. Urinary retention.

Correct Answer: A, B, & E.

Spironolactone (Aldactone) is used to treat hypertension and edema by removing excess fluid. Aldactone is known as a potassium-sparing diuretic. Confusion, fatigue, and weakness are signs of hyperkalemia, an adverse effect of spironolactone.

- **Option A:** One study mentions the following additional adverse effects in order from more to less common: dehydration, hyponatremia, gastrointestinal problems (nausea, vomiting, diarrhea or anorexia), neurological abnormalities (headache, drowsiness, asterixis, confusion, or coma), and skin rashes.
- **Option B:** Spironolactone blocks the hormone aldosterone, which can lead to fatigue. In addition, it can lower the blood pressure, and if this drop is sudden, the client may feel tired.
- **Option C:** Spironolactone is used to treat hypertension, so it would not produce this effect. Spironolactone is recommended in patients with resistant hypertension which is defined as uncontrolled blood pressure despite three antihypertensive drug combinations including a diuretic. Spironolactone is a mineralocorticoid receptor antagonist and causes anti-androgenic side effects.
- **Option D:** Leg cramps are an adverse effect of hypokalemia. Hyperkalemia is an adverse effect of spironolactone. This drug is contraindicated in patients with hyperkalemia and in those at increased risk of developing hyperkalemia.
- **Option E:** Symptoms of hypokalemia may include attacks of severe muscle weakness, eventually leading to paralysis and possibly respiratory failure. Muscular malfunction may result in paralysis of the bowel, low blood pressure, muscle twitches and mineral deficiencies (tetany).
- **Option F:** Urinary retention is a side effect of anticholinergics. Medications with anticholinergic properties, such as tricyclic antidepressants, cause urinary retention by decreasing bladder detrusor muscle contraction.

24. A female client is undergoing a complete physical examination as a requirement for college. When checking the client's respiratory status, the nurse observes respiratory excursion to help assess:

- A. Lung vibrations
- B. Vocal sounds
- C. Breath sounds
- D. Chest movements.

Correct Answer: D. Chest movements

The nurse observes respiratory excursion to help assess chest movements. Normally, thoracic expansion is symmetrical; unequal expansion may indicate pleural effusion, atelectasis, pulmonary embolism, or a rib or sternum fracture. During the inspection, the examiner should pay attention to the pattern of breathing: thoracic breathing, thoracoabdominal breathing, costal markings, and use of accessory breathing muscles. The use of accessory breathing muscles (i.e., scalenes, sternocleidomastoid muscle, intercostal muscles) could point to excessive breathing effort caused by pathologies.

- **Option A:** After asking the client to say "99," the nurse palpates the vibrations transmitted from the bronchopulmonary system along the solid surfaces of the chest wall to the nurse's palms. An increase in the tactile fremitus points towards an increased intraparenchymal density and a decreased fremitus hints towards a pleural process that separates the pleura from the parenchyma (pleural effusion, pneumothorax).
- **Option B:** The nurse assesses vocal sounds to evaluate air flow when checking for tactile fremitus. Palpation should focus on detecting abnormalities like masses or bony crepitus. Of note, the fremitus can also be auscultated and can be referred to as vocal fremitus.

- **Option C:** The nurse assesses breath sounds during auscultation. The movement of air generates normal breath sounds through the large and small airways. Normal breath sounds have a frequency of approximately 100 Hz. The absence of breath sounds should prompt the health care provider to consider shallow breath, abnormal anatomy, or pathologic entities such as airway obstruction, bulla, hyperinflation, pneumothorax, pleural effusion or thickening, and obesity.

25. A patient at a mental health clinic is taking Haldol (haloperidol) for treatment of schizophrenia. She calls the clinic to report abnormal movements of her face and tongue. The nurse concludes that the patient is experiencing which of the following symptoms:

- A. Comorbid depression
- B. Psychotic hallucinations
- C. Negative symptoms of schizophrenia
- D. Tardive dyskinesia

Correct Answer: D. Tardive dyskinesia

Abnormal facial movements and tongue protrusion in a patient taking haloperidol is most likely due to tardive dyskinesia, an adverse reaction to the antipsychotic. Tardive dyskinesia is a syndrome that includes a group of iatrogenic movement disorders caused by the blockade of dopamine receptors. The movement disorders include akathisia, dystonia, buccolingual stereotypy, myoclonus, chorea, tics and other abnormal involuntary movements which are commonly caused by the long-term use of typical antipsychotics.

- **Option A:** Depression and anxiety is frequently seen in many schizophrenic patients and may be further aggravated or diminished by antipsychotic treatments. Haloperidol is a conventional antipsychotic used in schizophrenia and psychosis.
- **Option B:** Psychotic hallucinations may be visual or auditory but do not include abnormal movements. Hallucinations are most often associated with schizophrenia, a mental illness characterized by disordered thoughts and behaviors.
- **Option C:** Depression may occur along with schizophrenia and would be characterized by such symptoms as loss of affect, appetite and/or sleep changes, and anhedonia. These depressive changes and lack of volition are part of the negative symptoms of schizophrenia.

26. A 79-year-old man with a known history of osteoporosis is admitted to the orthopedic ward after a fall in his garden, which led to a hip fracture. The interdisciplinary team convenes to discuss his immediate care plan. Recognizing the acute nature of his injury and the associated discomfort, the nurse contemplates which intervention should take precedence to ensure optimal patient comfort and recovery. Which of the following nursing actions should be given top priority for this patient?

- A. Promptly administering analgesic medications as prescribed by the physician.
- B. Initiating gentle range of motion exercises for the affected limb.
- C. Applying cold compresses to the fractured area to mitigate swelling.

D. Coordinating an early consultation with the physical therapy department.

- **Option B:** While range-of-motion exercises can be beneficial in the recovery phase, they are not the immediate priority following a fresh fracture. Starting them too early can exacerbate pain and potentially disrupt the healing process.
- **Option C:** Applying ice packs may not be appropriate immediately after surgery or in the presence of open wounds.
- **Option D:** Physical therapy is essential for rehabilitation after a fracture, but it's not the immediate priority. Initial focus should be on pain management and stabilization of the fracture.

27. The nurse is assessing the adaptation of the female client to changes in functional status after a brain attack (stroke). The nurse assesses that the client is adapting most successfully if the client:

- A. Gets angry with family if they interrupt a task.
- B. Experiences bouts of depression and irritability.
- C. Has difficulty with using modified feeding utensils.
- D. Consistently uses adaptive equipment in dressing self.

Correct Answer: D. Consistently uses adaptive equipment in dressing self

Clients are evaluated as coping successfully with lifestyle changes after a brain attack (stroke) if they make appropriate lifestyle alterations, use the assistance of others, and have appropriate social interactions.

- **Option A:** Identify previous methods of dealing with life problems. Determine presence of support systems. Provides opportunity to use behaviors previously effective, build on past successes, and mobilize resources.
- **Option B:** Encourage the patient to express feelings, including hostility or anger, denial, depression, sense of disconnectedness. Demonstrates acceptance of the patient in recognizing and beginning to deal with these feelings.
- **Option C:** Emphasize small gains either in recovery of function or independence. Consolidates gains, helps reduce feelings of anger and helplessness, and conveys sense of progress. Support behaviors and efforts such as increased interest/participation in rehabilitation activities. Suggest possible adaptation to changes and understanding about your own role in future lifestyle.

28. The nurse is caring for a hospitalized client with a diagnosis of ulcerative colitis. Which finding, if noted on assessment of the client, would the nurse report to the physician? A. Bloody diarrhea

- A. Bloody diarrhea
- B. Hypotension
- C. A hemoglobin of 12 mg/dL
- D. Rebound tenderness

Correct Answer: D. Rebound tenderness

Rebound tenderness may indicate peritonitis. During the physical exam, pertinent findings include fever and abdominal tenderness to palpation which usually is diffuse with wall rigidity in more septic presentations. Signs of peritonitis must be reported to the physician. It is important to conduct a thorough exam as certain thoracic or pelvic pathologies can mimic peritoneal irritation (empyema causing diaphragmatic irritation and cystitis/pyelonephritis causing peritoneum adjacent pain).

- **Option A:** Bloody diarrhea is expected to occur in ulcerative colitis. Ulcerative colitis's main symptom is bloody diarrhea, with or without mucus. Associated symptoms also include urgency or tenesmus, abdominal pain, malaise, weight loss, and fever, depending on the extent and severity of the disease.
- **Option B:** Because of the blood loss, the client may be hypotensive. In ulcerative colitis, bleeding can arise from the lining of the rectum or large intestine, and this blood can be visible in the stool. The bleeding generally comes from the ulcers that have formed in the lining of the large intestine or rectum.
- **Option C:** Because of the blood loss, the hemoglobin level may be lower than normal. It may also be necessary to treat the loss of blood that has happened. If the client developed anemia from blood loss, he may need to supplement with iron, folic acid, or vitamin B12, depending on what your health provider says. In serious cases of blood loss, a blood transfusion might be required.

29. The nurse provides medication instructions to a client with peptic ulcer disease. Which statement, if made by the client, indicates the best understanding of the medication therapy?

- A. "The cimetidine (Tagamet) will cause me to produce less stomach acid."
- B. "Sucralfate (Carafate) will change the fluid in my stomach."
- C. "Antacids will coat my stomach."
- D. "Omeprazole (Prilosec) will coat the ulcer and help it heal."

Correct Answer: A. "The cimetidine (Tagamet) will cause me to produce less stomach acid."

Cimetidine (Tagamet), a histamine H₂ receptor antagonist, will decrease the secretion of gastric acid. The H₂-receptor antagonist cimetidine competitively blocks histamine from stimulating the H₂-receptors located on the gastric parietal cells (these cells are responsible for hydrochloric acid secretion and secretion of the intrinsic factor). The effect results in reducing the volume of gastric acid secretion from stimuli, including histamine, food, caffeine, and insulin.

- **Option B:** Sucralfate (Carafate) promotes healing by coating the ulcer. By forming a polyanion gel, it acts as a physical barrier between luminal contents and mucosa. It also increases the production of mucus by increasing prostaglandin production. Sucralfate prevents the breakdown of mucus by pepsin A, reducing ulcerogenesis.
- **Option C:** Antacids neutralize acid in the stomach. The antacids reduce the acid reaching the duodenum by neutralizing the acid present in the stomach. The salts' mechanism of neutralization of acid varies, and each salt has a different mechanism with the ultimate goal of acid neutralization.
- **Option D:** Omeprazole (Prilosec) inhibits gastric acid secretion. Omeprazole is a proton pump inhibitor. It inhibits the parietal cell H⁺ / K⁺ ATP pump, the final step of acid production. In turn, omeprazole suppresses gastric basal and stimulated acid secretion. The inhibitory effects of omeprazole occur rapidly within 1 hour of administration, with the maximum effect occurring in 2 hours.

30. A client with acute asthma showing inspiratory and expiratory wheezes and a decreased expiratory volume should be treated with which of the following classes of medication right away?

- A. Beta-adrenergic blockers
- B. Bronchodilators
- C. Inhaled steroids
- D. Oral steroids

Correct Answer: B. Bronchodilators

Bronchodilators are the first line of treatment for asthma because bronchoconstriction is the cause of reduced airflow. Bronchodilators are indicated for individuals that have lower than optimal airflow through the lungs. The mainstay of treatment is beta-2 agonists that target the smooth muscles in the bronchioles of the lung. Various respiratory conditions may require bronchodilators, including asthma and chronic obstructive pulmonary disease.

- **Option A:** Beta-adrenergic blockers aren't used to treat asthma and can cause bronchoconstriction. The catecholamines, epinephrine, and norepinephrine bind to B1 receptors and increase cardiac automaticity as well as conduction velocity. B1 receptors also induce renin release, and this leads to an increase in blood pressure. In contrast, binding to B2 receptors causes relaxation of the smooth muscles along with increased metabolic effects such as glycogenolysis.
- **Option C:** Inhaled steroids may be given to reduce the inflammation but aren't used for emergency relief. Inhaled corticosteroids have potent glucocorticoid activity and work directly at the cellular level by reversing capillary permeability and lysosomal stabilization to reduce inflammation. The onset of action is gradual and may take anywhere from several days to several weeks for maximal benefit with consistent use.
- **Option D:** Corticosteroids produce their effect through multiple pathways. In general, they produce anti-inflammatory and immunosuppressive effects, protein and carbohydrate metabolic effects, water and electrolyte effects, central nervous system effects, and blood cell effects. Oral administration is more common for chronic treatment. Patients should receive non-systemic therapy whenever possible, to minimize systemic exposure.

31. A nurse is beginning to care for a client in labor. The physician has prescribed an IV infusion of Pitocin. The nurse ensures that which of the following is implemented before initiating the infusion?

- A. Placing the client on complete bed rest
- B. Continuous electronic fetal monitoring
- C. An IV infusion of antibiotics
- D. Placing a code cart at the client's bedside

Correct Answer: B. Continuous electronic fetal monitoring

Continuous electronic fetal monitoring should be implemented during an IV infusion of Pitocin. Continuous electronic fetal monitoring should be performed for a minimum of 20 minutes before starting oxytocin and should be continued until the baby is delivered.

- **Option A:** Complete bed rest is not a necessity before initiating Pitocin infusion. Pitocin is indicated for the initiation or improvement of uterine contractions, where this is desirable and considered suitable for reasons of fetal or maternal concern, in order to achieve vaginal delivery.
- **Option C:** It is unnecessary to administer IV antibiotics before Pitocin infusion. Immediately administer broad-spectrum antibiotics only to patients with severe postabortion infection.
- **Option D:** A code cart may be placed beside the client but in case of overdose, contact the Poison Control Center.

32. The nurse teaches a patient with cancer of the liver about high-protein, high-calorie diet choices. Which snack choice by the patient indicates that the teaching has been effective?

- A. Fresh fruit salad
- B. Orange sherbet
- C. French fries
- D. Strawberry yogurt

Correct Answer: D. Strawberry yogurt

- **Option D:** Yogurt has high biologic value because of the protein and fat content.
- **Option A:** Fruit salad does not have high amounts of protein or fat.
- **Option B:** Orange sherbet is lower in fat and protein than yogurt.
- **Option C:** French fries are high in calories from fat but low in protein.

33. Which of the following parameters would the nurse monitor to evaluate the effectiveness of thickened feedings for an infant with gastroesophageal reflux disease (GERD)?

- A. Vomiting
- B. Stools
- C. Uterine
- D. Weight

Correct Answer: A. Vomiting

Thickened feedings are used with GER to stop the vomiting. Therefore, the nurse would monitor the child's vomiting to evaluate the effectiveness of using the thickened feedings.

- **Option B:** Feed thickeners are commonly used for managing infants with GOR despite the lack of strong supporting evidence. It is postulated that feed thickener reduces GOR by increasing the viscosity or 'stickiness' of the liquid content, enabling the feed to be retained in the stomach.
- **Option C:** However, feed thickeners can increase the energy density and osmolality of the feed which may increase the frequency of relaxation of the lower esophageal sphincter and delay gastric emptying, worsening GOR.

- **Option D:** If feedings are ineffective, this should be noted before there is any change in the child's weight

34. Which of the following is the most common symptom of myocardial infarction (MI)?

- A. Chest pain
- B. Dyspnea
- C. Edema
- D. Palpitations

Correct Answer: A. Chest pain

The most common symptom of an MI is chest pain, resulting from deprivation of oxygen to the heart. Myocardial ischemia can present as chest pain, upper extremity pain, mandibular, or epigastric discomfort that occurs during exertion or at rest. The chest pain is usually retrosternal and is sometimes described as the sensation of pressure or heaviness. The pain often radiates to the left shoulder, neck, or arms with no obvious precipitating factors, and it may be intermittent or persistent. The pain usually lasts for more than 20 minutes. It is usually not affected by positional changes or active movement of the region.

- **Option B:** Dyspnea is the second most common symptom, related to an increase in the metabolic needs of the body during an MI. Myocardial ischemia can also present as dyspnea or fatigue, which are known to be ischemic equivalents.
- **Option C:** Edema is a later sign of heart failure, often seen after an MI. Myocardial edema is a consequence of ischemia and infarction and has functional importance because edema impairs myocyte contractility. The extent of myocardial edema revealed by T2-weighted cardiac magnetic resonance (CMR) imaging correlates with the transmural extent of infarction.
- **Option D:** Palpitations may result from reduced cardiac output, producing arrhythmias. The MI can also present atypically with subtle findings such as palpitations, or more dramatic manifestations, such as cardiac arrest. The MI can sometimes present with no symptoms.

35. A nurse is administering IV furosemide to a patient admitted with congestive heart failure. After the infusion, which of the following symptoms is not expected?

- A. Increased urinary output
- B. Decreased edema
- C. Decreased pain
- D. Decreased blood pressure

Correct Answer: C. Decreased pain

Furosemide, a loop diuretic, does not alter pain. The Food and Drug Administration (FDA) has approved the use of furosemide in the treatment of conditions with volume overload and edema secondary to congestive heart failure exacerbation, liver failure, or renal failure including the nephrotic syndrome.

- **Option A:** Furosemide acts on the kidneys to increase urinary output. Furosemide inhibits tubular reabsorption of sodium and chloride in the proximal and distal tubules, as well as in the thick ascending loop of Henle by inhibiting sodium-chloride cotransport system resulting in excessive excretion of water along with sodium, chloride, magnesium, and calcium.
- **Option B:** Fluid may move from the periphery, decreasing edema. Careful monitoring of the clinical condition of the patient, daily weight, fluids intake, and urine output, electrolytes, i.e., potassium and magnesium, kidney function monitoring with serum creatinine and serum blood urea nitrogen level is vital to monitor the response to furosemide. Replete electrolytes if indicated as diuresis with furosemide lead to electrolyte depletion, and adjust the dose or even hold off on furosemide if laboratory work shows signs of kidney dysfunction.
- **Option D:** Fluid load is reduced, lowering blood pressure. Furosemide can be a second-line agent in heart failure patients with symptoms, and in patients with advanced kidney disease with an estimated glomerular filtration rate, less than 30 ml per minute the loop diuretics (furosemide) are preferred over thiazide diuretics to treat hypertension.

36. A fifty-year-old client has a tracheostomy and requires tracheal suctioning. The first intervention in completing this procedure would be to:

- A. Change the tracheostomy dressing.
- B. Provide humidity with a trach mask.
- C. Apply oral or nasal suction.
- D. Deflate the tracheal cuff.

Correct Answer: C. Apply oral or nasal suction.

Before deflating the tracheal cuff, the nurse will apply oral or nasal suction to the airway to prevent secretions from falling into the lung. Dressing change and humidity do not relate to suctioning. Airway suctioning is a procedure routinely done in most care settings, including acute care, sub-acute care, long-term care, and home settings. Suctioning is performed when the patient is unable to effectively move secretions from the respiratory tract.

- **Option A:** Airways suctioning is indicated for multiple reasons. Most commonly suctioning is done for the removal of secretions from the respiratory tract, but sometimes also for removal of blood or other materials like meconium in specific cases. Airway suctioning is also performed for diagnostic purposes.
- **Option B:** Suctioning of the lower airways should be done in a sterile manner with single-use gloves and suction catheters to prevent contamination and secondary infection. After preparation with appropriate equipment at the bedside and monitoring continuous heart rate and oxygen saturation (as available), the patient should be suctioned with appropriately sized equipment for their airway.
- **Option D:** After preparation with appropriate equipment at the bedside and monitoring continuous heart rate and oxygen saturation (as available), the patient should be suctioned with appropriately sized equipment for their airway.

37. When the nurse described the client as “that nasty old man in room 201,” the nurse is exhibiting which ethical dilemma?

- A. Gender bias and ageism

- B. HIPAA violation
- C. Beneficence
- D. Code of ethics violation

Correct Answer: A. Gender bias and ageism

Stereotyping an “old man” as “nasty” is a gender bias and an ageism issue. The nurse is verbalizing a negative descriptor about the client. Anyone who lives long enough is at risk of experiencing ageism. In Western, industrialized countries, older people are often perceived as unproductive and as using too much of society’s resources (Gullette 2004). As countries’ demographics shift toward larger percentages of older citizens (due to declines in birth rates and increases in longevity), aging is often framed in public policy debates as a social problem, and the hyperbolic language that is frequently used (e.g., “the gray tsunami”) to describe shifting demographics contributes to ageism.

- **Option B:** The Health Insurance Portability and Accountability Act of 1996 is a landmark piece of legislation that was introduced to simplify the administration of healthcare, eliminate wastage, prevent healthcare fraud, and ensure that employees could maintain healthcare coverage when between jobs. A HIPAA violation is a failure to comply with any aspect of HIPAA standards and provisions detailed in 45 CFR Parts 160, 162, and 164.
- **Option C:** Beneficence is defined as an act of charity, mercy, and kindness with a strong connotation of doing good to others including moral obligation. All professionals have the foundational moral imperative of doing right.
- **Option D:** Serious ethical violations are acts that not only disregard codes of medical ethics, but also risk directly harming patients and subjecting the wrongdoer to criminal, tort, or medical board actions.

38. Hormones secreted by Islets of Langerhans

- A. Progesterone
- B. Testosterone
- C. Insulin
- D. Hemoglobin

Correct Answer: C. Insulin

The Islets of Langerhans are the regions of the pancreas that contain its endocrine cells. Insulin is a peptide hormone secreted in the body by beta cells of islets of Langerhans of the pancreas and regulates blood glucose levels. Medical treatment with insulin is indicated when there is inadequate production or increased demands of insulin in the body.

- **Option A:** Progesterone (Choice A) is produced by the ovaries. Progesterone is an endogenous steroid hormone that is commonly produced by the adrenal cortex as well as the gonads, which consist of the ovaries and the testes. Progesterone is also secreted by the ovarian corpus luteum during the first ten weeks of pregnancy, followed by the placenta in the later phase of pregnancy.
- **Option B:** Testosterone (Choice B) is secreted by the testicles of males and ovaries of females. Testosterone is the primary male hormone responsible for regulating sex differentiation, producing male sex characteristics, spermatogenesis and fertility. Testosterone is responsible for the development of primary sexual development, which includes testicular descent, spermatogenesis, enlargement of the penis and testes, and increasing libido.

- **Option D:** Hemoglobin (Choice D) is a protein molecule in the red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide. Hemoglobin is an oxygen-binding protein found in erythrocytes which transports oxygen from the lungs to tissues. Each hemoglobin molecule is a tetramer made of four polypeptide globin chains. Each globin subunit contains a heme moiety formed of an organic protoporphyrin ring and a central iron ion in the ferrous state (Fe²⁺). The iron molecule in each heme moiety can bind and unbind oxygen, allowing for oxygen transport in the body.

39. A child is seen in the pediatrician's office for complaints of bone and joint pain. Which of the following other assessment findings may suggest leukemia?

- A. Increased activity level
- B. Increased appetite
- C. Petechiae
- D. Abdominal pain

Correct Answer: C. Petechiae

- **Option C:** The most frequent signs and symptoms of leukemia are a result of infiltration of the bone marrow. These include fever, pallor, fatigue, anorexia, and petechiae, along with bone and joint pain. Petechiae is brought about by damaged or broken blood vessels underneath the skin.
- **Option A:** Leukemia increases inflammation in the body, which can make a person feel tired and experience fatigue causing decreased activity level.
- **Option B:** Increased appetite can occur but it usually isn't a presenting symptom.
- **Option D:** Abdominal pain may be caused by areas of inflammation from normal flora within the GI tract or any number of other causes.

40. A child age 7 was unable to receive the measles, mumps, and rubella (MMR) vaccine at the recommended scheduled time. When would the nurse expect to administer the MMR vaccine?

- A. In a month from now
- B. In a year from now
- C. At age 10
- D. At age 13

Correct Answer: C. At age 10

Based on the recommendations of the American Academy of Family Physicians and the American Academy of Pediatrics, the MMR vaccine should be given at the age of 10 if the child did not receive it between the ages of 4 to 6 years as recommended. Immunization for diphtheria and tetanus is required at age 13.

- **Option A:** Children should get two doses of MMR vaccine, starting with the first dose at 12 to 15 months of age, and the second dose at 4 through 6 years of age.
- **Option B:** Children can receive the second dose earlier as long as it is at least 28 days after the first dose.

- **Option D:** MMR vaccine is given later than some other childhood vaccines because antibodies transferred from the mother to the baby can provide some protection from disease and make the MMR vaccine less effective until about 1 year of age.

41. A client had undergone radiation therapy (external). The expected side effects include the following apart from:

- A. Hair loss
- B. Ulceration of oral mucous membranes
- C. Constipation
- D. Headache

Correct Answer: C. Constipation

- **Option C:** Diarrhea, not constipation is the side effect of radiation therapy which usually starts during or right after the treatment and may last for several weeks.
- **Options A, B, and D:** These are common side effects of radiation therapy.

42. An adult woman is admitted to an isolation unit in the hospital after tuberculosis was detected during a pre-employment physical. Although frightened about her diagnosis, she is anxious to cooperate with the therapeutic regimen. The teaching plan includes information regarding the most common means of transmitting the tubercle bacillus from one individual to another. Which contamination is usually responsible?

- A. Eating utensils
- B. Hands
- C. Milk products
- D. Droplet nuclei

Correct Answer: D. Droplet nuclei.

The most frequent means of transmission of the tubercle bacillus is by droplet nuclei. The bacillus is present in the air as a result of coughing, sneezing, and expectoration of sputum by an infected person. Although usually a lung infection, tuberculosis is a multi-system disease with protean manifestation. The principal mode of spread is through inhalation of infected aerosolized droplets.

- **Option A:** The tubercle bacillus is not transmitted by eating utensils. Some exogenous microbes can be transmitted via reservoirs such as linens or eating utensils. The TB bacteria are put into the air when a person with TB disease of the lungs or throat coughs, speaks or sings. People nearby may breathe in these bacteria and become infected.
- **Option B:** Hands are the primary method of transmission of the common cold. When a person breathes in TB bacteria, the bacteria can settle in the lungs and begin to grow. From there, they can move through the blood to other parts of the body, such as the kidney, spine, and brain.
- **Option C:** The tubercle bacillus is not transmitted by means of contaminated food. Contact with contaminated food or water could cause outbreaks of salmonella, infectious hepatitis, typhoid, or cholera.

43. Nurse Rachel teaches a client who has been recently diagnosed with hepatitis A about untoward signs and symptoms related to Hepatitis that may develop. The one that should be reported immediately to the physician is:

- A. Restlessness
- B. Yellow urine
- C. Nausea
- D. Clay-colored stools

Correct Answer: D. Clay-colored stools

Clay-colored stools are indicative of hepatic obstruction. Acute HAV infection is typically a self-limited illness characterized by nausea, vomiting, right upper quadrant abdominal discomfort, malaise, anorexia, myalgia, fatigue, and fever. Patients may develop dark urine and pale stools within a week, followed by jaundice, icteric (yellow-tinted) sclera, and pruritus.

- **Option A:** Restlessness is not a symptom related to hepatitis A. The incubation period usually ranges from 14 to 28 days but can last up to 50 days. The severity of symptoms varies with age and comorbidities, particularly underlying chronic liver disease. Most children with acute HAV infection are asymptomatic.
- **Option B:** One of the symptoms of hepatitis A is dark urine. Patients usually have elevated levels of serum alanine aminotransferase, aspartate aminotransferase, bilirubin, alkaline phosphatase, and lambda-glutamyl transpeptidase. These lab abnormalities typically resolve within 1 to 6 weeks following the onset of symptoms.
- **Option C:** Sudden nausea and vomiting are some of the symptoms, but it is not of immediate concern. Extrahepatic manifestations rarely occur but may include pancreatitis, rash, acute kidney injury with interstitial nephritis or glomerulonephritis, pneumonitis, pericarditis, hemolysis, and acute cholecystitis.

44. A newborn weighed 7 pounds at birth. At 6 months of age, the infant could be expected to weigh:

- A. 14 pounds
- B. 18 pounds
- C. 25 pounds
- D. 30 pounds

Correct Answer: A. 14 pounds

- Option A: The infant's birth weight should double by 6 months of age.
- Options B, C, and D: These weight gains are greater than the expected by 6 months of age.

45. A 2-year-old is to be admitted in the pediatric unit. He is diagnosed with febrile seizures. In preparing for his admission, which of the following is the most important nursing action?

- A. Place a urine collection bag and specimen cup at the bedside
- B. Order a stat admission CBC
- C. Pad the side rails of his bed
- D. Place a cooling mattress on his bed

Correct Answer: C. Pad the side rails of his bed

The child has a diagnosis of febrile seizures. Precautions to prevent injury and promote safety should take precedence. Febrile seizure status is defined as a seizure lasting longer than 30 minutes. Therefore, prompt treatment of prolonged seizures of a febrile nature is as necessary as prompt treatment of prolonged seizures arising from other etiologies.

- **Option A:** Preparing for routine laboratory studies is not as high a priority as preventing injury and promoting safety. A patient with a normal general and neurologic exam, whose history is consistent with a simple febrile seizure, does not need a further laboratory, imaging, or neurophysiologic evaluation.
- **Option B:** Preparing for routine laboratory studies is not as high a priority as preventing injury and promoting safety. A lumbar puncture may be a consideration in the setting of fever and seizures. For a patient with the appropriate history of a febrile seizure and a rapid return to baseline, no lumbar puncture is necessary.
- **Option D:** A cooling blanket must be ordered by the physician and is usually not used unless other methods for the reduction of fever have not been successful. There is no specific treatment for simple or complex febrile seizures other than appropriate treatment for underlying etiologies driving the ongoing febrile illness. Antipyretics have not been shown to prevent a recurrence of febrile seizures.

46. The parents of Suzanne, a child with attention deficit hyperactivity disorder, tell the nurse they have tried everything to calm their child and nothing has worked. Which action by the nurse is most appropriate initially?

- A. Actively listen to the parents' concern before planning interventions
- B. Encourage the parents to discuss these issues with the mental health team
- C. Provide literature regarding the disorder and its management
- D. Tell the parents they are overreacting to the problem

Correct Answer: A. Actively listens to the parents' concerns before planning interventions.

The nurse would encourage parents to fully discuss and describe their perception of the problem in order to assess the family system before determining appropriate interventions. The nurse must listen to parents' feelings; including parents in providing and planning care for the child with ADHD is important.

- **Option B:** The nurse has not explored the problem and is deciding before adequately assessing the situation that the mental team should be consulted. Give positive feedback for meeting expectations; manage the environment (e.g. provide a quiet place free of distractions for task completion).
- **Option C:** Providing literature regarding the disorder and its management may be useful intervention; however, the initial action needs to involve a more thorough exploration of the parents'

concerns. Ensuring the child's safety and that of others; stop unsafe behavior; provide close supervision, and give clear directions about acceptable and unacceptable behavior.

- **Option D:** Telling the parents they are overreacting to the problem is inappropriate because it dismisses the parents' legitimate concerns and belittles their feelings.

47. The client passes a urinary stone, and lab analysis of the stone indicates that it is composed of calcium oxalate. Based on this analysis, which of the following would the nurse specifically include in the dietary instructions?

- A. Increase intake of meat, fish, plums, and cranberries.
- B. Avoid citrus fruits and citrus juices.
- C. Avoid green, leafy vegetables such as spinach.
- D. Increase intake of dairy products.

Correct Answer: C. Avoid green, leafy vegetables such as spinach.

Oxalate is found in dark green foods such as spinach. Other foods that raise urinary oxalate are rhubarb, strawberries, chocolate, wheat bran, nuts, beets, and tea. The more oxalate that is absorbed from the digestive tract, the more oxalate in the urine. Often a combination of calcium from foods or beverages with meals and fewer high-oxalate foods is required.

- **Option A:** Eating large amounts of protein may increase the risk of kidney stone formation. The daily protein needs can usually be met with 2-3 servings a day, or 4 to 6 ounces. Eating more than this if you are at risk of kidney stones is unnecessary.
- **Option B:** Oxalate is produced as an end product of Vitamin C (ascorbic acid) metabolism. Large doses of Vitamin C may increase the amount of oxalate in the urine, increasing the risk of kidney stone formation. If taking a supplement, do not take more than 500 mg of Vitamin C daily.
- **Option D:** A diet rich in calcium helps reduce the amount of oxalate being absorbed by the body, so stones are less likely to form. Eat calcium-rich foods and beverages every day (2 to 3 servings) from dairy foods or other calcium-rich foods.

48. The nurse is giving medication teachings to a client receiving theophylline. The nurse instructed the client to limit the intake of which of the following?

- A. Apple and banana
- B. Yogurt and cheese
- C. Tuna and oysters
- D. Cola and chocolate

Correct Answer: D. Cola and chocolate

Theophylline is a methylxanthine bronchodilator. The nurse instructs the client to limit the intake of xanthine-containing foods such as chocolate, cola, and coffee.

- **Options A, B, & C:** These food items can be eaten by a client taking theophylline.

49. Nurse Marty is monitoring a client for adverse reactions to dantrolene (Dantrium). Which adverse reaction is most common?

- A. Excessive tearing
- B. Urine retention
- C. Muscle weakness
- D. Slurred speech

Correct Answer: C. Muscle weakness

The most common adverse reaction to dantrolene is muscle weakness. The drug also may depress liver function or cause idiosyncratic hepatitis. The intravenous administration of dantrolene in healthy volunteers has resulted in skeletal muscle weakness, dyspnea, respiratory muscle weakness, and decreased inspiratory capacity. These are expected symptoms given the mechanism of action of the medication.

- **Option A:** For those taking the oral capsule for muscle spasticity, liver function tests require monitoring, and dantrolene discontinued if signs and symptoms of liver injury appear. These include elevated LFTs, jaundice, right upper quadrant pain, etc. These symptoms typically resolve upon the discontinuation of dantrolene. If dantrolene is to be reinstated, per recommendations, the patient should be inpatient, and the drug initiated in very small doses with gradual increases.
- **Option B:** Although urine retention is an adverse reaction associated with dantrolene use; they aren't as common as muscle weakness. When using the lyophilized form of dantrolene, large volumes of sterile water are administered with the medication. Although mannitol is included with the dantrolene, monitoring fluid status and output is paramount to the ongoing care of resuscitation of these patients.
- **Option D:** Muscle weakness is rarely severe enough to cause slurring of speech, drooling, and enuresis. Oral dantrolene carries a black box warning for the potential for hepatotoxicity, including overt hepatitis. Hepatic function should be evaluated before the administration of the oral capsule form and require monitoring throughout the course of treatment. The medication should stop immediately if liver function becomes impaired.

50. The wife admits that she is a victim of abuse and opens up about her persistent distaste for sex. This sexual disorder is:

- A. Sexual desire disorder
- B. Sexual arousal disorder
- C. Orgasm disorder
- D. Sexual Pain Disorder

Correct Answer: A. Sexual desire disorder

Has little or no sexual desire or has a distaste for sex. Hypoactive sexual desire disorder (HSDD) and sexual aversion disorder (SAD) are an under-diagnosed group of disorders that affect men and women. Despite their prevalence, these two disorders are often not addressed by healthcare providers and patients due their private and awkward nature.

- **Option B:** Failure to maintain the physiologic requirements for sexual intercourse. Sexual arousal disorder is characterized by a lack or absence of sexual fantasies and desire for sexual activity in a

situation that would normally produce sexual arousal, or the inability to attain or maintain typical responses to sexual arousal. The disorder is found in the DSM-IV.

- **Option C:** Persistent and recurrent inability to achieve an orgasm. Orgasmic disorder is the lack of or delay in sexual climax (orgasm) even though sexual stimulation is sufficient and the woman is sexually aroused mentally and emotionally. Women may not have an orgasm if love-making ends too soon, there is not enough foreplay, or they are afraid of losing control or letting go.
- **Option D:** Also called dyspareunia. Individuals with this disorder suffer genital pain before, during and after sexual intercourse. Painful intercourse can occur for reasons that range from structural problems to psychological concerns. Many women have painful intercourse at some point in their lives. The medical term for painful intercourse is dyspareunia, defined as persistent or recurrent genital pain that occurs just before, during, or after intercourse.

51. A client completing requirements for student teaching reports to the nurse an incident in which a student was rude and disrespectful. The client states, "None of the students respects my teaching ability." The nurse identifies this as an example of which common negative cognition?

- A. Labeling
- B. Fortune telling
- C. Overgeneralization
- D. "Should" statement

Correct Answer: C. Overgeneralization

The client in this situation is overgeneralizing the response of one particular student, inferring that the entire class has this attitude and blowing the incident out of proportion. Overgeneralization frequently affects people with depression or anxiety disorders. It is a way of thinking where you apply one experience to all experiences, including those in the future.

- **Option A:** Labeling is the application of negative labels to oneself or others. This label may be a reasonable reflection of who they are right now, but it also carries a belief that the behavior reflects a person's essence.
- **Option B:** Fortune-telling is the conviction that things will not turn out right, despite evidence to the contrary. Fortune telling is a cognitive distortion in which you predict a negative outcome without realistically considering the actual odds of that outcome. It is linked to anxiety and depression, and is one of the most common cognitive distortions that arise during the course of cognitive restructuring.
- **Option D:** "Should" statements refer to statements establishing standards for self and others. Should statements are a common negative thinking pattern, or cognitive distortion, that can contribute to feelings of fear and worry. They also put unreasonable demands and pressure on ourselves, which can make us feel guilty or like we've failed.

52. Nurse Joy is caring for a client after a bronchoscopy and biopsy. Which of the following signs, if noticed in the client, should be reported immediately to the physician?

- A. Dry cough

- B. Hematuria
- C. Bronchospasm
- D. Blood-streaked sputum

Correct Answer: C. Bronchospasm

If a biopsy was performed during a bronchoscopy, blood-streaked sputum is expected for several hours. The client should be assessed for signs of complications, which would include cyanosis, dyspnea, stridor, bronchospasm, hemoptysis, hypotension, tachycardia, and dysrhythmias. Cardiac arrhythmias may also occur especially in patients with pre-existing cardiac disease.

- **Option A:** A dry cough may be expected. In 1% to 3% of patients, pneumothorax may occur after transbronchial biopsies. Small pneumothoraces may be managed conservatively, while symptomatic and large pneumothorax will require chest tube insertion and hospitalization.
- **Option B:** Hematuria is unrelated to this procedure. A tension pneumothorax results in hemodynamic instability and should be recognized even without imaging studies. Appropriate life-saving measures such as chest tube insertion should be undertaken immediately.
- **Option D:** Frank blood indicates hemorrhage. In most cases, bleeding is usually self-limited. The pulmonologists should carefully ascertain for hemostasis, and in the event of severe bleeding prompt management should be immediately instituted.

53. The human body functions optimally in a state of homeostasis.

- A. True
- B. False
- C. Maybe
- D. Homeostasis has nothing to do with metabolic balance.

Correct Answer: A. True

The maintenance of acid-base balance, which in one part of homeostasis, is evidenced by an arterial plasma pH value of 7.35-7.45. Many mechanisms in the body work together to achieve and maintain this delicate narrow range of pH that is essential for normal cell function.

54. After administering bethanechol to a patient with urine retention, the nurse in charge monitors the patient for adverse effects. Which is most likely to occur?

- A. Decreased peristalsis
- B. Increase heart rate
- C. Dry mucous membranes
- D. Nausea and Vomiting

Correct Answer: D. Nausea and Vomiting

Bethanechol will increase GI motility, which may cause nausea, belching, vomiting, intestinal cramps, and diarrhea. Bethanechol directly stimulates cholinergic receptors in the parasympathetic nervous system while stimulating the ganglia to a lesser extent.

- **Option A:** Peristalsis is increased rather than decreased. Stimulation of muscarinic receptors in the GI tract restores peristalsis, increases motility, and increases the resting lower esophageal sphincter pressure.
- **Option B:** With high doses of bethanechol, cardiovascular responses may include vasodilation, decreased cardiac rate, and decreased the force of cardiac contraction, which may cause hypotension.
- **Option C:** Salivation or sweating may gently increase because of its cholinergic effects.

55. For which time period would the nurse notify the health care provider that the client had no bowel sounds?

- A. 2 minutes
- B. 3 minutes
- C. 4 minutes
- D. 5 minutes

Correct Answer: D. 5 minutes

To completely determine that bowel sounds are absent, the nurse must auscultate each of the four quadrants for at least 5 minutes; 2, 3, or 4 minutes is too short a period to arrive at this conclusion. The first item to listen for is the presence of bowel sounds. To chart an assessment finding of no bowel sounds, the nurse needs to listen over the quadrant for at least five minutes. The nurse should also do the auscultation before palpation and percussion to avoid influencing bowel sounds.

- **Option A:** In most cases, bowel sounds are present, but the nurse needs to categorize them. She should listen for the intensity of the sound – whether it is soft or strong. The nurse should also listen for frequency. Hypoactive bowel sounds could indicate a problem, so if the nurse is having trouble hearing them, this is significant.
- **Option B:** Auscultating bowel sounds can allow the nurse to pinpoint areas where an obstruction may have occurred. Finding no bowel sounds can mean an ileus or obstruction above that area of the intestine.
- **Option C:** Hypoactive bowel sounds are considered as one every three to five minutes, and this can indicate diarrhea, anxiety, or gastroenteritis. Hyperactive bowel sounds are often found before a blockage. It is quite common to find one quadrant with hyperactive bowel sounds and one with none or hypoactive ones.

56. A nurse is providing instructions to a client who is taking doxapram (Dopram). Which of the following statements made by the client needs further instructions?

- A. "I need to take the medication before meals".
- B. "I need to take the medication at bedtime".
- C. "I need to avoid drinking coffee".
- D. "I will not chew or crush long acting form of the medications".

Correct Answer: B. "I need to take the medication at bedtime".

Doxapram (Dopram) is a central nervous system stimulant. One of the side effects is insomnia so instruct the client to take it at least 6 hours before bedtime to prevent it.

- **Options A, C, & D:** These are appropriate instructions regarding the use of doxapram.

57. A client with suspected gastric cancer undergoes an endoscopy of the stomach. Which of the following assessments made after the procedure would indicate the development of a potential complication?

- A. The client complains of a sore throat.
- B. The client displays signs of sedation.
- C. The client experiences a sudden increase in temperature.
- D. The client demonstrates a lack of appetite.

Correct Answer: C. The client experiences a sudden increase in temperature.

The most likely complication of an endoscopic procedure is perforation. A sudden temperature spike within 1 to 2 hours after the procedure is indicative of perforation and should be reported immediately to the physician. This most commonly occurs when additional procedures are carried out at the same time. The infections are normally minor and treatable with a course of antibiotics.

- **Option A:** A sore throat is to be anticipated after an endoscopy. Risks of endoscopy may include persistent pain in the area of the endoscopy or a numb throat for a few hours due to the use of a local anesthetic.
- **Option B:** Clients are given sedatives during the procedure, so it is expected that they will display signs of sedation after the procedure is completed. Risks of endoscopy may include over-sedation, although sedation is not always necessary.
- **Option D:** A lack of appetite could be the result of many factors, including the disease process. There may be some soreness. With this type of endoscopy, there may be bloating and soreness, but these usually resolve quickly.

58. When teaching a client with COPD to conserve energy, the nurse should teach the client to lift objects:

- A. While inhaling through an open mouth.
- B. While exhaling through pursed lips.
- C. After exhaling but before inhaling.
- D. While taking a deep breath and holding it.

Correct Answer: B. While exhaling through pursed lips.

Exhaling requires less energy than inhaling. Therefore, lifting while exhaling saves energy and reduces perceived dyspnea. When one practices regularly, breathing exercises can help exert oneself less during daily activities. They can also potentially aid in return to exercising, which can lead to feeling more energetic overall.

- **Option A:** Pursing the lips prolongs exhalation and provides the client with more control over breathing. It's been shown to reduce how hard one has to work to breathe. It helps release air trapped in the lungs. It promotes relaxation. It reduces shortness of breath.

- **Option C:** Lifting after exhalation but before inhaling is similar to lifting with the breath held. The purpose of pursed lip breathing is to help keep the airways open. This helps your airways to remain open. Pursed lip breathing also slows down the breathing rate and calms the patient down.
- **Option D:** This should not be recommended because it is similar to the Valsalva maneuver, which can stimulate cardiac dysrhythmias. The purpose of coordinated breathing is to help assure adequate oxygen to the working muscles and to prevent the client from holding the breath.

59. Which conceptual analysis point of the framework for rigor used for interpretive phenomenology refers to how the study findings will continue to have meaning for the reader?

- A. Resonance
- B. Concreteness
- C. Actualization
- D. Openness

Correct Answer: C. Actualization

Actualization refers to how the study findings will continue to have meaning for the reader. IPA's emphasis on sense-making by both participant and researcher means that it can be described as having cognition as a central analytic concern, and this suggests an interesting theoretical alliance with the cognitive paradigm that is dominant in contemporary psychology.

- **Option A:** Within an interpretive tradition of qualitative research, resonance refers to a researcher's posture of openness and receptivity toward potential meanings embedded in text. It serves as an important ontological and epistemological counterpoint to the postpositivist stance of objective analysis of data.
- **Option B:** In IPA, researchers gather qualitative data from research participants using techniques such as interviews, diaries, or focus groups. Typically, these are approached from a position of flexible and open-ended inquiry, and the interviewer adopts a stance that is curious and facilitative (rather than, say, challenging and interrogative).
- **Option D:** Usually, participants in an IPA study are expected to have certain experiences in common with one another: the small-scale nature of a basic IPA study shows how something is understood in a given context, and from a shared perspective, a method sometimes called homogeneous sampling.

60. Which pulse should the nurse palpate during rapid assessment of an unconscious male adult?

- A. Radial
- B. Brachial
- C. Femoral
- D. Carotid

Correct Answer: D. Carotid

During a rapid assessment, the nurse's first priority is to check the patient's vital functions by assessing his airway, breathing, and circulation. To check a patient's circulation, the nurse must assess his heart and vascular network function. This is done by checking his skin color, temperature, mental status and, most importantly, his pulse. The nurse should use the carotid artery to check a patient's circulation.

- **Option A:** In a patient with circulatory problems or a history of compromised circulation, the radial pulse may not be palpable. Examiners frequently evaluate the radial artery during a routine examination of adults, due to the unobtrusive position required to palpate it and its easy accessibility in various types of clothing. Like other distal peripheral pulses (such as those in the feet) it also may be quicker to show signs of pathology.
- **Option B:** The brachial pulse is palpated during rapid assessment of an infant. The brachial artery is often the site of evaluation during cardiopulmonary resuscitation of infants. It is palpated proximal to the elbow between the medial epicondyle of the humerus and the distal biceps tendon.
- **Option C:** The femoral pulse may be the most sensitive in assessing for septic shock and is routinely checked during resuscitation. It is palpated distally to the inguinal ligament at a point less than halfway from the pubis to the anterior superior iliac spine.

61. In an acute care medical unit, Nurse Jeremy is meticulously evaluating the fluid balance of Mr. Thompson, a 72-year-old male client with a history of congestive heart failure and recently diagnosed acute kidney injury. It's crucial for Nurse Jeremy to ensure that Mr. Thompson's fluid intake and output are closely monitored and managed to prevent any further deterioration of his renal and cardiac functions. The medical team has crafted a meticulous fluid management plan to optimize Mr. Thompson's renal perfusion while preventing fluid overload which could exacerbate his heart failure. As part of this endeavor, Nurse Jeremy is tasked with educating Mr. Thompson and his family about the importance of fluid balance and how it should ideally be maintained. Amidst this backdrop, Nurse Jeremy is keen on elucidating the standard relationship between fluid intake and urine output to Mr. Thompson's family to foster better understanding and compliance with the fluid management plan. Which of the following statements should Nurse Jeremy utilize to explain the typical relationship between fluid intake and urine output?

- A. Fluid intake should be double the urine output.
- B. Fluid intake should be approximately equal to the urine output.
- C. Fluid intake should be half the urine output.
- D. Fluid intake should be inversely proportional to the urine output.
- E. Fluid intake should be proportionate to the client's body weight.
- F. Fluid intake should exceed urine output by 500ml to maintain homeostasis.
- G. Fluid intake should be guided by the client's thirst mechanism.

Correct Answer: B. Fluid intake should be approximately equal to the urine output.

Under normal physiological conditions, fluid intake should be approximately equal to urine output to maintain homeostasis and prevent dehydration or fluid overload. This equilibrium supports optimal renal function and overall fluid balance.

- **Option A:** Doubling the fluid intake in relation to urine output could lead to fluid overload, especially in clients with compromised renal or cardiac function.
- **Option C:** Having fluid intake as half the urine output would indicate a negative fluid balance which could lead to dehydration and potentially compromise renal function.
- **Option D:** Fluid intake being inversely proportional to urine output does not align with physiological norms and could result in improper fluid balance.
- **Option E:** While fluid requirements may be influenced by body weight, the direct comparison between fluid intake and urine output should still follow the principle of equilibrium.
- **Option F:** A predetermined excess of fluid intake over urine output does not adhere to the individualized nature of fluid balance and could potentially lead to fluid overload.
- **Option G:** While the thirst mechanism can be a guide, it may not be reliable, especially in elderly or ill clients, or those on certain medications that may impair thirst perception or fluid balance. Hence, relying solely on the thirst mechanism without monitoring actual intake and output could be perilous.

62. The biopsy of Mr. Gonzales confirms the diagnosis of cirrhosis. Mr. Gonzales is at increased risk for excessive bleeding primarily because of:

- A. Impaired clotting mechanism
- B. Varix formation
- C. Inadequate nutrition
- D. Trauma of invasive procedure

Correct Answer: A. Impaired clotting mechanism

Cirrhosis of the liver results in decreased Vitamin K absorption and formation of clotting factors resulting in impaired clotting mechanism.

- **Option B:** Esophageal varices sometimes form when blood flow to the liver is blocked, most often by scar tissue in the liver caused by liver disease.
- **Option C:** Inadequate nutrition alone cannot cause excessive bleeding in cirrhosis.
- **Option D:** An invasive procedure may cause trauma that may result in bleeding, but the client has not yet undergone any invasive procedure.

63. Which finding indicates to the nurse that a client with a burn injury has a positive perception of his appearance?

- A. Allowing family members to change his dressings
- B. Discussing future surgical reconstruction
- C. Performing his own morning care
- D. Wearing the pressure dressings as ordered

Correct Answer: C. Performing his own morning care

Indicators that the client with a burn injury has a positive perception of his appearance include the willingness to touch the affected body part. Self-care activities such as morning care foster feelings of

self-worth, which are closely linked to body image.

- **Option A:** Encourage the patient and SO to view wounds and assist with care as appropriate. This promotes acceptance of the reality of injury and of change in body and image of self as different.
- **Option B:** Discussing future reconstruction would not indicate a positive perception of appearance. Assist the patient to identify the extent of actual change in appearance and body function. This helps begin the process of looking to the future and how life will be different.
- **Option D:** Wearing the dressing will assist in decreasing complications, but will not increase self-perception. However, give positive reinforcement of progress and encourage endeavors toward attainment of rehabilitation goals. Words of encouragement can support the development of positive coping behaviors.

64. Topical antibiotics work by:

- A. Inhibiting replication of a virus.
- B. Blocking histamine-1 and -2 receptors.
- C. Binding to fungal cell membranes.
- D. Inhibiting bacterial cell wall synthesis.

Correct Answer: D. Inhibiting bacterial cell wall synthesis

Topical antibiotics work by inhibiting bacterial cell wall synthesis. The pharmacology behind antibiotics includes destroying the bacterial cell by either preventing cell reproduction or changing a necessary cellular function or process within the cell.

- **Option A:** This describes antiviral actions. It inhibits DNA synthesis and viral replication after it is converted to acyclovir triphosphate by viral and cellular enzymes. Acyclovir is an antiviral agent that incorporates itself into viral DNA preventing further synthesis.
- **Option B:** This describes the action of antipruritics. Antipruritic drugs act centrally by a property related to sedation; H1 receptor antagonists have a peripheral antipruritic action only when the itch is due to histamine release, as in the wealing disorders.
- **Option C:** This describes the action of antifungals. Antifungals can be grouped into three classes based on their site of action: azoles, which inhibit the synthesis of ergosterol (the main fungal sterol); polyenes, which interact with fungal membrane sterols physicochemically; and 5-fluorocytosine, which inhibits macromolecular synthesis.

65. A client is admitted with a diagnosis of hypothyroidism. An initial assessment of the client would reveal:

- A. Slow pulse rate, weight loss, diarrhea, and cardiac failure
- B. Weight gain, lethargy, slowed speech, and decreased respiratory rate
- C. Rapid pulse, constipation, and bulging eyes
- D. Decreased body temperature, weight loss, and increased respirations

Correct Answer: B. Weight gain, lethargy, slowed speech, and decreased respiratory rate

- **Option B:** Hypothyroidism occurs when the thyroid gland does not make enough thyroid hormone. Symptoms of hypothyroidism include weight gain, lethargy, slow speech, and decreased

respirations.

- Options A and D: They do not describe symptoms associated with myxedema.
- Option C: These symptoms are associated with Grave's disease.

66. What is the appropriate infusion time for the dialysate in your 38 y.o. patient with chronic renal failure undergoing peritoneal dialysis?

- A. 15 minutes
- B. 30 minutes
- C. 1 hour
- D. 2 to 3 hours

Correct Answer: A. 15 minutes

Dialysate should be infused quickly. The dialysate should be infused over 15 minutes or less when performing peritoneal dialysis. The fluid exchange takes place over a period ranging from 30 minutes to several hours. Each exchange takes about 30 to 40 minutes. During an exchange, the client can read, talk, watch television, or sleep. With CAPD, the client can keep the solution in the belly for 4 to 6 hours or more. The time that the dialysis solution is in the belly is called the dwell time. Usually, the client changes the solution at least four times a day and sleep with solution in the belly at night

- **Option B:** The client's schedule will change as he works his dialysis exchanges into his routine. If he does CAPD during the day, he has some control over when he does the exchanges. However, he'll still need to stop his normal activities and take about 30 minutes to perform an exchange. If he does automated peritoneal dialysis, he'll have to set up his cyclor every night.
- **Option C:** Between exchanges, the client keeps his catheter and transfer set hidden inside his clothing. At the beginning of an exchange, he'll remove the disposable cap from the transfer set and connect the set to a tube that branches like the letter Y. One branch of the Y-tube connects to the drain bag, while the other connects to the bag of fresh dialysis solution.
- **Option D:** With automated peritoneal dialysis, a machine called a cyclor fills and empties the belly three to five times during the night. In the morning, the client begins the day with a fresh solution in his belly. He may leave this solution in his belly all day or do one exchange in the middle of the afternoon without the machine. People sometimes call this treatment continuous cyclor-assisted peritoneal dialysis or CCPD.

67. Clients with chronic illnesses are more likely to get pneumonia when which of the following situations is present?

- A. Dehydration
- B. Group living
- C. Malnutrition
- D. Severe periodontal disease

Correct Answer: B. Group living

Clients with chronic illnesses generally have poor immune systems. Often, residing in group living situations increases the chance of disease transmission. Pneumonia is a fairly prevalent disease and

carries a heavy burden in all populations. A study carried out by the US Centers for Disease Control and Prevention (CDC) aimed at estimating its burden in North America found that CAP accounted for the eighth leading cause of mortality in the United States and the seventh leading cause of mortality in Canada after adjusting for various gender and age differences.

- **Option A:** Pneumonia can also cause dehydration from fever and decreased thirst and appetite, which may require treatment with extra fluids intravenously. Potential benefits of fluids are replacing fluid lost because of fever or rapid breathing, treating dehydration, and reducing the viscosity of mucus.
- **Option C:** Pneumonia is common in malnourished children and is frequently associated with fatal outcomes, especially in children younger than 24 months of age. Studies consistently reported a two- to threefold greater risk of mortality in cases with pneumonia associated with malnutrition. Therefore, pneumonia and malnutrition are two of the biggest killers in childhood diseases.
- **Option D:** Various pathogenic bacteria have been found in patients with deep periodontal pockets. The association between periodontal disease and pneumonia may be due to colonization by pathogenic bacteria in the periodontal pocket, as inhalation of a pathogen is considered a risk factor for pneumonia.

68. You are acting as a preceptor for a newly graduated RN during her second week of orientation. You would assign the new RN under your supervision to provide care to which patients? Select all that apply.

- A. A 38-year old with moderate persistent asthma awaiting discharge.
- B. A 63-year old with a tracheostomy needing tracheostomy care every shift.
- C. A 56-year old with lung cancer who has just undergone left lower lobectomy.
- D. A 49-year old just admitted with a new diagnosis of esophageal cancer.

Correct Answer: A and B.

- **Option A:** A patient who is waiting for discharge may be stable enough for the care of the student nurse. The client is the center of care. The needs of the client must be competently met with the knowledge, skills and abilities of the staff to meet these needs.
- **Option B:** The new RN is at an early point in her orientation. The most appropriate patients to assign to her are those in stable condition who require routine care. In other words, the nurse who delegates aspects of care to other members of the nursing team must balance the needs of the client with the abilities of those to which the nurse is delegating tasks and aspects of care, among other things such as the scopes of practice and the policies and procedures within the particular healthcare facility.
- **Option C:** The patient with the lobectomy will require the care of a more experienced nurse, who will perform frequent assessments and monitoring for postoperative complications. Some needs require high levels of professional judgment and skill; and other patient needs are somewhat routine and without the need for high levels of professional judgment and skill.
- **Option D:** The patient admitted with newly diagnosed esophageal cancer will also benefit from care by an experienced nurse. This patient may have questions and needs a comprehensive admission assessment. As the new nurse advances through her orientation, you will want to work with her in providing care for these patients with more complex needs.

69. Which of the following instructions should be included in the nurse's teaching regarding oral contraceptives?

- A. Weight gain should be reported to the physician.
- B. An alternate method of birth control is needed when taking antibiotics.
- C. If the client misses one or more pills, two pills should be taken per day for 1 week.
- D. Changes in the menstrual flow should be reported to the physician.

Correct Answer: B. An alternate method of birth control is needed when taking antibiotics.

When the client is taking oral contraceptives and begins antibiotics, another method of birth control should be used. Antibiotics decrease the effectiveness of oral contraceptives. Antibiotics are suspected to diminish oral contraceptive efficacy by two main mechanisms: induction of the cytochrome P450 group of hepatic microsomal enzymes and interference with enterohepatic cycling of ethinylestradiol.

- **Option A:** Approximately 5–10 pounds of weight gain is not unusual. Women who stop taking the pill often do so because they think it has been causing them to gain weight. Clinical studies in this area are contradictory: Some women said that they gained weight, while others reported losing weight. This is why both weight gain and weight loss are listed as possible side effects on the product information of hormonal contraceptives.
- **Option C:** If the client misses a birth control pill, she should be instructed to take the pill as soon as she remembers the pill. If she misses two, she should take two; if she misses more than two, she should take the missed pills but use another method of birth control for the remainder of the cycle.
- **Option D:** Changes in menstrual flow are expected in clients using oral contraceptives. Often these clients have lighter menses. All hormonal contraceptives are associated with changes in menstrual bleeding patterns. When beginning a new hormonal contraception method, some people may experience irregular bleeding or spotting. Others may notice changes in the length or heaviness of bleeding, and some may stop bleeding entirely.

70. A nurse provides medication instructions to a first-time mother. Which statement made by the mother indicates a need for further instructions?

- A. "I should mix the medication in the baby food and give it when I feed the child".
- B. "I should administer the oral medication sitting in an upright position and with the head elevated".
- C. "I will give my child a toy after giving the medication".
- D. "I will offer my child a juice drink after swallowing the medication".

Correct Answer: A. "I should mix the medication in the baby food and give it when I feed the child".

The nurse would teach the mother to avoid putting medications in foods because it may cause an unpleasant taste to the food, and the child may refuse to accept the same food in the future. Additionally, the child may not consume the entire serving and would not require medication dosage.

- **Option B:** Administering the medication in an upright position and head elevation will prevent the risk of aspiration. Do not squirt medicine directly at the back of the baby's throat. This may cause the child to choke.
- **Option C:** Offering a toy will provide comfort measures to the child. Praise the child every time he takes the medicine without a struggle. (Giving a special sticker works well for some children.)

- **Option D:** The mother should offer drinks such as juice or a soft drink to lessen the aftertaste of the medication. Some medicines can be put in a small amount of juice or sugar water. Follow the instructions from the doctor, nurse, or pharmacist. Do not put medicine in a full bottle or cup in case the infant does not drink very much.

71. The mid-deltoid injection site is seldom used for I.M. injections because it:

- A. Can accommodate only 1 ml or less of medication.
- B. Bruises too easily.
- C. Can be used only when the patient is lying down.
- D. Does not readily absorb parenteral medication.

Correct Answer: A. Can accommodate only 1 ml or less of medication

The mid-deltoid injection site can accommodate only 1 ml or less of medication because of its size and location (on the deltoid muscle of the arm, close to the brachial artery and radial nerve). It is becoming increasingly important for clinicians to identify a safer intramuscular (IM) injection site in the deltoid muscle because of possible complications following the vaccine administration of IM injections.

- **Option B:** However, Cook reported that these 4 injection sites have the potential to cause injury to the subdeltoid/subacromial bursa and/or anterior branch of the axillary nerve with the arm in the anatomical position. Additionally, we showed that the axillary nerve often runs near the site 5 cm below the mid-acromion lateral border, and concluded that this site is unsuitable for IM injection in terms of the high risk for the complications related to this nerve.
- **Option C:** The deltoid muscle has been used in clinical settings because it is easy for clinicians to administer injections at this site and for patients to expose it, and it is the most commonly used site for vaccines worldwide. Four injection sites have been recommended as safer and appropriate IM injection sites in the deltoid muscle: the first site is 1 to 3 fingerbreadths (5 cm) below the mid-acromion, the second is a triangular injection site, the third is the middle third of the deltoid muscle, and the fourth is a mid-deltoid site.
- **Option D:** The following complications have been reported after the administration of IM injections: injection site reactions such as pain, erythema, and swelling due to over-or under penetration by the needle, axillary or radial nerve palsies, musculoskeletal injuries, local sepsis, and vascular complications. Therefore, it is becoming increasingly important to establish a safer site for IM injections.

72. A nurse is giving instructions to a client who is receiving mycophenolate mofetil (CellCept) and mycophenolic acid (Myfortic) after undergoing a heart transplant. The nurse tells the client to anticipate the following side effects, except?

- A. Hypersomnia.
- B. Vomiting.
- C. Hypertension.
- D. Diarrhea.

Correct Answer: A. Hypersomnia.

Mycophenolate mofetil and mycophenolic acid are a potent immunosuppressive drug that is used as a part of standard immunosuppressive therapy to prevent the body from rejecting an organ transplant. These medications can cause diarrhea, vomiting, sepsis, back pain, neutropenia, hypertension, and insomnia.

73. What does a critique of a research study always include? Select all that apply.

- A. Determining its strengths and weaknesses.
- B. Researching similar studies.
- C. Using critical reading skills.
- D. Explaining your own personal opinions.

Correct Answers: A, C

Reading a single article can act as a springboard into researching the topic more widely and aids in ensuring the nursing practice remains current and is supported by existing literature.

- **Option A:** Similar to a recipe, the description of materials and methods will allow others to replicate the study elsewhere if needed. It should both contain and justify the exact specifications of selection criteria, sample size, response rate and any statistics used.
- **Option B:** The discussion should use previous research work and theoretical concepts as the context in which the new study can be interpreted. Any limitations of the study, including bias, should be clearly presented.
- **Option C:** Not all peer reviewers have expert knowledge on certain subject matters, which can introduce bias and sometimes a conflict of interest.
- **Option D:** Publication bias can occur when editors only accept manuscripts that have a bearing on the direction of their own research or reject manuscripts with negative findings.

74. A postoperative client has an order for Demerol (meperidine) 75mg and promethazine (Phenergan) 25mg IM every 3–4 hours as needed for pain. The combination of the two medications produces a/an:

- A. Antagonist effect
- B. Excitatory effect
- C. Synergistic effect
- D. Agonist effect

Correct Answer: C. Synergistic effect

- Option C: The combination of the two medications produces an effect greater than that of either drug used alone.
- Option A: Antagonist effects are those in which the actions of the drugs oppose one another.
- Option B: The drugs would have a combined depressing, not excitatory, effect.
- Option D: Agonist effects are similar to those produced by chemicals normally present in the body.

75. The nurse documents positive ballottement in the client's prenatal record. The nurse understands that this indicates which of the following?

- A. Palpable contractions on the abdomen.
- B. Passive movement of the unengaged fetus.
- C. Fetal kicking felt by the client.
- D. Enlargement and softening of the uterus.

Correct Answer: B. Passive movement of the unengaged fetus.

Ballottement indicates passive movement of the unengaged fetus. Ballottement is when the lower uterine segment or the cervix is tapped by the examiner's finger and left there, the fetus floats upward, then sinks back and a gentle tap is felt on the finger.

- **Option A:** Ballottement is not a contraction. Contractions can be felt by placing a hand on the abdomen and feeling when the uterus becomes hard, and when it relaxes. It is therefore possible to assess the length of a contraction by taking the time at the beginning and end of the contraction.
- **Option C:** Fetal kicking felt by the client represents quickening. Usually, quickening occurs naturally at about the middle of a pregnancy. A woman pregnant for the first time (i.e., a primigravida woman) typically feels fetal movements at about 18–20 weeks, whereas a woman who has given birth at least once (i.e., a para woman) will typically feel movements around 15–17 weeks.
- **Option D:** Enlargement and softening of the uterus is known as Piskacek's sign. The Piskacek's sign is an indication of pregnancy. Specifically, Piskacek's sign consists of noting a palpable lateral bulge or soft prominence at one of the locations where the uterine tube meets the uterus. Piskacek's sign can be noted in the seventh to eighth week of gestation.

76. Which nursing intervention would be most appropriate if a male client develops orthostatic hypotension while taking amitriptyline (Elavil)?

- A. Consulting with the physician about substituting a different type of antidepressant.
- B. Advising the client to sit up for 1 minute before getting out of bed.
- C. Instructing the client to double the dosage until the problem resolves.
- D. Informing the client that this adverse reaction should disappear within 1 week.

Correct Answer: B. Advising the client to sit up for 1 minute before getting out of bed.

To minimize the effects of amitriptyline-induced orthostatic hypotension, the nurse should advise the client to sit up for 1 minute before getting out of bed. Amitriptyline is FDA approved medication to treat depression in adults. Secondary to its alpha-adrenergic receptor blockade, it can cause orthostatic hypotension, dizziness, and sedation. It can also cause heart rate variability, slow intracardiac conduction, induce various arrhythmias, and cause QTc (corrected QT) prolongation.

- **Option A:** Orthostatic hypotension commonly occurs with tricyclic antidepressant therapy. Cardiac symptoms include tachycardia, hypotension, conduction abnormalities include QTc prolongation. Amitriptyline is in the tricyclic antidepressant (TCA) drug classification and acts by blocking the reuptake of both serotonin and norepinephrine neurotransmitters. The three-ring central structure, along with a side chain, is the basic structure of tricyclic antidepressants. Amitriptyline is a tertiary amine and has strong binding affinities for alpha-adrenergic, histamine (H1), and muscarinic (M1)

receptors. It is more sedating and has increased anticholinergic properties compared to other TCAs.

- **Option C:** In these cases, the dosage may be reduced or the physician may prescribe nortriptyline, another tricyclic antidepressant. Once the patient is stable, amitriptyline should be continued for three months or longer to prevent relapse of depression. In cases of therapy cessation, the clinician should gradually taper to avoid withdrawal. Amitriptyline administration comes in various forms, the most common being oral form. The initial dose recommended for depression is 25 mg/day at bedtime, as it can be sedating.
- **Option D:** Orthostatic hypotension disappears only when the drug is discontinued. The most commonly encountered side effects of amitriptyline include weight gain, gastrointestinal symptoms like constipation, xerostomia, dizziness, headache, and somnolence. Patients on amitriptyline can have anticholinergic, antihistaminic, and alpha-adrenergic blocking effects. It may not be appropriate for patients with cardiac problems.

77. Sudden infant death syndrome (SIDS) is one of the most common causes of death in infants. At what age is the diagnosis of SIDS most likely?

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

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

SIDS can occur any time between 1 week and 1 year of age. The incidence peaks at 2 to 4 months of age. Sudden infant death syndrome (SIDS) is the abrupt and unexplained death of an infant less than 1-year old. Despite a thorough investigation (a careful review of clinical history, death scene investigation, and a complete autopsy), a cause for the patient's demise is not identified.

- **Option A:** SIDS frequently occurs during sleep, and it is the leading cause of death in infants one to twelve months of age in the United States. Due to inconsistencies in the use of SIDS as a diagnostic term, sudden unexpected infant death (SUID) was introduced.
- **Option C:** The peak incidence occurs between 2 and 4 months, and 90 percent of cases occur before six months of age. According to the Centers for Disease Control and Prevention (CDC), the incidence of SIDS in 2017 was 35.4 per 100,000 live births in the United States.
- **Option D:** Prior to the introduction of campaigns to reduce SIDS deaths, death rates were noted to vary significantly between Asian populations, aboriginal people in Australia, the population of the United Kingdom, the population of the United States, and the population of New Zealand.

78. A nurse is assessing the blood pressure of a client diagnosed with primary hypertension. The nurse ensures accurate measurement by avoiding which of the following?

- A. Seating the client with arm bared, supported, and at heart level.
- B. Measuring the blood pressure after the client has been seated quietly for 5 minutes.
- C. Using a cuff with a rubber bladder that encircles at least 80% of the limb.

D. Taking a blood pressure within 15 minutes after nicotine or caffeine ingestion.

Correct Answer: D. Taking a blood pressure within 15 minutes after nicotine or caffeine ingestion.

BP should be taken with the client seated with the arm bared, positioned with support, and at heart level. The client should sit with the legs on the floor, feet uncrossed, and not speak during the recording. The client should not have smoked tobacco or taken in caffeine in the 30 minutes preceding the measurement. First, the patient should be questioned regarding recent caffeine consumption, exercise, or smoking. If any of these activities have occurred within the last 30 minutes, blood pressure measurement should be postponed until this period has passed.

- **Option A:** If a manual measurement is being performed, the bell or diaphragm of a stethoscope should be placed over the medial antecubital fossa over the approximate location of the brachial artery. The blood pressure cuff should be inflated 30 mm Hg beyond the point at which the radial pulse is no longer palpable.
- **Option B:** The client should rest quietly for 5 minutes before the reading is taken. The patient should be encouraged to empty his/her bladder. Upon return, the patient should be seated in a quiet room on a chair with back support. Both feet should be flat on the floor with the legs uncrossed, and this seated position should be maintained for at least 5 minutes.
- **Option C:** The cuff bladder should encircle at least 80% of the limb being measured. Gauges other than a mercury sphygmomanometer should be calibrated every six (6) months to ensure accuracy. At this time, a properly sized cuff should be placed directly over the patient's arm, no clothing should be underneath the cuff, and sleeves should not be rolled above the cuff. Once the cuff is in position, the patient's arm should be supported so that the middle of the cuff is at the level of the right atrium.

79. A researcher wants to discover why patients of certain ethnic backgrounds are reluctant to ask for pain medication. Because there is little data in the literature on this topic, the researcher designs a study to explore the relationships between cultural belief systems, the experience of pain, and the effective use of medication to relieve pain. The researcher plans to use the findings of this study to formulate hypotheses for a future study. What is a characteristic of this study?

- A. It is a quasi-experimental study.
- B. It will lead to level II data.
- C. It has a directional hypothesis.
- D. It is a hypothesis-generating study.

Correct Answer: D. It is a hypothesis-generating study.

Not enough is known in this area at this time to formulate hypotheses, so the researcher will conduct this qualitative study and use the findings to generate hypotheses for future studies. In hypothesis-generating research, the researcher explores a set of data searching for relationships and patterns and then proposes hypotheses that may then be tested in some subsequent study.

- **Option A:** This is a qualitative study, not a quasi-experimental study. Qualitative research involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. Qualitative research is the opposite of quantitative research, which

involves collecting and analyzing numerical data for statistical analysis.

- **Option B:** Level II evidence is obtained from at least one well-designed randomized, controlled trial. Evidence is obtained from at least one well-designed RCT (e.g. large multi-site RCT). Levels of evidence (sometimes called hierarchy of evidence) are assigned to studies based on the methodological quality of their design, validity, and applicability to patient care. These decisions give the “grade (or strength) of recommendation.”
- **Option C:** This study has no hypothesis. A directional hypothesis is a prediction made by a researcher regarding a positive or negative change, relationship, or difference between two variables of a population.

80. A client is brought to the emergency unit with third-degree burns on the posterior trunk, right arm, and left posterior leg. Using the Rule of Nines, what is the total body surface area (TBSA) that has been burned?

- A. 36%
- B. 54%
- C. 45%
- D. 27%

Correct Answer: A. 36%

The Rule of Nines, also known as the Wallace Rule of Nines, is a tool used by trauma and emergency medicine providers to assess the total body surface area (TBSA) involved in burn patients. Based on the rule of nines, the posterior trunk equals 18%, right arm equals 9%, and the left posterior leg equals 9%. Therefore, a total of 36%.

- **Option B:** The Rule of Nines estimation of body surface area burned is based on assigning percentages to different body areas. The entire head is estimated as 9% (4.5% for anterior and posterior). The entire trunk is estimated at 36% and can be further broken down into 18% for anterior components and 18% for the back.
- **Option C:** The anterior aspect of the trunk can further be divided into chest (9%) and abdomen (9%). The upper extremities total 18% and thus 9% for each upper extremity. Each upper extremity can further be divided into anterior (4.5%) and posterior (4.5%).
- **Option D:** The lower extremities are estimated at 36%, 18% for each lower extremity. Again this can be further divided into 9% for the anterior and 9% for the posterior aspect. The groin is estimated at 1%.

81. A client with a positive Mantoux test result will be sent for a chest x-ray. For which of the following reasons is this done?

- A. To confirm the diagnosis.
- B. To determine if a repeat skin test is needed.
- C. To determine the extent of the lesions.
- D. To determine if this is a primary or secondary infection.

Correct Answer: C. To determine the extent of the lesions.

If the lesions are large enough, the chest x-ray will show their presence in the lungs. A positive Mantoux test indicates exposure to tuberculosis or latent tuberculosis. However, this test lacks specificity, and patients require subsequent visits to interpret the result and a chest x-ray for confirmation of the disease.

- **Option A:** Sputum culture confirms the diagnosis. Mycobacterial culture is the gold standard for diagnosis. Mycobacterial culture should be performed on both the solid and liquid medium. Liquid media culture can detect very low bacterial load and is considered a gold standard. Culture essential for drug susceptibility testing.
- **Option B:** There can be false-positive and false-negative skin test results. Although the test is considered relatively sensitive, false-positive results are seen with BCG vaccination. The Mantoux test should never be regarded as a confirmatory test.
- **Option D:** A chest x-ray can't determine if this is a primary or secondary infection. Apart from these, Tuberculin skin testing and/or interferon-gamma release assay should be performed depending on the situation. These tests should not be wholly relied upon in the diagnosis of active tuberculosis, but assist in diagnosis.

82. A client is prescribed with Pentamidine (Pentam) IV for the treatment of *Pneumocystis carinii* pneumonia. Suddenly, the client develops a temperature of 101.5°F. The nurse in charge knows that this sign would mostly indicate which of the following?

- A. An overdosage of the medication.
- B. The need for an additional dosage.
- C. The client has developed another infection.
- D. The client is experiencing the therapeutic effect of the medication.

Correct Answer: C. The client has developed another infection.

Pentamidine can cause low white blood cells or low platelets in your blood, so the client is most likely developing another infection that brings about these side effects.

- **Options A, B, & D:** These are inappropriate interpretations.

83. A 48-year-old male patient with a history of uncontrolled hypertension and chronic smoking presents to the emergency room with acute abdominal pain and vomiting for the last 48 hours. An abdominal CT scan reveals a focal thickening of a segment of the small bowel. The consulting gastroenterologist believes that the patient might have an ischemic bowel. As part of the teaching rounds, the gastroenterology nurse educator, interested in ensuring that the nurses can understand the pathology at hand, quizzes them about the anatomical structure of the gastrointestinal (GI) tract. Given the relevance of understanding the layered architecture of the GI tract in order to appreciate the intricacies of diseases like bowel ischemia, which of the following layers, integral to the structure of the digestive tract, should the instructor ask students to identify as NOT one of the four primary tunics?

- A. Mucosa
- B. Glandulosa
- C. Submucosa
- D. Muscularis

Correct Answer: B. Glandulosa

“Glandulosa” is not one of the four primary tunics found throughout the digestive tract. Instead, the four tunics are the mucosa, submucosa, muscularis, and serosa (or adventitia in some areas), each with distinct functions related to digestion and nutrient absorption.

- **Option A:** This is incorrect as the mucosa is indeed one of the primary layers of the GI tract. It is the innermost layer and serves multiple functions, including secretion, absorption, and protection.
- **Option C:** This is incorrect as the submucosa is one of the primary layers of the GI tract. It lies just outside the mucosa and consists of connective tissue, blood vessels, lymphatic vessels, and nerves. It provides nutrition to the mucosa and supports it.
- **Option D:** This is incorrect. The muscularis is another primary layer of the GI tract. It comprises two layers of smooth muscle (inner circular and outer longitudinal) that propel food and chyme through the GI tract. This process is known as peristalsis.

84. For the first 72 hours after thyroidectomy surgery, nurse Jamie would assess the female client for Chvostek’s sign and Trousseau’s sign because they indicate which of the following?

- A. Hypocalcemia
- B. Hypercalcemia
- C. Hypokalemia
- D. Hyperkalemia

Correct Answer: A. Hypocalcemia

The client who has undergone a thyroidectomy is at risk for developing hypocalcemia from inadvertent removal or damage to the parathyroid gland. The client with hypocalcemia will exhibit a positive Chvostek’s sign (facial muscle contraction when the facial nerve in front of the ear is tapped) and a positive Trousseau’s sign (carpal spasm when a blood pressure cuff is inflated for a few minutes). These signs aren’t present with hypercalcemia, hypokalemia, or hyperkalemia.

- **Option B:** Severe hypercalcemia inhibits neuromuscular and myocardial depolarization leading to muscle weakness and arrhythmias. Cardiovascular effects include prolonged PR interval, short QT interval, widened QRS complex, and bradycardia. Increased thirst with polydipsia and polyuria is seen initially, progressing to nephrolithiasis and nephrocalcinosis in chronic cases.
- **Option C:** Significant muscle weakness occurs at serum potassium levels below 2.5 mmol/L but can occur at higher levels if the onset is acute. Similar to the weakness associated with hyperkalemia, the pattern is ascending in nature affecting the lower extremities, progressing to involve the trunk and upper extremities and potentially advancing to paralysis.
- **Option D:** Physical exam findings may include hypertension and edema in the setting of renal disease. There may also be signs of hypoperfusion. Muscle tenderness may be present in patients with rhabdomyolysis. Jaundice may be seen in patients with hemolytic conditions. Patients may have muscle weakness, flaccid paralysis, or depressed deep tendon reflexes.

85. A nurse is working with a client who has schizophrenia, paranoid type. Which of the following outcomes related to the client's delusional perceptions would the nurse establish?

- A. The client will demonstrate realistic interpretation of daily events in the unit.
- B. The client will perform daily hygiene and grooming without assistance.
- C. The client will take prescribed medications without difficulty.
- D. The client will participate in unit activities.

Correct Answer: A. The client will demonstrate realistic interpretation of daily events in the unit.

A client with schizophrenia, paranoid type, has distorted perceptions and views people, institutions, and aspects of the environment as plotting against him. The desired outcome for someone with delusional perceptions would be to have a realistic interpretation of daily events. Unlike DSM-5, ICD-10 further subcategories schizophrenia based on the key presenting symptoms as either paranoid schizophrenia, hebephrenic schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia, post-schizophrenic depression, residual schizophrenia, and simple schizophrenia.

- **Option B:** The client with a distorted perception of the environment would not necessarily have impairments affecting hygiene and grooming skills. A thorough risk assessment must also be undertaken to determine the risk of harm to self and others. The first schizophrenic episode usually occurs during early adulthood or late adolescence. Individuals often lack insight at this stage; therefore few will present directly to seek help for their psychotic symptoms.
- **Option C:** For the initial treatment of acute psychosis, it is recommended to commence an oral second-generation antipsychotic (SGA) such as aripiprazole, olanzapine, risperidone, quetiapine, asenapine, lurasidone, sertindole, ziprasidone, brexpiprazole, molindone, iloperidone, etc. Sometimes, if clinically needed, alongside a benzodiazepine such as diazepam, clonazepam or lorazepam to control behavioral disturbances and non-acute anxiety. First generation antipsychotic (FGA) like trifluoperazine, Fluphenazine, haloperidol, pimozide, sulpiride, flupentixol, chlorpromazine, etc. are not commonly used as the first line but can be used.
- **Option D:** Although taking medications and participating in unit activities may be appropriate outcomes for nursing intervention; these responses are not related to client perceptions. Cognitive-behavioral therapy (CBT) and the use of art and drama therapies help counteract the negative symptoms of the disease, improve insight, and assist relapse prevention.