

# Kevin's Review - 85 NCLEX Practice Questions

**1. The client has orders for a nasogastric (NG) tube insertion. During the procedure, instructions that will assist in the insertion would be:**

- A. Instruct the client to tilt his head back for insertion in the nostril, then flex his neck for the final insertion.
- B. After insertion into the nostril, instruct the client to extend his neck.
- C. Introduce the tube with the client's head tilted back, then instruct him to keep his head upright for final insertion.
- D. Instruct the client to hold his chin down, then back for insertion of the tube.

**Correct Answer: A. Instruct the client to tilt his head back for insertion in the nostril, then flex his neck for the final insertion.**

NG insertion technique is to have the client first tilt his head back for insertion into the nostril, then to flex his neck forward and swallow. A common error when placing the tube is to direct the tube in an upward direction as it enters the nares; this will cause the tube to push against the top of the sinus cavity and cause increased discomfort. The tip should instead be directed parallel to the floor, directly toward the back of the patient's throat.

- **Option B:** Extension of the neck will impede NG tube insertion. The patient can be given a cup of water with a straw in it to sip from to help ease the passage of the tube. The tube should be advanced with firm, constant pressure while the patient is sipping. If there is a great deal of difficulty in passing the tube, a helpful maneuver is to withdraw the tube and attempt again after a short break in the contralateral nares as the tube may have become coiled in the oropharynx or nasal sinus.
- **Option C:** In intubated patients, the use of reverse Sellick's maneuver (pulling the thyroid cartilage up rather than pushing it down during intubation) and freezing the NG tube may help facilitate placement of the tube. Once the tube has been inserted an appropriate length, typically around 55 cm as previously noted, it should be secured to the patient's nose with tape.
- **Option D:** Nasogastric tubes are, as one might surmise from their name, tubes that are inserted through the nares to pass through the posterior oropharynx, down the esophagus, and into the stomach. The most common complications related to the placement of nasogastric tubes are discomfort, sinusitis, or epistaxis, all of which typically resolve spontaneously with the removal of the nasogastric tube.

**2. Mrs. Baker was instructed by the nurse on foods to encourage her child's diet concerning the latter's iron deficiency anemia. which of the following if stated by the mother would indicate the need for further instruction?**

- A. Fish
- B. Lean meats
- C. Whole-grain breads
- D. Yellow vegetables

**Correct Answer: D. Yellow vegetables**

If a parent states that she should stress the intake of yellow vegetables, she needs additional teaching because yellow vegetables are not a good source of iron. Leafy greens, especially dark ones, are among the best sources of nonheme iron.

- **Option A:** Some seafood provides heme iron. Shellfish such as oysters, clams, scallops, crabs, and shrimp are good sources. Most fish contain iron. Although canned sardines are good sources of iron, they're also high in calcium. Calcium may bind with iron and reduce its absorption.
- **Option B:** All meat and poultry contain heme iron. Red meat, lamb, and venison are the best sources. Poultry and chicken have lower amounts. Eating meat or poultry with nonheme iron foods, such as leafy greens, along with vitamin C-rich fruit can increase iron absorption.
- **Option C:** Whole-grain breads are good food source of iron and should be supported and encouraged. It may be a good idea to choose iron-fortified cereals, bread products, orange juice, rice, and pasta. Also, fermented and sprouted grains and legumes are a better choice for people with iron deficiency because sprouting and fermenting break down anti-nutrient compounds that negatively impact iron absorption.

**3. In the neonatal intensive care unit (NICU) of Tranquil Beginnings Hospital, Nurse Veronica is starting her shift. She's handed over the care of baby Ethan, who was born 12 hours ago with a noticeable cleft lip. The new parents, first-timers, are understandably concerned and have a lot of questions. As part of her assessment and while preparing to guide and reassure the parents, Nurse Veronica pays particular attention to potential complications that might be directly related to baby Ethan's cleft lip. While evaluating a newborn like Ethan with a cleft lip, which of the following aspects of his health should the nurse be particularly vigilant about, anticipating that it will most likely be compromised?**

- A. Sucking ability
- B. Respiratory status
- C. Locomotion
- D. GI function
- E. Auditory function
- F. Vision

**Correct Answer: A. Sucking ability**

Newborns with a cleft lip often have difficulty creating a seal and generating the necessary suction for effective breastfeeding or bottle-feeding. This is a primary concern and often requires specialized feeding techniques or tools to support adequate nutrition. In this scenario, Nurse Veronica would focus on guiding and supporting Ethan's parents in managing his feeding needs, helping them understand his sucking challenges, and introducing them to specialized feeding techniques or tools designed for babies with a cleft lip.

- **Option B:** While respiratory issues can be a concern in newborns for various reasons, a cleft lip, in isolation, does not directly impact the respiratory system.
- **Option C:** Locomotion, or movement, is not typically affected by a cleft lip. This option pertains more to the physical ability to move, which is unrelated to the condition in question.
- **Option D:** A cleft lip does not directly affect gastrointestinal function. However, feeding difficulties related to the cleft lip might indirectly impact weight gain and nutrition.
- **Option E:** Although children with cleft palate (which can co-exist with cleft lip) may have an increased risk of middle ear infections that can affect hearing, a cleft lip alone does not directly

impact auditory function.

- **Option F:** Vision is not impacted by a cleft lip.

**4. Immediately post-op after a prostatectomy, which complications require priority assessment of your patient?**

- A. Pneumonia
- B. Hemorrhage
- C. Urine retention
- D. Deep vein thrombosis

**Correct Answer: B. Hemorrhage**

Hemorrhage is a potential complication. Postoperative hemorrhage is a rare but severe complication in LRP. Bleeding generally originates from injured venous vessels in the prostatectomy area, which is always self-limiting due to tissue compression in the pelvic space. However, it is not easy for slightly larger arteries to stop bleeding automatically.

- **Option A:** Pneumonia may occur if the patient doesn't cough and deep breathe. Postoperative pneumonia is an important cause of morbidity and mortality and represents an important financial burden of \$10.5 billion per year. Patients undergoing surgery, especially complex procedures, are at a greater risk due to intubation, post-surgical atelectasis, and long hospital stays exposing them to hospital-acquired pathogens. It has been estimated that approximately one out of four deaths within six days of surgery is due to its complications.
- **Option C:** Urine retention isn't a problem soon after surgery because a catheter is in place. Although leaving a temporary indwelling catheter is standard practice after radical prostatectomy to allow anastomotic healing, urinary catheterization represents a source of infection, significant discomfort, and anxiety for the patient following radical prostatectomy.
- **Option D:** Thrombosis may occur later if the patient doesn't ambulate. Historically, the reported rate of symptomatic VTEs is low in open prostatectomy series, as well as robot-assisted radical prostatectomy (RARP) series. As a result, it is unclear which patients are at the highest risk of VTEs developing and who would benefit from medical prophylaxis, given the low incidence of VTEs and a possible increase in complications with the use of heparin.

**5. You are assessing a patient who has sustained a cat bite to the left hand. The cat is up-to-date immunizations. The date of the patient's last tetanus shot is unknown. Which of the following is the priority nursing diagnosis?**

- A. Impaired Skin Integrity related to puncture wounds
- B. Ineffective Health Maintenance related to immunization status
- C. Risk for Infection related to organisms specific to cat bites
- D. Risk for Impaired Mobility related to potential tendon damage

**Correct Answer: C. Risk for Infection related to organisms specific to cat bites.**

Cat's mouths contain a virulent organism, *Pasteurella multocida*, that can lead to septic arthritis or bacteremia. Infections resulting from bites of all animal species are poly-microbial with aerobic and

anaerobic bacteria; dogs and cats have an oral flora of Pasteurella, Staph, and Strep most commonly. In cat bites and scratches, Bartonella infections are an additional concern.

- **Option A:** The initial injury is the result of the physical trauma of teeth puncturing and/or tearing soft tissue, and in the case of some dog bites, blunt force breaking bones. Cat bites are narrow and deep as the animal rarely pulls or shakes its head, simply biting and holding. Because the cat bite wound is deep and narrow, it is much more likely to seal itself relatively quickly, providing an anaerobic environment for the inoculated bacteria as well as initially appearing less consequential and prolonging time to seeking medical care.
- **Option B:** A tetanus shot can be given before discharge. The patient's Tdap status should be updated if necessary. Patients should be encouraged to get an updated tetanus vaccination. The prognosis for most animal bites is excellent. However, it is essential to know that, on average, about 30 to 50 people die from dog bites each year.
- **Option D:** There is also a risk for tendon damage due to deep puncture wounds. Cat bites deeper than superficial need thorough irrigation under local anesthesia and the wound left open. The patient should be discharged with a week's course of amoxicillin-clavulanate and given strict wound care precautions.

**6. Which client statement informs the nurse that his teaching about the proper use of an incentive spirometer was effective?**

- A. "I should breathe out as fast and as hard as possible into the device."
- B. "I should inhale slowly and steadily to keep the balls up."
- C. "I should use the device three times a day, after meals."
- D. "The entire device should be washed thoroughly in sudsy water once a week."

**Correct Answer: B. "I should inhale slowly and steadily to keep the balls up."**

Proper use of an SMI requires the client to take slow, steady inhalations, every hour or two, 5 to 10 reps each time. Spirometry is one of the most readily available and useful tests for pulmonary function. It measures the volume of air exhaled at specific time points during complete exhalation by force, which is preceded by a maximal inhalation. The most important variables reported include total exhaled volume, known as the forced vital capacity (FVC), the volume exhaled in the first second, known as the forced expiratory volume in one second (FEV1), and their ratio (FEV1/FVC).

- **Option A:** The patient must breathe in as much air as they can with a pause lasting for less than 1s at the total lung capacity. The mouthpiece is placed just inside the mouth between the teeth, soon after the deep inhalation. The lips should be sealed tightly around the mouthpiece to prevent air leakage. Exhalation should last at least 6 seconds, or as long as advised by the instructor. If only the forced expiratory volume is to be measured, the patient must insert the mouthpiece after performing step 1 and must not breathe from the tube.
- **Option C:** The procedure is repeated in intervals separated by 1 minute until two matching, and acceptable results are acquired. Spirometry has proved to be a crucial tool in diagnosing lung disease, monitoring patients for their pulmonary function, and assessing their fitness for various procedures.
- **Option D:** Only the mouthpiece can be successfully rinsed or wiped clean. The device should not be submerged in water. Spirometry is an apparatus used to assess pulmonary function for diagnostic or monitoring purposes. The procedure must be explained thoroughly to the subject patient by competent personnel who underwent training under supervision by a specialist mentor and will undergo periodic retraining in order to ensure that the results obtained are as accurate as

possible and the complications are kept to a minimum.

**7. You are conducting a health assessment in a high school clinic. A 14-year-old girl, who is a lead ballet dancer in her school's performing arts program, comes in for a routine check-up. She has a BMI of 18 and appears fatigued. During the assessment, she hesitantly discloses her inability to eat, occasionally induced vomiting after meals, and severe constipation. She also mentions increased pressure to maintain a certain physique for her upcoming performances. Given her age, extracurricular activities, and the presented symptoms, which of the following conditions would you most likely suspect?**

- A. Multiple sclerosis
- B. Anorexia nervosa
- C. Bulimia nervosa
- D. Systemic sclerosis
- E. Gastrointestinal obstruction
- F. Performance anxiety

**Correct Answer: B. Anorexia nervosa**

Anorexia nervosa is an eating disorder characterized by weight loss, difficulties maintaining an appropriate body weight for height, age, and stature, and, in many individuals, a distorted body image. The girl's BMI of 18, inability to eat, induced vomiting, and the context of pressure from her ballet performances strongly suggest anorexia nervosa. While bulimia nervosa also involves episodes of overeating followed by purging, the girl's low BMI and inability to eat align more closely with anorexia nervosa. The other options are less consistent with the presented symptoms and context.

**8. For a diabetic male client with a foot ulcer, the physician orders bed rest, a wet-to-dry dressing change every shift, and blood glucose monitoring before meals and bedtime. Why are wet-to-dry dressings used for this client?**

- A. They contain exudate and provide a moist wound environment.
- B. They protect the wound from mechanical trauma and promote healing.
- C. They debride the wound and promote healing by secondary intention.
- D. They prevent the entrance of microorganisms and minimize wound discomfort.

**Correct Answer: C. They debride the wound and promote healing by secondary intention.**

For this client, wet-to-dry dressings are most appropriate because they clean the foot ulcer by debriding exudate and necrotic tissue, thus promoting healing by secondary intention. Treatment of diabetic foot ulcers should be systematic for an optimal outcome. The most important point is to identify if there is any evidence of ongoing infection, by obtaining a history of chills, fever, looking for the presence of purulence or presence of at least two signs of inflammation that includes, pain, warmth, erythema or induration of the ulcer.

- **Option A:** Moist, transparent dressings contain exudate and provide a moist wound environment. Transparent films are indicated for use as primary or secondary dressings for wounds with little to

no exudate such as stage I and II pressure ulcers, partial-thickness wounds, donor sites, and wounds with necrotic tissue or slough.

- **Option B:** Dry sterile dressings protect the wound from mechanical trauma and promote healing. Dry dressings are gauze pads that lie under rolled gauze and tape – and the category also includes standard bandages. You may have this type of dressing, which is intuitive and simple for most people to take care of and change, for wounds that are relatively dry themselves.
- **Option D:** Hydrocolloid dressings prevent the entrance of microorganisms and minimize wound discomfort. Hydrocolloid dressings provide a moist and insulating healing environment which protects uninfected wounds while allowing the body's own enzymes to help heal wounds. These dressings are unique because they don't have to be changed as often as some other wound dressings and are easy to apply.

**9. The nurse is instructing a client with diabetes mellitus about peritoneal dialysis. The nurse tells the client that it is important to maintain the dwell time for the dialysis at the prescribed time because of the risk of:**

- A. Infection
- B. Hyperglycemia
- C. Fluid overload
- D. Disequilibrium syndrome

**Correct Answer: B. Hyperglycemia**

An extended dwell time increases the risk of hyperglycemia in the client with diabetes mellitus as a result of absorption of glucose from the dialysate and electrolyte changes. Diabetic clients may require extra insulin when receiving peritoneal dialysis. Hypertonicity in these hyperglycemic episodes is almost always due exclusively to glucose gain. A rare manifestation of severe hyperglycemia in subjects on dialysis is the development of pulmonary edema, which is corrected after correction of hyperglycemia with insulin.

- **Option A:** All dialysis treatments include a certain risk of infection because of the decreased immune defenses of patients in established renal failure (ERF) and because dialysis techniques increase the potential of microbial contamination. Peritoneal dialysis (PD), and in particular continuous ambulatory PD (CAPD), is associated with a high risk of infection of the peritoneum, subcutaneous tunnel, and catheter exit site.
- **Option C:** Patients in PD with rapid peritoneal transport have reduced ultrafiltration, increased glucose absorption, and albumin loss in the dialysate. This phenomenon induces fluid overload, hypertension, dyslipidemia, and malnutrition, along with increased mortality.
- **Option D:** The exact incidence of dialysis disequilibrium is not known, but seems to be decreasing since the early days of hemodialysis, most likely due to the fact that current patients are initiated on dialysis at much lower urea concentrations than previously. Measurement of urea in the blood and cerebrospinal fluid (CSF) showed that after hemodialysis treatment, there was a substantial gradient, with the urea concentration in the CSF being higher than that in the blood.

**10. Nurse Jonel is providing information to a community group about violence in the family. Which statement by a group member would indicate a need to provide additional information?**

- A. "Abuse occurs more in low-income families".
- B. "Abusers are often jealous or self-centered".
- C. "Abusers use fear and intimidation".
- D. "Abusers usually have poor self-esteem".

**Correct Answer: A. "Abuse occurs more in low-income families"**

Personal characteristics of an abuser include low self-esteem, immaturity, dependence, insecurity, and jealousy. Risk factors for domestic and family violence include individual, relationship, community, and societal issues. There is an inverse relationship between education and domestic violence. Lower education levels correlate with more likely domestic violence. Childhood abuse is commonly associated with becoming a perpetrator of domestic violence as an adult. Perpetrators of domestic violence commonly repeated acts of violence with new partners. Drug and alcohol abuse greatly increases the incidence of domestic violence.

- **Option B:** Children who are victims or witness domestic and family violence may believe that violence is a reasonable way to resolve a conflict. Males who learn that females are not equally respected are more likely to abuse females in adulthood. Females who witness domestic violence as children are more likely to be victimized by their spouses. While females are often the victim of domestic violence, gender roles can be reversed.
- **Option C:** Domination may include emotional, physical, or sexual abuse that may be caused by an interaction of situational and individual factors. This means the abuser learns violent behavior from their family, community, or culture. They see violence and are victims of violence.
- **Option D:** Domestic and family violence has no boundaries. This violence occurs in intimate relationships regardless of culture, race, religion, or socioeconomic status. All healthcare professionals must understand that domestic violence, whether in the form of emotional, psychological, sexual, or physical violence, is common in our society and should develop the ability to recognize it and make the appropriate referral.

**11. A nurse is monitoring a client who is taking digoxin (Lanoxin). All of which are the side effects associated with the medication, except?**

- A. Anorexia
- B. Blurred vision
- C. Diarrhea
- D. Tremors

**Correct Answer: D. Tremors**

Signs of digoxin toxicity are as follows, anorexia, nausea, vomiting, diarrhea, and blurred vision.

**12. A client with paranoid thoughts refuses to eat because he believes the food has poisoned. The most appropriate initial action is to**

- A. Taste the food in the client's presence.
- B. Suggest that food be brought from home.
- C. Simply state the food is not poisoned.

D. Inform the client he will be tube fed if he does not eat.

**Correct Answer: C. Simply state the food is not poisoned.**

This action presents reality. Interact with clients on the basis of things in the environment. Try to distract the client from their delusions by engaging in reality-based activities (e.g., card games, simple arts and crafts projects, etc). When thinking is focused on reality-based activities, the client is free of delusional thinking during that time. Helps focus attention externally.

- **Option A:** Do not touch the client; use gestures carefully. Suspicious clients might misinterpret touch as either aggressive or sexual in nature and might interpret it as a threatening gesture. People who are psychotic need a lot of personal space. Show empathy regarding the client's feelings; reassure the client of your presence and acceptance. The client's delusion can be distressing. Empathy conveys your caring, interest, and acceptance of the client. Important clues to underlying fears and issues can be found in the client's seemingly illogical fantasies.
- **Option B:** Attempt to understand the significance of these beliefs to the client at the time of their presentation. Important clues to underlying fears and issues can be found in the client's seemingly illogical fantasies. Recognize the client's delusions as the client's perception of the environment. Recognizing the client's perception can help you understand the feelings he or she is experiencing.
- **Option D:** Initially do not argue with the client's beliefs or try to convince the client that the delusions are false and unreal. Arguing will only increase a client's defensive position, thereby reinforcing false beliefs. This will result in the client feeling even more isolated and misunderstood.

### **13. Spinnbarkeit is an indicator of ovulation which is characterized as:**

- A. Thin watery mucus which can be stretched into a long strand about 10 cm.
- B. Thick mucus that is detached from the cervix during ovulation.
- C. Thin mucus that is yellowish in color with fishy odor.
- D. Thick mucus vaginal discharge is influenced by high levels of estrogen.

**Correct Answer: A. Thin watery mucus which can be stretched into a long strand about 10 cm**

At the midpoint of the cycle when the estrogen level is high, the cervical mucus becomes thin and watery to allow the sperm to easily penetrate and get to the fallopian tubes to fertilize an ovum. This is called spinnbarkeit. And the woman feels "wet". When progesterone is secreted by the ovary, the mucus becomes thick and the woman will feel "dry".

- **Option B:** Creamy cervical mucus is considered non-fertile since it greatly restricts the movement of sperm. It is often pearly white or creamy yellow. It is thick and feels like lotion when rubbed between the fingers.
- **Option C:** Although "yeast" is the name most women know, bacterial vaginosis (BV) actually is the most common vaginal infection in women of reproductive age. Bacterial vaginosis often will cause an abnormal smelling vaginal discharge. The discharge usually is thin and milky, and is described as having a "fishy" odor.
- **Option D:** Spinnbarkeit mucus is the stringy, stretchy quality of cervical mucus found especially around the time of ovulation. Usually a result of high estrogen levels, spinnbarkeit mucus refers to the egg white quality of cervical mucus that is easier for sperm to penetrate.



**14. A client, age 41, visits the gynecologist. After examining her, the physician suspects cervical cancer. The nurse reviews the client's history for risk factors for this disease. Which history finding is a risk factor for cervical cancer?**

- A. Pregnancy complicated with eclampsia at age 27
- B. Spontaneous abortion at age 19
- C. Onset of sporadic sexual activity at age 17
- D. Human papillomavirus infection at age 32

**Correct Answer: D. Human papillomavirus infection at age 32**

- **Option D:** Like other viral and bacterial venereal infections, human papillomavirus is a risk factor for cervical cancer. Other risk factors for this disease include multiple sex partners, multiple pregnancies, long-term use of oral contraceptives and diethylstilbestrol (DES).
- **Options A and B:** A spontaneous abortion and pregnancy complicated by eclampsia aren't risk factors for cervical cancer.
- **Option C:** Risk factors for this disease include frequent sexual intercourse before age 16.

**15. A pregnant client, age 32, asks the nurse why her doctor has recommended a serum alpha fetoprotein. The nurse should explain that the doctor has recommended the test:**

- A. Because it is a state law
- B. To detect cardiovascular defects
- C. Because of her age
- D. To detect neurological defects

**Correct Answer: D. To detect neurological defects**

Alpha fetoprotein is a screening test done to detect neural tube defects such as spina bifida. Alpha-fetoprotein (AFP) is a plasma protein produced by the embryonic yolk sac and the fetal liver. AFP levels in serum, amniotic fluid, and urine functions as a screening test for congenital disabilities, chromosomal abnormalities, as well as some other adult occurring tumors and pathologies.

- **Option A:** The test is not mandatory, as stated in answer A. Patients having amniocentesis must be duly counseled about the procedure, as well as, the associated risks. There is a risk of obstetric mishap following amniocentesis; a miscarriage can happen in less than 1% of cases. Some other very rare complications of amniocentesis are preterm labor, infection (amnionitis), iatrogenic trauma, or injury to the developing fetus or mother.
- **Option B:** It does not indicate cardiovascular defects. Maternal blood AFP levels often as part of triple (AFP, Estriol, and hCG) or quadruple (AFP, implies Estriol, hCG and Inhibin A) screening test for birth defects. Levels are usually interpreted for age, race, weight, and gestational age. The elevated levels imply a significant risk of having birth defects, hence, further evaluation may be required to assess the level of risk.
- **Option C:** The mother's age has no bearing on the need for the test, so answer C is incorrect. A significant number of patients with elevated maternal AFP do not develop birth defects, but there may be an increased risk of obstetric complications like premature rupture of membrane, placenta

accreta, increta, and packet.

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

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

**Correct Answer: D. Bence Jones protein in the urine**

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

**17. A male client with type 1 diabetes mellitus asks the nurse about taking an oral antidiabetic agent. Nurse Jack explains that these medications are only effective if the client:**

- A. Prefers to take insulin orally.
- B. Has type 2 diabetes.
- C. Has type 1 diabetes.
- D. Is pregnant and has type 2 diabetes.

**Correct Answer: B. Has type 2 diabetes.**

Oral antidiabetic agents are only effective in adult clients with type 2 diabetes. Antidiabetic drugs (with the exception of insulin are all pharmacological agents that have been approved for hyperglycemic treatment in type 2 diabetes mellitus (DM). If lifestyle modifications (weight loss, dietary modification, and exercise) do not sufficiently reduce A1C levels (target level: < 7%), pharmacological treatment with antidiabetic drugs should be initiated.

- **Option A:** These drugs may be classified according to their mechanism of action as insulinotropic or non-insulinotropic. They are available as monotherapy or combination therapies, with the latter involving two (or, less commonly, three) antidiabetic drugs and/or insulin. The drug of choice for all type 2 diabetic patients is metformin. This drug has beneficial effects on glucose metabolism and promotes weight loss or at least weight stabilization.
- **Option C:** Oral antidiabetic agents aren't effective in type 1 diabetes. All patients with T1DM require insulin therapy. Multiple daily insulin injections (MDI) using a basal/bolus insulin regimen or continuous subcutaneous insulin infusion through an insulin pump are the preferred treatment.

- **Option D:** Pregnant and lactating women aren't prescribed oral antidiabetic agents because the effect on the fetus is uncertain. Most antidiabetic drugs are not recommended or should be used with caution in patients with moderate or severe renal failure or other significant comorbidities. Oral antidiabetic drugs are not recommended during pregnancy or breastfeeding.

**18. The nurse is preparing to discharge a client following a laparoscopic cholecystectomy. The nurse should:**

- A. Instruct the client to avoid a tub bath for 48 hours
- B. Instruct the client to expect clay-colored stools
- C. Instruct the client that she can expect lower abdominal pain for the next week
- D. Instruct the client that she can resume a regular diet in the next 24 hours

**Correct Answer: A. Instruct the client to avoid a tub bath for 48 hours**

- Option A: Following a laparoscopic cholecystectomy, the client should avoid a tub bath for 48 hours to prevent the dressing from soaking.
- Option B: The stools should not be clay-colored.
- Option C: Pain is usually located in the shoulders.
- Option D: The client should not resume a regular diet until clear liquids have been tolerated.

**19. In teaching a female client who is HIV-positive about pregnancy, the nurse would know more teaching is necessary when the client says:**

- A. The baby can get the virus from my placenta.”
- B. “I’m planning on starting on birth control pills.”
- C. “Not everyone who has the virus gives birth to a baby who has the virus.”
- D. “I’ll need to have a C-section if I become pregnant and have a baby.”

**Correct Answer: D. “I’ll need to have a C-section if I become pregnant and have a baby.”**

A Cesarean section delivery isn't necessary when the mother is HIV-positive.

- **Option A:** The human immunodeficiency virus (HIV) is transmitted from mother to child via the transplacental route.
- **Option B:** The use of birth control will prevent the conception of a child who might have HIV.
- **Option C:** It's true that a mother whose HIV positive can give birth to a baby who's HIV negative.

**20. Which client outcome would best indicate successful treatment for a client with an antisocial personality disorder?**

- A. The client exhibits charming behavior when around authority figures.
- B. The client has decreased episodes of impulsive behaviors.
- C. The client makes statements of self-satisfaction.

D. The client's statements indicate no remorse for behaviors.

**Correct Answer: B. The client has decreased episodes of impulsive behaviors**

A client with antisocial personality disorder typically has frequent episodes of acting impulsively with poor ability to delay self-gratification. Therefore, decreased frequency of impulsive behaviors would be evidence of improvement. Of those children with conduct disorder, 25% of girls and 40% of boys will meet the diagnostic criteria for antisocial personality disorder. Boys exhibit symptoms earlier than girls, who often only elicit these symptoms in puberty.

- **Option A:** Disregard for and the violation of others' rights are common manifestations of this personality disorder, which displays symptoms that include failure to conform to the law, inability to sustain consistent employment, deception, manipulation for personal gain, and incapacity to form stable relationships.
- **Option C:** Self-satisfaction would be viewed as a positive change if the client expresses low self-esteem; however, this is not a characteristic of a client with antisocial personality disorder. Many individuals diagnosed with antisocial personality disorder remain a burden to their families, coworkers, and closely associated peers, such as neighbors, despite becoming less troublesome with age. Mental health comorbidities and associated addictive disorders, as well as higher mortality rates due to suicides and homicides, only add to this burden.
- **Option D:** Charming behavior when around authority figures and statements indicating no remorse are examples of symptoms typical of someone with this disorder and would not indicate successful treatment. Antisocial personality disorder (ASPD) is a deeply ingrained and rigid dysfunctional thought process that focuses on social irresponsibility with exploitive, delinquent, and criminal behavior with no remorse.

**21. Which of the following calcium channel blockers has the most potent peripheral smooth muscle dilator effect?**

- A. diltiazem (Cardizem)
- A. diltiazem (Cardizem)
- B. nifedipine (Adalat CC)
- C. nimodipine (Nymalize)
- D. verapamil (Calan)

**Correct Answer: B. nifedipine (Adalat CC)**

Nifedipine has the strongest peripheral smooth muscle dilator effect of all the calcium channel blockers. Nifedipine inhibits the entry of calcium ions by blocking these voltage-dependent L-type calcium channels in vascular smooth muscle and myocardial cells. The reduced intracellular calcium, results in a reduction of peripheral arterial vascular resistance and dilatation of coronary arteries, leading to a reduction in systemic blood pressure and increased myocardial oxygen delivery. Other choices have less of a vasodilator effect.

- **Option A:** Diltiazem is a non-dihydropyridine calcium channel blocker. Therapeutic effects occur through various mechanisms. Primarily, diltiazem inhibits the inflow of calcium ions into the cardiac smooth muscle during depolarization. Reduced intracellular calcium concentrations equate to increased smooth muscle relaxation resulting in arterial vasodilation and, therefore, decreased blood pressure.

- **Option C:** During the depolarization of smooth muscle cells of blood vessels, there is an influx of calcium ions. The primary function of nimodipine is to block voltage-gated L-type calcium channels in their inactive conformation, avoiding this influx, to prevent vasoconstriction.
- **Option D:** Verapamil is a non-dihydropyridine calcium channel blocker. Calcium channel blockers inhibit the entry of calcium ions into the slow L-type calcium channels in the myocardium and vascular smooth muscle during depolarization. This inhibition will produce relaxation of coronary vascular smooth muscle as well as coronary vasodilation, which is helpful in patients with hypertension.

**22. An employer establishes a physical exercise area in the workplace and encourages all employees to use it. This is an example of which level of health promotion?**

- A. Primary prevention
- B. Secondary prevention
- C. Tertiary prevention
- D. Passive prevention

**Correct Answer: A. Primary prevention**

Primary prevention precedes disease and applies to healthy patients. Primary prevention includes those preventive measures that come before the onset of illness or injury and before the disease process begins. Examples include immunization and taking regular exercise to prevent health problems from developing in the future.

- **Option B:** Secondary prevention focuses on patients who have health problems and are at risk for developing complications. Secondary prevention includes those preventive measures that lead to early diagnosis and prompt treatment of a disease, illness, or injury. This should limit disability, impairment or dependency and prevent more severe health problems from developing in the future.
- **Option C:** Tertiary prevention enables patients to gain health from others' activities without doing anything themselves. Tertiary prevention includes those preventive measures aimed at rehabilitation following a significant illness. At this level, health educators work to retrain, re-educate and rehabilitate the individual who has already had an impairment or disability.
- **Option D:** Prevention, as it relates to health, is really about avoiding disease before it starts. It has been defined as the plans for, and the measures taken, to prevent the onset of a disease or other health problem before the occurrence of the undesirable health event.

**23. During a routine physical examination to assess a male client's deep tendon reflexes, the nurse should make sure to:**

- A. Use the pointed end of the reflex hammer when striking the Achilles' tendon.
- B. Support the joint where the tendon is being tested.
- C. Tap the tendon slowly and softly.
- D. Hold the reflex hammer tightly.

**Correct Answer: B. Support the joint where the tendon is being tested.**

To prevent the attached muscle from contracting, the nurse should support the joint where the tendon is being tested. With clean hands on a fully relaxed joint, the tendon/target is struck with sufficient force to elicit the reflex while the clinician's eyes are focused on the proximal muscle group, looking for contraction, rather than the distal appendage, looking for movement.

- **Option A:** The nurse should use the flat, not pointed, end of the reflex hammer when striking the Achilles' tendon. (The pointed end is used to strike over small areas, such as the thumb placed over the biceps tendon). A variety of tools are used to elicit a reflex which ranges from specialized to improvised, with specialized hammers being generally preferable. The most commonly used specialized reflex hammers are grouped into 3 types by the shape of the head: triangular/tomahawk shaped (Taylor), T-shaped (Tromner, Buck), or circular (Queen Square, Babinski).
- **Option C:** Tapping the tendon slowly and softly wouldn't provoke a deep tendon reflex response. The technique may vary slightly depending on what type of tool is used or what reflex is being tested, for instance, circular hammers can be "dropped" passively through an arc using gravity to strike the patellar tendon, but when striking the biceps tendon are generally swung like a drumstick.
- **Option D:** The nurse should hold the reflex hammer loosely, not tightly, between the thumb and fingers so it can swing in an arc. If a patient is hyperreflexic, a clinician's finger may be all that is needed because the forces needed are so slight. With any tool, a finger can be placed on the tendon to help guide the clinician's blow to the correct location, to help feel the contraction, and to reduce discomfort for the patient by cushioning the blow. This is most commonly done when eliciting the biceps reflex.

**24. Nurse Cristina is caring for a client who experiences false sensory perceptions with no basis in reality. These perceptions are known as:**

- A. Delusions
- B. Hallucinations
- C. Loose associations
- D. Neologisms

**Correct Answer: B. Hallucinations**

Hallucinations are visual, auditory, gustatory, tactile, or olfactory perceptions that have no basis in reality. The word "hallucination" comes from Latin and means "to wander mentally." Hallucinations are defined as the "perception of a nonexistent object or event" and "sensory experiences that are not caused by stimulation of the relevant sensory organs." Hallucinations occur frequently in people with psychiatric conditions, including schizophrenia and bipolar disorder, however, you don't necessarily need to have a mental illness to experience hallucinations.

- **Option A:** Delusions are false beliefs, rather than perceptions, that the client accepts as real. Delusions are defined as fixed, false beliefs that conflict with reality. Despite contrary evidence, a person in a delusional state can't let go of their convictions. Delusions are often reinforced by the misinterpretation of events. Many delusions also involve some level of paranoia. For example, someone might contend that the government is controlling our every move via radio waves despite evidence to the contrary.
- **Option C:** Loose associations are rapid shifts among unrelated ideas. A thought disturbance demonstrated by speech that is disconnected and fragmented, with the individual jumping from one idea to another unrelated or indirectly related idea. It is essentially equivalent to derailment.

- **Option D:** Neologisms are bizarre words that have meaning only to the client. A newly coined word or expression. In a neurological or psychopathological context, neologisms, whose origins and meanings are usually nonsensical and unrecognizable (e.g., klipno for watch), are typically associated with aphasia or schizophrenia.

**25. The client being treated for esophageal varices has a Sengstaken-Blakemore tube inserted to control the bleeding. The most important assessment is for the nurse to:**

- A. Check that the hemostat is on the bedside.
- B. Monitor IV fluids for the shift.
- C. Regularly assess respiratory status.
- D. Check that the balloon is deflated on a regular basis.

**Correct Answer: C. Regularly assess respiratory status.**

The respiratory system can become occluded if the balloon slips and moves up the esophagus, putting pressure on the trachea. This would result in respiratory distress and should be assessed frequently. Scissors should be kept at the bedside to cut the tube if distress occurs. This is a safety intervention.

- **Option A:** Variceal band ligation is preferred to sclerotherapy for bleeding varices and for non-bleeding medium-to-large varices to decrease bleeding risk. Ligation has lower rates of rebleeding, fewer complications, more rapid cessation of bleeding, and a higher rate of variceal eradication.
- **Option B:** Treat coagulopathy as necessary. Fresh frozen plasma may increase blood volume and increase rebleeding risk. IV octreotide to lower portal venous pressure as adjuvant to endoscopic management. An IV bolus of 50 micrograms followed by a drip of 50 micrograms/hr.
- **Option D:** If endoscopic treatment fails, consider self-expanding esophageal metal stents or peroral placement of Sengstaken-Blakemore-type tubes for up to 24 hours to stabilize the patient for TIPS. As many as two-thirds of patients with variceal bleeding develop an infection, most commonly spontaneous bacterial peritonitis, UTI, or pneumonia. Antibiotic prophylaxis with oral norfloxacin 400 mg or IV ceftriaxone, 1 g q24h for up to a week, is indicated.

**26. The physician has ordered a placebo for a chronic pain client. You are a newly hired nurse and you feel very uncomfortable administering the medication. What is the first action that you should take?**

- A. Prepare the medication and hand it to the physician.
- B. Check the hospital policy regarding the use of the placebo.
- C. Follow a personal code of ethics and refuse to give it.
- D. Contact the charge nurse for advice.

**Correct Answer: D. Contact the charge nurse for advice.**

A charge nurse is a resource person who can help locate and review the policy. If the physician is insistent, he or she could give the placebo personally, but delaying the administration does not endanger the health or safety of the client.

- **Option A:** In a treatment setting it is unethical to deliberately misinform the patient. However, placebo effects can be an important factor in a biopsychosocial context. Clinicians need to consider some ethical issues relating to placebo effects. According to Pittrof and Rubenstein, the ethical use of placebo effects should always benefit the patient and involve disclosure.
- **Option B:** Placebo effects may thus be defined as psychological and/or physiological responses that follow the administration of active and non-active substances when coupled with an affirmation of the treatment effects. The ethical use of placebo effects in a clinical setting should rely on realistic expectations and be based on best practice. The use of a placebo in clinical settings might still be seen as controversial by some.
- **Option C:** While following one's own ethical code is correct, you must ensure that the client is not abandoned and that care continues. Placebo effects, when considered as supplements to pharmacologically active substances, should aim to increase patients' well-being. It is unethical to deliberately misinform patients.

**27. Which of the following individuals are communicating a message? Select all that apply.**

- A. A mother spanking her son for playing with matches
- B. A teenage boy isolating himself and playing loud music
- C. A biker sporting an eagle tattoo on his biceps
- D. A teenage girl writing, "No one understands me."
- E. A father checking for new e-mail on a regular basis

**Correct Answer: A, B, C, and D.**

The nurse should determine that spanking, isolating, getting tattoos, and writing are all ways in which people communicate messages to others. It is estimated that about 70% to 90% of communication is nonverbal. It is the act of conveying meanings from one body or group to another through the use of mutually understood signs, symbols, and semiotic rules.

- **Option A:** Nonverbal communication involves the transmission of messages without the use of words. It involves facial expression, posture, touch, gestures, physical appearance, eye contact, and other body movements. These are considered more accurate expressions of true feelings. Gestures impart meanings that are more powerful than words.
- **Option B:** Listening is the ability to accurately receive and interpret messages in the communication process. (e.g., radio, audio conferencing). Various modes or mediums to transmit and receive the information are referred to as "communication channels."
- **Option C:** Sight is the process, power, or function of seeing (e.g., the sights of the newly-built hospital). Physical appearance or artifacts involves items in the client's environment such as grooming or the use of clothing and jewelry. They may convey nonverbal messages that might enhance or hinder the real message of the spoken words.
- **Option D:** Reading refers to the complex cognitive process of decoding symbols involving word recognition, comprehension, fluency, and motivation (e.g., written letters, memos, chats, and messaging).
- **Option E:** Communication is the process of sharing information or the process of generating and transmitting meanings. The father checking for new emails on a regular basis lacks some of the elements of communication, such as the stimulus, receiver, and channel.



**28. Twelve hours after being admitted for sustaining burns on 50% of their body, a patient's blood glucose level has been recorded at 90 mg/dL. Earlier in the day, the patient exhibited signs of shock and pain, but has since been stabilized with IV fluids and pain management. Given the current blood glucose reading in the context of their condition, what is the most appropriate next step for the nurse?**

- A. Notify the emergency team.
- B. Document the finding as the only action.
- C. Ask the client if anyone in her family has diabetes mellitus.
- D. Slow the intravenous infusion of dextrose 5% in Ringer's lactate.

**Correct Answer: B. Document the finding as the only action.**

Neural and hormonal compensation to the stress of the burn injury in the emergent phase increases liver glucose production and release. An acute rise in the blood glucose level is an expected client response and is helpful in the generation of energy needed for the increased metabolism that accompanies this trauma.

- **Option A:** The glucose level is not high enough to alert the emergency team. A variety of laboratory tests will be needed within the first 24 hours of a patient's admission (some during the initial resuscitative period and others after the patient is stabilized).
- **Option C:** A family history of diabetes could make her more of a risk for the disease, but this is not a priority at this time. The secondary assessment shouldn't begin until the primary assessment is complete; resuscitative efforts are underway; and lines, tubes, and catheters are placed.
- **Option D:** Infusion of an IV fluid containing dextrose may further increase the client's blood glucose. The ideal burn resuscitation is the one that effectively restores plasma volume, with no adverse effects. Isotonic crystalloids, hypertonic solutions, and colloids have been used for this purpose, but every solution has its advantages and disadvantages. None of them is ideal, and none is superior to any of the others.

**29. A client is brought to the emergency department and states that he has accidentally been taking two times his prescribed dose of Warfarin (Coumadin). After observing that the client has no evidence of any obvious bleeding, the nurse should do which of the following?**

- A. Draw a sample for activated partial thromboplastin time (aPTT) level.
- B. Draw a sample for prothrombin time (PT) level and international normalized ratio (INR).
- C. Prepare to administer Vitamin K.
- D. Prepare to administer Protamine sulfate.

**Correct Answer: B. Draw a sample for prothrombin time (PT) level and international normalized ratio (INR).**

The next action for the nurse to take is to draw a sample for INR and PT level to check the client's anticoagulation status and risk for bleeding. These results will provide information on how to manage the client by either giving an antidote such as Vitamin K or administering a blood transfusion. Specific evaluation of warfarin toxicity should involve evaluation of the patient's PT, INR, CBC, and BMP with

hepatic function, in addition to the standard co-ingestions and a focused evaluation surrounding their symptoms.

- **Option A:** The aPTT determines the effects of heparin therapy. It is recommended that patients undergo measurement of PT/INR and PTT during the initial presentation. For acute exposures, patients should receive serial INR assessments every 12-24 hours. If INR remains normalized at 36 hours and there are no signs of bleeding, no further testing is generally necessary.
- **Option C:** The results of the INR and PT level will be needed first. For these recommendations, coagulopathy is defined as INR > 1.4. Warfarin toxicity is defined as INR > 3.0 or >3.5 in a patient with a mechanical heart valve. Unintentional toxicity in patients who are treated with warfarin for an underlying condition (most common presentation).
- **Option D:** Protamine sulfate is the antidote for heparin overdose. Patients with elevated INR displaying evidence of coagulopathy during evaluation, do not need to be started on vitamin K unless the INR is greater than 10 or they have evidence of bleeding.

**30. A patient is in labor and has just been told she has a breech presentation. The nurse should be particularly alert for which of the following?**

- A. Quickening
- B. Ophthalmia neonatorum
- C. Pica
- D. Prolapsed umbilical cord

**Correct Answer: D. Prolapsed umbilical cord**

In a breech position, because of the space between the presenting part and the cervix, prolapse of the umbilical cord is common.

- **Option A:** Quickening is the woman's first perception of fetal movement.
- **Option B:** Ophthalmia neonatorum usually results from maternal gonorrhea and is conjunctivitis.
- **Option C:** Pica refers to the oral intake of nonfood substances.

**31. The nurse is caring for a client following a Billroth II procedure. On review of the post-operative orders, which of the following, if prescribed, would the nurse question and verify?**

- A. Irrigating the nasogastric tube.
- B. Coughing and deep breathing exercises.
- C. Leg exercises
- D. Early ambulation

**Correct Answer: A. Irrigating the nasogastric tube.**

In a Billroth II procedure, the proximal remnant of the stomach is anastomosed to the proximal jejunum. Patency of the NG tube is critical for preventing the retention of gastric secretions. The nurse should never irrigate or reposition the gastric tube after gastric surgery unless specifically ordered by the physician. In this situation, the nurse would clarify the order.

- **Option B:** The client may do coughing and deep breathing exercises. Discuss and identify stressful situations and how to avoid them. Investigate job-related issues. This can alter gastric motility, interfering with optimal digestion. The patient may require vocational counseling if a change in employment is indicated.
- **Option C:** Leg exercises are allowed to prevent thrombosis. Discuss the importance of eating small, frequent meals slowly and in a relaxed atmosphere; resting after meals; avoiding extremely hot or cold food; restricting high-fiber foods, caffeine, milk products, and alcohol, excess sugars and salt; and taking fluids between meals, rather than with food.
- **Option D:** Early ambulation is recommended after the procedure. Also, discuss the reasons for and importance of cessation of smoking. Smoking stimulates gastric acid production and may cause vasoconstriction, compromising mucous membranes and increasing the risk of gastric irritation and ulceration.

**32. The Nurse Practice Acts are an example of:**

- A. Statutory law
- B. Common law
- C. Civil law
- D. Criminal law

**Correct Answer: A. Statutory law**

The NPA is then interpreted into regulations by each state and territorial nursing board with the authority to regulate the practice of nursing care and the power to enforce the laws. Fifty states, the District of Columbia and 4 United States (US) territories, have state boards of nursing (BON) that are responsible for regulating their individual NPA.

- **Option B:** Common law results from judicial decisions made in courts when individual legal cases are decided. Examples of common law include informed consent, the patient's right to refuse treatment, negligence, and malpractice.
- **Option C:** Civil laws protect the rights of individuals within our society and provide for fair and equitable treatment when civil wrongs or violations occur (Garner, 2006). The consequences of civil law violations are damages in the form of fines or specific performance of good works such as public service. An example of a civil law violation for a nurse is negligence or malpractice.
- **Option D:** Criminal laws protect society as a whole and provide punishment for crimes, which are defined by municipal, state, and federal legislation (Garner, 2006). There are two classifications of crimes. A felony is a crime of a serious nature that has a penalty of imprisonment for longer than 1 year or even death. A misdemeanor is a less serious crime that has a penalty of a fine or imprisonment for less than 1 year. An example of criminal conduct for nurses is a misuse of a controlled substance.

**33. Normal lochial findings in the first 24 hours post-delivery include:**

- A. Bright red blood
- B. Large clots or tissue fragments
- C. A foul odor
- D. The complete absence of lochia

**Correct Answer: A. Bright red blood**

Lochia should never contain large clots, tissue fragments, or membranes. A foul odor may signal infection, as may absence of lochia.

- **Option B:** The blood clots in the lochia should get smaller and happen less often as the bleeding gets less over the first few days.
- **Option C:** Lochia with offensive odor may indicate infection.
- **Option D:** Complete absence of lochia might be a sign of infection.

**34. The client with Alzheimer's disease is being assisted with activities of daily living when the nurse notes that the client uses her toothbrush to brush her hair. The nurse is aware that the client is exhibiting:**

- A. Agnosia
- B. Apraxia
- C. Anomia
- D. Aphasia

**Correct Answer: A. Agnosia**

Agnosia is the term used to describe the loss of the ability to recognize what objects are and what they are used for. For an instance, a person with agnosia might try to use a fork instead of a spoon, a shoe instead of a cup or a knife instead of a pencil etc. With regard to people, this might involve failing to recognize who people are, not due to memory loss but rather as a result of the brain not working out the identity of a person on the basis of the information supplied by the eyes.

- **Option B:** Apraxia is the term used to describe the failure to carry out voluntary and purposeful movements notwithstanding the fact that muscular power, sensibility, and coordination are intact. In everyday terms, this might involve the inability to tie shoelaces, turn a tap on, fasten buttons or switch on a radio.
- **Option C:** Aphasia is the term used to describe a difficulty or loss of the ability to speak or understand spoken, written or sign language as a result of damage to the corresponding nervous center. This can become apparent in a number of ways. It might involve exchanging a word which is linked by meaning (e.g. time instead of clock), using the wrong word but one which sounds alike (e.g. boat instead of coat) or using a totally different word with no apparent connection. When accompanied by echolalia (the involuntary repetition of words or phrases spoken by another person) and the constant repetition of a word or phrase, the result can be a form of speech which is difficult for others to understand or a kind of jargon.
- **Option D:** Anomia is a form of aphasia in which the patient is unable to recall the names of everyday objects. Anomic aphasia is a language disorder that leads to trouble naming objects when speaking and writing. Brain damage caused by stroke, traumatic injury, or tumors can lead to anomic aphasia.

**35. Which of the following psychological symptoms would the nurse expect to find in a hospitalized client who is the only survivor of a train accident?**

- A. Denial

- B. Indifference
- C. Perfectionism
- D. Trust

**Correct Answer: A. Denial**

Denial can act as a protective response. If a situation is just too much to handle, the person may respond by refusing to perceive it or by denying that it exists. Many people use denial in their everyday lives to avoid dealing with painful feelings or areas of their life they don't wish to admit. This is a primitive and dangerous defense – no one disregards reality and gets away with it for long! It can operate by itself or, more commonly, in combination with other, more subtle mechanisms that support it.

- **Option B:** The client tends to be overwhelmed and disorganized by the trauma, not indifferent to it. The symptoms of PTSD include persistently re-experiencing the traumatic event, intrusive thoughts, nightmares, flashbacks, dissociation (detachment from oneself or reality), and intense negative emotional (sadness, guilt) and physiological reaction on being exposed to the traumatic reminder. Furthermore, problems with sleep and concentration, irritability, increased reactivity, increased startle response, hypervigilance, avoidance of traumatic triggers also occur. There is a significant impairment in social, occupational, and other areas of functioning.
- **Option C:** Perfectionism is more commonly seen in clients with eating disorders, not in clients with PTSD. Perfectionism—the tendency to hold unrealistically high standards—has been implicated in the development of and maintenance of eating disorders. Clinical perfectionism is a primary target of intervention in Cognitive Behavioral Therapy (CBT-E), the leading treatment for adults with eating disorders. Studies have shown that patients with anorexia nervosa and bulimia nervosa have higher levels of perfectionism than control subjects.
- **Option D:** Clients who have had a severe trauma often experience an inability to trust others. The initial step in the diagnosis of posttraumatic stress disorder is to obtain a detailed history. It is challenging for the patient at times to describe the nature and severity of the traumatic event, and they may choose to avoid mentioning it. However, the presentation and the duration of the symptoms are useful in making an accurate diagnosis. The health care workers must inquire about any depressive or anxiety symptoms, suicidal ideation or previous attempts, substance abuse, access to firearms.

**36. After determining a nursing diagnosis of acute pain, the nurse develops the following appropriate client-centered goal:**

- A. Encourage the client to implement guided imagery when pain begins.
- B. Determine the effect of pain intensity on client function.
- C. Administer analgesic 30 minutes before physical therapy treatment.
- D. Pain intensity reported as a 3 or less during hospital stay.

**Correct Answer: D. Pain intensity reported as a 3 or less during hospital stay.**

This is measurable and objective. Goals or desired outcomes describe what the nurse hopes to achieve by implementing the nursing interventions and are derived from the client's nursing diagnoses. Goals provide direction for planning interventions, serve as criteria for evaluating client progress, enable the client and nurse to determine which problems have been resolved, and help motivate the client and nurse by providing a sense of achievement.

- **Option A:** This is an example of nursing intervention. Nursing interventions are activities or actions that a nurse performs to achieve client goals. Interventions chosen should focus on eliminating or reducing the etiology of the nursing diagnosis.
- **Option B:** Evaluating is a planned, ongoing, purposeful activity in which the client's progress towards the achievement of goals or desired outcomes, and the effectiveness of the nursing care plan (NCP).
- **Option C:** This is an example of nursing intervention. Dependent nursing interventions are activities carried out under the physician's orders or supervision. Includes orders to direct the nurse to provide medications, intravenous therapy, diagnostic tests, treatments, diet, and activity or rest.

**38. A client has a positive reaction to the PPD test. The nurse correctly interprets this reaction to mean that the client has:**

- A. Active TB
- B. Had contact with Mycobacterium tuberculosis.
- C. Developed a resistance to tubercle bacilli.
- D. Developed passive immunity to TB.

**Correct Answer: B. Had contact with Mycobacterium tuberculosis.**

A positive PPD test indicates that the client has been exposed to tubercle bacilli. Exposure does not necessarily mean that active disease exists. If the infection risk is very high, the PPD test need not be repeated. The positive PPD test is usually followed by TB symptom assessment, physical exam, and chest radiograph. If there are no TB symptoms and no evidence of active tuberculosis infection on physical exam and chest radiograph, the patient most likely has latent TB. The treatment of latent TB should be encouraged once detected.

- **Option A:** A person with active infection usually presents with symptoms of the part affected and constitutional symptoms such as unexplained weight loss, fever, fatigue, loss of appetite, and night sweats. The latent TB, however, is asymptomatic and non-infectious. Early diagnosis of active TB is crucial to managing the disease in time and preventing its spread. The latent TB infection is non-infectious and asymptomatic, with a significant worldwide prevalence (33%).
- **Option C:** The benefit to the PPD test is the rapid identification of the presence of TB infection and, thus, the rapid diagnosis of TB. Although sometimes the infection may not be active, the detection of latent TB allows for treatment and decreases the risk of progression to active TB. It is a very simple and inexpensive skin test (not routinely recommended).
- **Option D:** Some individual's ability to react to tuberculin antigen wanes over time, which results in a false-negative reaction. In individuals with very old tuberculosis infection (many years), sensitization to tuberculin is weak, and the PPD test may be a false negative. However, if a subsequent test is administered, the tuberculin PPD may stimulate the immune system.

**39. The nurse enters the room of a client with a cognitive impairment disorder and asks what day of the week it is: what the date, month, and year are; and where the client is. The nurse is attempting to assess:**

- A. Confabulation
- B. Delirium

- C. Orientation
- D. Perseveration

**Correct Answer: C. Orientation**

The initial, most basic assessment of a client with cognitive impairment involves determining his level of orientation (awareness of time, place, and person). Interviews to assess memory, behavior, mood and functional status (especially complex actions such as driving and managing money are best conducted with the patient alone, so that family members or companions cannot prompt the patient. Information can also be gleaned from the patient's behavior on arrival in the doctor's office and interactions with staff.

- **Option A:** 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. Cognitive impairment in older adults has a variety of possible causes, including medication side effects, metabolic and/or endocrine derangements, delirium due to intercurrent illness, depression and dementia, with Alzheimer's dementia being most common. Some causes, like medication side effects and depression, can be reversed with treatment. Others, such as Alzheimer's disease, cannot be reversed, but symptoms can be treated for a period of time and families can be prepared for predictable changes.
- **Option B:** Delirium is a type of cognitive impairment; however, other symptoms are necessary to establish this diagnosis. Delirium, also known as the acute confusional state, is a clinical syndrome that usually develops in the elderly. It is characterized by an alteration of consciousness and cognition with reduced ability to focus, sustain, or shift attention. It develops over a short period and fluctuates during the day. The clinical presentation can vary, but usually, it flourishes with psychomotor behavioral disturbances such as hyperactivity or hypoactivity with increased sympathetic activity and impairment in sleep duration and architecture.
- **Option D:** The nurse may also assess for perseveration in a client with cognitive impairment, but the questions in this situation would not elicit the symptom response. Many people who are developing or have dementia do not receive a diagnosis. One study showed that physicians were unaware of cognitive impairment in more than 40 percent of their cognitively impaired patients. Another study found that more than half of patients with dementia had not received a clinical cognitive evaluation by a physician. The failure to evaluate memory or cognitive complaints is likely to hinder treatment of underlying disease and comorbid conditions, and may present safety issues for the patient and others. In many cases, the cognitive problem will worsen over time.

**40. Mrs. Johnson tells the nurse that she is very worried because her 2-year old child does not finish his meals. What should the nurse advise the mother?**

- A. Make the child seat with the family in the dining room until he finishes his meal
- B. Provide quiet environment for the child before meals
- C. Do not give snacks to the child before meals
- D. Put the child on a chair and feed him

**Correct Answer: Answer C. Do not give snacks to the child before meals.**

If the child is hungry he/she is more likely to finish his meals. Therefore, the mother should be advised not to give snacks to the child. Set times for meals and snacks and try to stick to them. A child who skips a meal finds it reassuring to know when to expect the next one. Avoid offering snacks or pacifying

hungry kids with cups of milk or juice right before a meal — this can diminish their appetite and decrease their willingness to try a new food being offered.

- **Option A:** The child is a “busy toddler.” He/she will not be able to keep still for a long time. For some kids, dinner becomes a negotiation session from the very start, and parents have been using dessert as an incentive for decades. But this doesn’t encourage healthy eating. Instead, it creates the impression that “treats” are more valuable than mealtime food.
- **Option B:** Be alert to what toddlers say through their actions. A child who is building a tower of crackers or dropping carrots on the floor may be telling you he or she is full. Pushing food on a child who’s not hungry may dull the internal cues that help kids know when they’ve eaten enough. Kids can manage their hunger when they come to expect that food will be available during certain times of the day. If a child chooses not to eat anything at all, simply offer food again at the next meal or snack time.
- **Option D:** Kids should start finger feeding around 9 months of age and try using utensils by 15-18 months. Some parents think that not letting kids feed themselves is for the best, but it takes away control that rightfully belongs to kids at this age. They need to decide whether to eat, what they will eat, and how much to eat — this is how they learn to recognize the internal cues that tell them when they’re hungry and when they’re full. Just as important, toddlers need to learn and practice the mechanics of feeding themselves.

**41. The client being seen in a physician’s office has just been scheduled for a barium swallow the next day. The nurse writes down which of the following instructions for the client to follow before the test?**

- A. Fast for 8 hours before the test.
- B. Eat a regular supper and breakfast.
- C. Continue to take all oral medications as scheduled.
- D. Monitor own bowel movement pattern for constipation.

**Correct Answer: A. Fast for 8 hours before the test**

A barium swallow is an x-ray study that uses a substance called barium for contrast to highlight abnormalities in the GI tract. The client should fast for 8 to 12 hours before the test, depending on the physician’s instructions. A barium swallow test (cine esophagram, swallowing study, esophagography, modified barium swallow study, videofluoroscopy swallow study) is a special type of imaging test that uses barium and X-rays to create images of the upper gastrointestinal (GI) tract.

- **Option B:** The client will need to stop eating and drinking for about 8 hours before the swallowing test. Generally, this means after midnight. A barium swallow test may be performed as an outpatient procedure or as part of the client’s stay in a hospital. The way the test is done may vary depending on the client’s condition and his healthcare provider’s practices.
- **Option C:** Most oral medications also are withheld before the test. The client should tell the provider about all medicines he is taking. This includes prescriptions, over-the-counter medicines, and herbal supplements. He may need to stop taking these before the swallowing test.
- **Option D:** After the procedure, the nurse must monitor for constipation, which can occur as a result of the presence of barium in the GI tract. The client may have constipation or impacted stool after the swallowing test if all of the barium does not pass out of the body. The client should drink plenty of fluids in the days following the exam.



**42. According to Rubin's theory of maternal role adaptation, the mother will go through 3 stages during the postpartum period. These stages are:**

- A. Going through, adjustment period, adaptation period
- B. Taking-in, taking hold and letting-go
- C. Attachment phase, adjustment phase, adaptation phase
- D. Taking-hold, letting-go, attachment phase

**Correct Answer: B. Taking-in, taking-hold and letting-go**

Rubin's theory states that the 3 stages that a mother goes through for maternal adaptation are: taking-in, taking-hold and letting-go. In the taking-in stage, the mother is more passive and dependent on others for care. In taking-hold, the mother begins to assume a more active role in the care of the child and in letting-go, the mother has become adapted to her maternal role.

- **Option A:** The taking-in phase usually sets 1 to 2 days after delivery. This is the time of reflection for the woman because within the 2 to 3 day period, the woman is passive. The taking-in phase provides time for the woman to regain her physical strength and organize her rambling thoughts about her new role.
- **Option C:** The taking hold phase starts 2 to 4 days after delivery. The woman starts to initiate actions on her own and makes decisions without relying on others. She starts to focus on the newborn instead of herself and begins to actively participate in newborn care. The woman still needs positive reinforcements despite the independence that she is already showing because she might still feel insecure about the care of her child.
- **Option D:** During the letting go phase, the woman finally accepts her new role and gives up her old roles like being a childless woman or just a mother of one child. This is the phase where postpartum depression may set in. Readjustment of relationships is needed for an easy transition to this phase.

**43. A nurse caring for a patient with an infectious disease who requires isolation should refer to guidelines published by the:**

- A. National League for Nursing (NLN)
- B. Centers for Disease Control (CDC)
- C. American Medical Association (AMA)
- D. American Nurses Association (ANA)

**Correct Answer: B. Centers for Disease Control (CDC)**

The Center of Disease Control (CDC) publishes and frequently updates guidelines on caring for patients who require isolation. CDC is responsible for controlling the introduction and spread of infectious diseases, and provides consultation and assistance to other nations and international agencies to assist in improving their disease prevention and control, environmental health, and health promotion activities.

- **Option A:** The National League of Nursing's (NLN's) major function is accrediting nursing education programs in the United States. The NLN, the premier organization for nurse educators, offers professional development, teaching resources, research grants, testing services, and public policy initiatives to its 40,000 individual and 1,200 institutional members, comprising nursing

education programs across higher education and health care.

- **Option C:** The American Medical Association (AMA) is a national organization of physicians. American Medical Association (AMA), organization of American physicians, the objective of which is “to promote the science and art of medicine and the betterment of public health.” It was founded in Philadelphia in 1847 by 250 delegates representing more than 40 medical societies and 28 colleges.
- **Option D:** The American Nurses’ Association (ANA) is a national organization of registered nurses. ANA guides the profession on issues of nursing practice, health policy, and social concerns that impact patient wellbeing. Through their position statements, ANA amplifies the voice of nurses and educates both consumers and policymakers.

**44. 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.

**45. Which of the following is a true statement about normal ovulation?**

- A. It occurs on the 14th day of every cycle.
- B. It may occur between 14-16 days before next menstruation.

- C. Every menstrual period is always preceded by ovulation.
- D. The most fertile period of a woman is 2 days after ovulation.

**Correct Answer: B. It may occur between 14-16 days before next menstruation.**

Not all menstrual cycles are ovulatory. Normal ovulation in a woman occurs between the 14th to the 16th day before the next menstruation. A common misconception is that ovulation occurs on the 14th day of the cycle. This is a misconception because ovulation is determined not from the first day of the cycle but rather 14-16 days before the next menstruation.

- **Option A:** Ovulation occurs approximately 10-12 hours after the LH peak. The LH surge is initiated by a dramatic rise of estradiol produced by the preovulatory follicle
- **Option C:** The luteal phase is 14 days long in most women. If the corpus luteum is not rescued by pregnancy, it will undergo atresia. The resultant progesterone withdrawal results in menses.
- **Option D:** The follicular phase begins from the first day of menses until ovulation. The development of ovarian follicles characterizes this phase. The LH surge is initiated by a dramatic rise of estradiol produced by the preovulatory follicle and results in subsequent ovulation. The LH surge stimulates luteinization of the granulosa cells and stimulates the synthesis of progesterone responsible for the midcycle FSH surge. Also, the LH surge stimulates resumption of meiosis and the completion of reduction division in the oocyte with the release of the first polar body.

**46. A 34-year-old female client is requesting information about mammograms and breast cancer. She isn't considered at high risk for breast cancer. What should the nurse tell this client?**

- A. She should have had a baseline mammogram before age 30
- B. When she begins having yearly mammograms, breast self-examinations will no longer be necessary
- C. She should perform breast self-examination during the first 5 days of each menstrual cycle
- D. She should eat a low-fat diet to further decrease her risk of breast cancer

**Correct Answer: D. She should eat a low-fat diet to further decrease her risk of breast cancer**

- **Option D:** A low-fat diet (one that maintains weight within 20% of recommended body weight) has been found to decrease a woman's risk of breast cancer.
- **Option A:** A baseline mammogram should be done between ages 30 and 40.
- **Option B:** The client should continue to perform monthly breast self-examinations even when receiving yearly mammograms.
- **Option C:** Monthly breast self-examinations should be done between days 7 and 10 of the menstrual cycle.

**47. The nurse is caring for a female client with active upper GI bleeding. What is the appropriate diet for this client during the first 24 hours after admission?**

- A. Regular diet
- B. Skim milk
- C. Nothing by mouth

D. Clear liquids

**Correct Answer: C. Nothing by mouth**

Shock and bleeding must be controlled before oral intake, so the client should receive nothing by mouth. When the bleeding is controlled, the diet is gradually increased, starting with ice chips and then clear liquids. In patients hospitalized for acute upper gastrointestinal bleeding due to an ulcer with high risk of rebleeding or with variceal bleeding, it is recommended to wait at least 48 h after endoscopic therapy before initiating oral or enteral feeding.

- **Option A:** A regular diet is incorrect. Proton pump inhibitors (PPIs) are beneficial for both ulcer and non-ulcer diseases as they reduce the risk of re-bleeding by clot stabilization. Endoscopy should only be performed after hemodynamic stability has been achieved and should not be delayed by more than 24 hours.
- **Option B:** Skim milk shouldn't be given because it increases gastric acid production, which could prolong bleeding. Further research found that ingesting milk increases the production of stomach acid, which can worsen gastritis symptoms. Any relief gastritis sufferers experience after drinking a glass of milk is likely to be temporary; within a half-hour, symptoms are usually worse, not better.
- **Option D:** A liquid diet is the first diet offered after bleeding and shock are controlled. They can be fed with clear liquids soon after endoscopy. Clear liquids provide the advantage that if the patient starts to bleed again, sedation and anesthesia can be given within two hours after the last ingestion

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

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

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

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

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

any defects with the cubam receptor at the terminal ileum, the result will show a low level of labeled cobalamin in urine as it will remain in the intestines and is likely to be excreted in feces.

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

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

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

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

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

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

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

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

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

- **Option A:** A flat affect, alogia, apathy, avolition, and anhedonia refer to the negative symptoms. Negative symptoms list the diminution or loss of normal function. Avolition is a form of emotional or behavioral paralysis that can diminish your drive to participate in social activities and meet goals as well as your ability to complete daily tasks. Many people mistake this negative symptom for "laziness." In Greek, an means "without" and hedone means "pleasure," so in simple terms, anhedonia is a state where you are unable to feel pleasure. For people with schizophrenia, this can

mean a lack of enthusiasm for activities, hobbies, passions, and pleasures once enjoyed.

- **Option B:** As negative symptoms indicate deficits in functioning they are also called deficit symptoms. Negative symptoms, including lack of emotion, decreased joy or motivation, delayed speech, and difficulty beginning and sustaining activities, can be scary and extremely debilitating. The most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes negative symptoms as “restricted emotional expression and avolition,” and includes the following five types.
- **Option C:** Defined in DSM-5 as a “decrease in verbal output or verbal expressiveness,” alogia (also known as “poverty of speech”) can make it nearly impossible to communicate your thoughts and carry on a conversation. People with alogia may answer a monosyllabic “yes” or “no” when responding to questions and/or experience delays in getting the words out. It should be noted that these speech delays are not the same as those caused by positive symptoms like auditory or visual hallucinations and disorganized thinking.

**51. Bryce is a child diagnosed with coarctation of aorta. While assessing him, Nurse Zach would expect to find which of the following?**

- A. Squatting posture
- B. Absent or diminished femoral pulses
- C. Severe cyanosis at birth
- D. Cyanotic ("tet") episodes

**Correct Answer: B. Absent or diminished femoral pulses**

Absent or diminished femoral pulse is a classic characteristic of coarctation of the aorta. In patients with neonatal coarctation evolving while the patent ductus arteriosus is closing, the lower extremity saturation can be low as perfusion to the lower body can be maintained by ductal patency. In the era of lower extremity pulse oximetry screening in newborns, a neonate could often pass with an acceptable saturation as it is less common for the ductus to contribute significantly unless other left heart structures are hypoplastic.

- **Option A:** Tet spells require a rapid and aggressive approach including positioning (knee-chest) to increase systemic vascular resistance, oxygen therapy to cause pulmonary vasodilation and systemic vasoconstriction, intravenous fluid bolus to improve the right ventricle filling and pulmonary flow; morphine, intravenous beta-blockers to help improve the right ventricle outflow obstruction by relaxing the muscle, and intravenous phenylephrine to increase systemic afterload.
- **Option C:** Severe cyanosis at birth is seen in such defects as transposition of the great vessels. The degree of cyanosis is dependent on the amount of mixing between the two parallel circuits. Factors affecting intracardiac mixing include the size and presence of an ASD or VSD. Cyanosis is not affected by exertion or supplemental oxygen.
- **Option D:** Tet episodes are characteristic of Tetralogy of Fallot. “Tet spells” or hypercyanotic episodes present during infancy or toddler age and decrease after 4 to 5 years of age. Dehydration or agitation commonly precipitate tet spells, and if patients do not receive prompt and adequate treatment, they can develop severe cyanosis and hypoxia that, subsequently, can cause syncope and even death.

**52. A female client with amyotrophic lateral sclerosis (ALS) tells the nurse, “Sometimes I feel so frustrated. I can’t do anything without help!” This**

***comment best supports which nursing diagnosis?***

- A. Anxiety
- B. Powerlessness
- C. Ineffective denial
- D. Risk for disuse syndrome

**Correct Answer: B. Powerlessness**

This comment best supports a nursing diagnosis of Powerlessness because ALS may lead to locked-in syndrome, characterized by an active and functioning mind locked in a body that can't perform even simple daily tasks. Discuss with the patient concerning his or her care (e.g., treatment options, convenience of visits, or time of ADLs). Allowing the patient to participate in discussions will increase his or her sense of independence or autonomy.

- **Option A:** Depression has a significant effect on the quality of life in patients with ALS, and studies have shown that treatment can improve quality of life. While no controlled trials have evaluated the treatment of depression in patients with ALS, Amitriptyline is commonly used as it can also treat other symptoms such as insomnia, sialorrhea, and pseudobulbar affect.
- **Option D:** Although Risk for disuse syndrome may be the nursing diagnosis associated with ALS, the client's comment specifically refers to an inability to act autonomously. Limb onset ALS (LO) is the predominant type, presenting in 70% of patients. LO ALS can be further classified as flail arm syndrome or brachial amyotrophic diplegia, which is characterized by LMN weakness and wasting. It usually starts proximally and often symmetrically, then progresses distally to a point where upper extremity function is severely impaired.
- **Option C:** A diagnosis of Ineffective denial would be indicated if the client didn't seem to perceive the personal relevance of symptoms or danger. Patients need to know that this disease causes the muscles to weaken, eventually to the point of paralysis. Patients should also be aware that the disease will get worse and ultimately lead to death. Unfortunately, there is no cure; however, numerous medications can help lessen the associated symptoms. Patients may begin to notice difficulty with fine motor skills, from speaking to writing, as well as with walking, and eventually breathing.

***53. A female client complains of periorbital aching, tearing, blurred vision, and photophobia in her right eye. Ophthalmologic examination reveals a small, irregular, nonreactive pupil — a condition resulting from acute iris inflammation (iritis). As part of the client's therapeutic regimen, the physician prescribes atropine sulfate (Atropisol), two drops of 0.5% solution in the right eye twice daily. Atropine sulfate belongs to which drug classification?***

- A. Parasympathomimetic agent
- B. Sympatholytic agent
- C. Adrenergic blocker
- D. Cholinergic blocker

**Correct Answer: D. Cholinergic blocker**

Atropine sulfate is a cholinergic blocker. It isn't a parasympathomimetic agent, a sympatholytic agent, or an adrenergic blocker. Atropine is an antimuscarinic that works through competitive inhibition of postganglionic acetylcholine receptors and direct vagolytic action, which leads to parasympathetic inhibition of the acetylcholine receptors in smooth muscle.

- **Option A:** Parasympathomimetics are a class of pharmacological agents that activate the parasympathetic division of the autonomic nervous system. These drugs work by mimicking or modifying the effects of acetylcholine (ACh), the primary neurotransmitter of the parasympathetic nervous system. Parasympathomimetic medications are classified into two main categories based on whether they are direct agonists or indirect agonists of ACh.
- **Option B:** Methyldopa is a centrally acting sympatholytic agent used in the treatment of hypertension. Alpha-methyldopa is converted to methyl norepinephrine centrally to decrease the adrenergic outflow by alpha-2 agonist action from the central nervous system, leading to reduced total peripheral resistance and decreased systemic blood pressure.
- **Option C:** The effects of the sympathetic nervous system can be blocked either by decreasing sympathetic outflow from the brain, suppressing release of norepinephrine from terminals, or by blocking postsynaptic receptors. Adrenergic antagonists reduce the effectiveness of sympathetic nerve stimulation and the effects of exogenously applied agonists, such as isoproterenol. Most often the receptor antagonists are divided into  $\alpha$ -receptor antagonists and  $\beta$ -receptor antagonists.

**54. A 50-year-old gentleman comes into a specialist's office complaining of chronic nasal congestion and reduced sense of smell. He's been trying over-the-counter nasal sprays, but the relief has been transient. Upon detailed inspection using a nasal speculum and light, the healthcare provider observes swollen tissues but also takes note of the prominent bony ridges on the lateral walls of the nasal cavity. These structures are integral for warming and humidifying inhaled air, as well as trapping particulates. Intending to test the medical student accompanying her on the rounds, the healthcare provider inquires, "Given their importance in nasal physiology, can you identify what these bony ridges are called?"**

- A. Choane
- B. Nasal septa
- C. Adenoids
- D. Turbinates

**Correct Answer: D. Turbinates**

The prominent bony ridges on the lateral walls of the nasal cavity that increase its surface area are called turbinates or nasal conchae. They play a crucial role in filtering, humidifying, and warming the inhaled air.

- **Option A:** The choane are the posterior nasal apertures that lead from the nasal cavity to the nasopharynx. They aren't the bony ridges observed on the lateral walls of the nasal cavity.
- **Option B:** The nasal septum refers to the structure, primarily the septum, that divides the nasal cavity into its two symmetrical halves. It doesn't refer to the bony ridges on the lateral walls.
- **Option C:** Adenoids, also known as the pharyngeal tonsils, adenoids are lymphatic tissues located in the high part of the throat, behind the nose. They aren't located in the nasal cavity and aren't the bony structures described.



**55. Which of the following is evidence that the controlling process is effective?**

- A. The things that were planned are done.
- B. Physicians do not complain.
- C. Employees are contented.
- D. There is an increase in customer satisfaction rate.

**Correct Answer: A. The things that were planned are done**

Controlling is defined as seeing to it that what is planned is done. Controlling involves ensuring that performance does not deviate from standards. Controlling consists of five steps: (1) set standards, (2) measure performance, (3) compare performance to standards, (4) determine the reasons for deviations and then (5) take corrective action as needed.

- **Option B:** Outcome standards measure the effectiveness of the service. They are set according to the type of service provided and the data are collected through systematic use of specific measurement tools such as questionnaires or comparison between pre-test and post-test performance.
- **Option C:** Process standards include care plans, the nursing procedures to be done to address the needs of the patients. Process standards focus on the practitioner and the activities carried out in delivering care. The development of standards and related criterion measures are then guided by the basic principles.
- **Option D:** Outcome standards focus on the end result of the nursing services and activities carried out and the changes which occurred. This approach is based on the belief that structure, process, and outcome are interdependent.

**56. Which of the following fetal positions is most favorable for birth?**

- A. Vertex presentation
- B. Transverse lie
- C. Frank breech presentation
- D. Posterior position of the fetal head

**Correct Answer: A. Vertex presentation**

Vertex presentation (flexion of the fetal head) is the optimal presentation for passage through the birth canal. Toward the end of pregnancy, the fetus moves into position for delivery. Normally, the position of a fetus is facing rearward (toward the woman's back) with the face and body angled to one side and the neck flexed, and presentation is head first.

- **Option B:** Transverse lie is an unacceptable fetal position for vaginal birth and requires a C-section. In transverse lie, the fetus lies horizontally across the birth canal and presents shoulder first. A cesarean delivery is done, unless the fetus is the second in a set of twins. In such a case, the fetus may be turned to be delivered through the vagina.
- **Option C:** Frank breech presentation, in which the buttocks present first, can be a difficult vaginal delivery. When delivered vaginally, babies that present buttocks first are more likely to be injured than those that present head first. Such injuries may occur before, during, or after birth. The baby

may even die. Complications are less likely when breech presentation is detected before labor or delivery.

- **Option D:** Posterior positioning of the fetal head can make it difficult for the fetal head to pass under the maternal symphysis pubis. In occiput posterior presentation (also called sunny-side up), the fetus is head first but is facing up (toward the mother's abdomen). It is the most common abnormal position or presentation. When a fetus faces up, the neck is often straightened rather than bent, and the head requires more space to pass through the birth canal. Delivery by a vacuum extractor or forceps or cesarean delivery may be necessary.

**57. A patient is admitted to the hospital with a diagnosis of primary hyperparathyroidism. A nurse checking the patient's lab results would expect which of the following changes in laboratory findings?**

- A. Elevated serum calcium
- B. Low serum parathyroid hormone (PTH)
- C. Elevated serum vitamin D
- D. Low urine calcium

**Correct Answer: A. Elevated serum calcium**

The parathyroid glands regulate the calcium level in the blood. In hyperparathyroidism, the serum calcium level will be elevated. The chronic excessive resorption of calcium from bone caused by excessive parathyroid hormone can result in osteopenia.

- **Option B:** Parathyroid hormone levels may be high or normal but not low. The main effects of parathyroid hormone are to increase the concentration of plasma calcium by increasing the release of calcium and phosphate from bone matrix, increasing calcium reabsorption by the kidney, and increasing renal production of 1,25-dihydroxyvitamin D-3 (calcitriol), which increases intestinal absorption of calcium.
- **Option C:** The body will lower the level of vitamin D in an attempt to lower calcium. Vitamin D levels should be measured in the evaluation of primary hyperparathyroidism. Vitamin D deficiency (a 25-hydroxyvitamin D level of less than 20 ng per milliliter) can cause secondary hyperparathyroidism, and repletion of vitamin D deficiency can help to reduce parathyroid hormone levels.
- **Option D:** Urine calcium may be elevated, with calcium spilling over from elevated serum levels. This may cause renal stones. In addition, the chronically increased excretion of calcium in the urine can predispose to the formation of renal stones.

**58. A client is complaining of painful contractions, or after pains, on postpartum day 2. Which of the following conditions would increase the severity of afterpains?**

- A. Bottle-feeding
- B. Diabetes
- C. Multiple gestation
- D. Primiparity

**Correct Answer: C. Multiple gestation**

Multiple gestation, multiparity, and conditions that cause overdistention of the uterus will increase the intensity of after-pains. Afterpain is a common phenomenon after vaginal delivery. Any factor that causes a delay in the process of uterus sub involution and consequently returning its size to pre-pregnancy status could affect the severity of afterpain.

- **Option A:** There was a positive correlation between the number of pregnancies and the duration of breastfeeding with mean score of afterpain. Also, the length of ambulation decreased the afterpain intensity. However, the intensity of afterpain had no significant relationship with stimulation with oxytocin in labor, prescription of methylergonovine, and also oxytocin after delivery. Considering that a longer duration of breastfeeding and ambulation in the early postpartum period could decrease afterpain, it is suggested to encourage postpartum mothers to begin breastfeeding and ambulation as soon as possible after birth.
- **Option B:** Diabetes has no correlation with afterpains. Afterpains (cramping) are the contractions of the uterus occurring in the days following childbirth. They are normal but can be uncomfortable. Afterpains are usually strongest on the second and third days following delivery, when the mother is breastfeeding or after she takes a uterus-contracting medication prescribed by her physician or midwife. Cramping is most noticeable after the birth of a second or third baby.
- **Option D:** After-pains are contractions that occur after labor and delivery. These contractions signal the process of involution, the process of the uterus shrinking back down to its pre-pregnancy size and shape. While after-pains are not a reason to worry, they can cause discomfort and even pain. After-pains can vary significantly from person to person. If this is not the first baby, the pain may be worse than experienced during previous pregnancies. For pain, the mother can use comfort measures like warm packs, massage of the fundus through the abdomen, and certain medications (with a practitioner's approval). Over-the-counter medication works well for most women.

**59. The client with cancer is receiving chemotherapy and develops thrombocytopenia. The nurse identifies which intervention is the highest priority in the nursing plan of care?**

- A. Monitoring temperature
- B. Monitoring for pathological factors
- C. Ambulation three times a day
- D. Monitoring the platelet count

**Correct Answer: D. Monitoring the platelet count**

- **Option D:** Thrombocytopenia indicates a decrease in the number of platelets in the circulating blood. A major concern is monitoring for and preventing bleeding.
- **Option A:** Relates to monitoring for infection particularly if leukopenia is present.
- **Options B and C:** Although monitoring the pathological factors and ambulation are important in the plan of care. They are not related directly to thrombocytopenia.

**60. The human cells specifically affected by HIV are:**

- A. Gonocytes
- B. CD4+ T lymphocytes

- C. Islet cells
- D. Red blood cells

**Correct Answer: B. CD4+ T lymphocytes**

HIV directly infects CD4+ T lymphocytes. HIV is a retrovirus that attacks CD4 T lymphocytes eventually leading to the death of these cells and severe immunodeficiency of the individual who has acquired the infection. Once the CD4 count becomes too low, host immune defenses cannot fend off opportunistic infections and malignancies.

- **Option A:** The presence of a CD4 count of less than 200 or an AIDS-defining illness in a patient with HIV is the criteria for a diagnosis of AIDS. Treatment of AIDS is focused on opportunistic illness or condition and decreasing the HIV viral load and monitoring for an increase in CD4 cells through antiretroviral therapy (ART.)
- **Option C:** HIV is a retrovirus, with two subtypes: HIV-1 and HIV-2.[2] The HIV-1 subtype is the most common and responsible for AIDS throughout most of the world. HIV-2 is found primarily in Western Africa and is much less common.
- **Option D:** The number of CD4 cells within the affected individual will fall by approximately 50-80 cells/uL per year without the initiation of ART, and the decline may be even faster once the count falls below 200 cells/uL.

**61. When planning care for a male client with burns on the upper torso, which nursing diagnosis should take the highest priority?**

- A. Ineffective airway clearance related to edema of the respiratory passages
- B. Impaired physical mobility related to the disease process
- C. Disturbed sleep pattern related to facility environment
- D. Risk for infection related to breaks in the skin

**Correct Answer: A. Ineffective airway clearance related to edema of the respiratory passages**

When caring for a client with upper torso burns, the nurse's primary goal is to maintain respiratory integrity. Therefore, option A should take the highest priority. Immediately assess the patient's airway, breathing, and circulation. Be especially alert for signs of smoke inhalation, and pulmonary damage: singed nasal hairs, mucosal burns, voice changes, coughing, wheezing, soot in the mouth or nose, and darkened sputum.

- **Option B:** This nursing diagnosis isn't appropriate because burns aren't a disease. Note circulation, motion, and sensation of digits frequently. Edema may compromise circulation to extremities, potentiating tissue necrosis and the development of contractures.
- **Option C:** Disturbed sleep pattern may be appropriate, but don't command a higher priority than the ineffective airway clearance because they don't reflect immediately life-threatening problems. Initially, the patient may use denial and repression to reduce and filter information that might be overwhelming. Some patients display a calm manner and alert mental status, representing a dissociation from reality, which is also a protective mechanism.
- **Option D:** Examine wounds daily, note and document changes in appearance, odor, or quantity of drainage. Indicators of sepsis (often occurs with full-thickness burn) requiring prompt evaluation and intervention. Note: Changes in sensorium, bowel habits, and the respiratory rate usually precede fever and alteration of laboratory studies.

**62. A client who is admitted to the ER for head trauma is diagnosed with an epidural hematoma. The underlying cause of epidural hematoma is usually related to which of the following conditions?**

- A. Laceration of the middle meningeal artery.
- B. Rupture of the carotid artery.
- C. Thromboembolism from a carotid artery.
- D. Venous bleeding from the arachnoid space.

**Correct Answer: A. Laceration of the middle meningeal artery.**

Epidural hematoma or extradural hematoma is usually caused by laceration of the middle meningeal artery. Most epidural hematomas result from arterial bleeding from a branch of the middle meningeal artery. The anterior meningeal artery or dural arteriovenous (AV) fistula at the vertex may be involved.

- **Option B:** Embolic strokes occur when clots migrate from the source to block more distal cerebral arteries causing cessation of brain tissue perfusion and ischemia. The embolic source can be cardiac, aortic, arterial, from a venous origin in the pelvis or lower limbs with the presence of a cardiac shunt resulting in paradoxical embolism, or an unknown source.
- **Option C:** An embolic stroke is a thromboembolism from a carotid artery that ruptures. Emboli can happen due to different mechanisms including blood stasis in an abnormal, structurally enlarged left cardiac chamber such as left ventricular aneurysm with subsequent thrombus formation, material detachment from structurally abnormal calcific degenerative valves, or embolus passage from the venous to the arterial circulation (paradoxical embolism) because of the presence of right to left cardiac shunt such as Patent Foramen Ovale (PFO).
- **Option D:** Venous bleeding from the arachnoid space is usually observed with a subdural hematoma. Up to 10% of EDHs are due to venous bleeding following the laceration of a dural venous sinus. In adults, up to 75% of EDHs occur in the temporal region. However, in children, they occur with similar frequency in the temporal, occipital, frontal, and posterior fossa regions.

**63. Jon has a potassium level of 6.5 mEq/L, which medication would nurse Wilma anticipate?**

- A. Potassium supplements
- B. Kayexalate
- C. Calcium gluconate
- D. Sodium tablets

**Correct Answer: B. Kayexalate**

The client's potassium level is elevated; therefore, Kayexalate would be ordered to help reduce the potassium level. Kayexalate is a cation-exchange resin, which can be given orally, by nasogastric tube, or by retention enema. Potassium is drawn from the bowel and excreted through the feces.

- **Option A:** Because the client's potassium level is already elevated, potassium supplements would not be given. Patients with neuromuscular weakness, paralysis, or ECG changes and elevated potassium of more than 5.5 mEq/L in patients at risk for ongoing hyperkalemia, or confirmed hyperkalemia of 6.5 mEq/L should have aggressive treatment. Exogenous sources of potassium should be immediately discontinued.

- **Option C:** Neither calcium gluconate nor sodium tablets would address the client's elevated potassium level. Calcium therapy will stabilize the cardiac response to hyperkalemia and should be initiated first in the setting of cardiac toxicity. Calcium does not alter the serum concentration of potassium but is a first-line therapy in hyperkalemia-related arrhythmias and ECG changes.
- **Option D:** Sodium bicarbonate infusion may be helpful in patients with metabolic acidosis. Bolus dosing of sodium bicarbonate is less effective. Loop or thiazide diuretics may be helpful in enhancing potassium excretion. They may be used in non-oliguric, volume overloaded patients but should not be used as monotherapy in symptomatic patients.

**64. Which of the following would the nurse identify as a presumptive sign of pregnancy?**

- A. Hegar sign
- B. Nausea and vomiting
- C. Skin pigmentation changes
- D. Positive serum pregnancy test

**Correct Answer: B. Nausea and vomiting**

Presumptive signs of pregnancy are subjective signs. Of the signs listed, only nausea and vomiting are presumptive signs.

- **Option A:** Hegar's sign is a non-sensitive indication of pregnancy in women — its absence does not exclude pregnancy. It pertains to the features of the cervix and the uterine isthmus. It is demonstrated as a softening in the consistency of the uterus, and the uterus and cervix seem to be two separate regions. It is a probable sign of pregnancy.
- **Option C:** The area around the nipples and the skin on the inner thighs, genitals, and neck might darken, possibly due to hormonal changes. The woman might notice a dark line from the navel to the pubic bone (linea nigra). Dark patches might develop on the face (chloasma). Avoid sun exposure, which can worsen chloasma. After childbirth, skin typically returns to its normal pigment over a period of several months.
- **Option D:** A positive serum pregnancy test is considered a probable sign, which is strongly suggestive of pregnancy.

**65. The nurse is aware that a neonate of a mother with diabetes is at risk for what complication?**

- A. Anemia
- B. Hypoglycemia
- C. Nitrogen loss
- D. Thrombosis

**Correct Answer: B. Hypoglycemia.**

- **Option B:** Neonates of mothers with diabetes are at risk for hypoglycemia due to increased insulin levels. During gestation, an increased amount of glucose is transferred to the fetus across the placenta. The neonate's liver cannot initially adjust to the changing glucose levels after birth. This may result in an overabundance of insulin in the neonate, resulting in hypoglycemia.

**66. A nursing diagnosis for bulimia nervosa is powerlessness related to feeling not in control of eating habits. The goal for this problem is:**

- A. Patient will learn problem-solving skills.
- B. Patient will have decreased symptoms of anxiety.
- C. Patient will perform self-care activities daily.
- D. Patient will verbalize how to set limits on others.

**Correct Answer: A. Patient will learn problem-solving skills.**

If the client learns problem-solving skills she will gain a sense of control over her life. Encourage the patient to take charge of their own life in a more healthful way by making their own decisions and accepting self as she or he is at this moment (including inadequacies and strengths). Patient often does not know what she or he may want for herself. Parents (mother) often make decisions for the patient. Patient may also believe she or he has to be the best in everything and holds self-responsible for being perfect.

- **Option B:** Anxiety is caused by powerlessness. Encourage the patient to express anger and acknowledge when it is verbalized. Important to know that anger is part of self and as such is acceptable. Expressing anger may need to be taught to the patient because anger is generally considered unacceptable in the family, and therefore the patient does not express it.
- **Option C:** Performing self-care activities will not decrease one's powerlessness. Assist the patient to assume control in areas other than dieting and weight loss such as management of their own daily activities, work, and leisure choices. Feelings of personal ineffectiveness, low self-esteem, and perfectionism are often part of the problem. The patient feels helpless to change and requires assistance to problem-solve methods of control in life situations.
- **Option D:** Setting limits to control imposed by others is a necessary skill but problem-solving skill is the priority. Monitor exercise programs and set limits on physical activities. Chart activity and level of work (pacing and so on). Moderate exercise helps in maintaining muscle tone, weight and combating depression; however, the patient may exercise excessively to burn calories.

**67. A patient who has been told by the health care provider that the cells in a bowel tumor are poorly differentiated asks the nurse what is meant by "poorly differentiated." Which response should the nurse make?**

- A. "Your tumor cells look more like immature fetal cells than normal bowel cells."
- B. "The cells in your tumor have mutated from the normal bowel cells."
- C. "The cells in your tumor do not look very different from normal bowel cells."
- D. "The tumor cells have DNA that is different from your normal bowel cells."

**Correct Answer: A. "Your tumor cells look more like immature fetal cells than normal bowel cells."**

- **Option A:** An undifferentiated cell has an appearance more like a stem cell or fetal cell and less like the normal cells of the organ or tissue.
- **Option B:** All tumor cells are mutations from the normal cells of the tissue.

- **Options C and D:** The DNA in cancer cells is always different from normal cells, whether the cancer cells are well differentiated or not.

**68. The following are signs that the placenta has detached, except?**

- A. Lengthening of the cord
- B. Uterus becomes more globular
- C. Sudden gush of blood
- D. Mother feels like bearing down

**Correct Answer: D. Mother feels like bearing down**

Placental detachment does not require the mother to bear down. A normal placenta will detach by itself without any effort from the mother.

- **Option A:** The most reliable sign is the lengthening of the umbilical cord as the placenta separates and is pushed into the lower uterine segment by progressive uterine retraction. Placing a clamp on the cord near the perineum makes it easier to appreciate this lengthening. Never place traction on the cord without countertraction on the uterus above the symphysis; otherwise, one may mistake cord lengthening due to impending prolapse or inversion for that of uncomplicated placental separation.
- **Option B:** The uterus takes on a more globular shape and becomes firmer. This occurs as the placenta descends into the lower segment and the body of the uterus continues to retract. This change may be clinically difficult to appreciate.
- **Option C:** As the placenta detaches, the spiral arteries are exposed in the placental bed; massive hemorrhage would occur if not for the structure of the uterus. The vessels supplying the placental bed traverse a latticework of crisscrossing muscle bundles that occlude and kink-off the vessels as they contract and retract following the expulsion of the placenta.

**69. Malou is diagnosed with major depression and spends the majority of the day lying in bed with the sheet pulled over his head. Which of the following approaches by the nurse would be the most therapeutic?**

- A. Question the client until he responds.
- B. Initiate contact with the client frequently.
- C. Sit outside the client's room.
- D. Wait for the client to begin the conversation.

**Correct Answer: B. Initiate contact with the client frequently**

The nurse should initiate brief, frequent contacts throughout the day to let the client know that he is important to the nurse. This will positively affect the client's self-esteem. Initially, provide activities that require minimal concentration (e.g., drawing, playing simple board games). Depressed people lack concentration and memory. Activities that have no "right or wrong" or "winner or loser" minimizes opportunities for the client to put himself/herself down.

- **Option A:** Eventually involve the client in group activities (e.g., group discussions, art therapy, dance therapy). Socialization minimizes feelings of isolation. Genuine regard for others can increase feelings of self-worth. Eventually maximize the client's contacts with others (first one



other, then two others, etc.). Contact with others distracts the client from self-preoccupation.

- **Option C:** When the client is in the most depressed state, involve the client in a one-to-one activity. Maximizes the potential for interactions while minimizing anxiety levels. Involve the client in gross motor activities that call for very little concentration (e.g., walking). Such activities will aid in relieving tensions and might help in elevating the mood.
- **Option D:** Evaluate the client's need for assertiveness training tools to pursue things he or she wants or needs in life. Arrange for training through community-based programs, personal counseling, literature, etc. Low self-esteem individuals often have feelings of unworthiness and have difficulty determining their needs and wants. Encourage the client to participate in a group therapy where the members share the same situations/feelings that they have. To minimize the feelings of isolation and provide an atmosphere where positive feedback and a more realistic appraisal of self are available.

**70. A nurse is performing an assessment of a primipara who is being evaluated in a clinic during her second trimester of pregnancy. Which of the following indicates an abnormal physical finding necessitating further testing?**

- A. Consistent increase in fundal height
- B. Fetal heart rate of 180 BPM
- C. Braxton Hicks contractions
- D. Quickening

**Correct Answer: B. Fetal heart rate of 180 BPM.**

The normal range of the fetal heart rate depends on gestational age. The heart rate is usually 160-170 BPM in the first trimester and slows with fetal growth, near and at term, the fetal heart rate ranges from 120-160 BPM. The other options are expected.

- **Option A:** A fundal height measurement is typically done to determine if a baby is small for its gestational age. The measurement is generally defined as the distance in centimeters from the pubic bone to the top of the uterus. The expectation is that after week 24 of pregnancy the fundal height for a normally growing baby will match the number of weeks of pregnancy — plus or minus 2 centimeters.
- **Option C:** Braxton Hicks contractions are sporadic contractions and relaxation of the uterine muscle. Sometimes, they are referred to as prodromal or “false labor” pains. It is believed they start around 6 weeks gestation but usually are not felt until the second or third trimester of the pregnancy.
- **Option D:** Quickening often occurs between the 16th to the 22nd week of pregnancy. This is called a presumptive sign of pregnancy as the other movements of the woman's body can mimic early fetal movements such as flatus, peristalsis, and abdominal muscle contractions. A multiparous woman will usually first notice these fluttering movements of the fetus at an earlier gestation than a primiparous woman.

**71. What statement by the client indicates the need for further discussion regarding the outcome of skin grafting (allografting) procedures?**

- A. “For the first few days after surgery, the donor sites will be painful.”

- B. "Because the graft is my own skin, there is no chance it won't 'take'."
- C. "I will have some scarring in the area when the skin is removed for grafting."
- D. "Once all grafting is completed, my risk for infection is the same as it was before I was burned."

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

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

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

**72. A 23-year-old patient in the 27th week of pregnancy has been hospitalized on complete bed rest for 6 days. She experiences sudden shortness of breath, accompanied by chest pain. Which of the following conditions is the most likely cause of her symptoms?**

- A. Myocardial infarction due to a history of atherosclerosis.
- B. Pulmonary embolism due to deep vein thrombosis (DVT).
- C. Anxiety attacks due to worries about her baby's health.
- D. Congestive heart failure due to fluid overload.

**Correct Answer: B. Pulmonary embolism due to deep vein thrombosis (DVT).**

In a hospitalized patient on prolonged bed rest, the most likely cause of sudden onset shortness of breath and chest pain is pulmonary embolism. Pregnancy and prolonged inactivity both increase the risk of clot formation in the deep veins of the legs. These clots can then break loose and travel to the lungs.

- **Option A:** Atherosclerosis is the disease primarily responsible for most acute coronary syndrome (ACS) cases. Approximately 90% of myocardial infarctions (MIs) result from an acute thrombus that obstructs an atherosclerotic coronary artery. Plaque rupture and erosion are considered to be the major triggers for coronary thrombosis. Following plaque erosion or rupture, platelet activation and aggregation, coagulation pathway activation, and endothelial vasoconstriction occur, leading to coronary thrombosis and occlusion.

- **Option C:** There is no reason to suspect an anxiety disorder in this patient. Though anxiety is a possible cause of her symptoms, the seriousness of pulmonary embolism demands that it be considered first.
- **Option D:** According to 2017 American Heart Association (AHA) data, heart failure affects an estimated 6.5 million Americans aged 20 years and older. [31] With improved survival of patients with acute myocardial infarction and with a population that continues to age, heart failure will continue to increase in prominence as a major health problem in the United States.

**73. A client who has been diagnosed with bladder cancer is scheduled for an ileal conduit. Preoperatively, the nurse reinforces the client's understanding of the surgical procedure by explaining that an ileal conduit:**

- A. Is a temporary procedure that can be reversed later.
- B. Diverts urine into the sigmoid colon, where it is expelled through the rectum.
- C. Conveys urine from the ureters to a stoma opening in the abdomen.
- D. Creates an opening in the bladder that allows urine to drain into an external pouch.

**Correct Answer: C. Conveys urine from the ureters to a stoma opening in the abdomen.**

An ileal conduit is a permanent urinary diversion in which a portion of the ileum is surgically resected and one end of the segment is closed. The ureters are surgically attached to this segment of the ileum, and the open end of the ileum is brought to the skin surface on the abdomen to form the stoma. The client must wear a pouch to collect the urine that continually flows through the conduit. The bladder is removed during the surgical procedure and the ileal conduit is not reversible.

- **Option A:** Commonly, a permanent urinary diversion is created after surgery to treat a bladder or pelvic malignancy, but it can be performed for other functional and anatomical abnormalities of the urinary tract. Ileal conduits are the most common form of incontinent urinary diversion, other options providing continent urinary diversion do exist, and these are more widely practiced in America, whereas in Europe, ileal conduits are preferred.
- **Option B:** Diversion of the urine to the sigmoid colon is called a ureter ileosigmoidostomy. When bladder cancer is treated with curative intent, continence-preserving orthotopic urinary bladder replacement is preferred. For heterotopic urinary bladder replacement, a reservoir is fashioned from an ileal or ileocecal segment. Urine is diverted to the rectum by way of the sigmoid colon.
- **Option D:** An opening in the bladder that allows urine to drain externally is called a cystostomy. Cystostomy is the general term for the surgical creation of an opening into the bladder; it may be a planned component of urologic surgery or an iatrogenic occurrence. Often, however, the term is used more narrowly to refer to suprapubic cystostomy or suprapubic catheterization.

**74. A client sustained burns on the back. These areas appear dry, blotchy cherry red, blistering, doesn't blanch, no capillary refill, and reduced or absent sensation. This type of burn depth is classified as?**

- A. Superficial partial-thickness burn
- B. Superficial dermal
- C. Deep partial-thickness burn

D. Full-thickness burn

**Correct Answer: C. Deep partial-thickness burn**

Deep partial-thickness burn: blistering, dry, blotchy cherry red, doesn't blanch, no capillary refill, and reduced or absent sensation. Generally, heals in 3-6 weeks, but scar formation results and skin grafting may be required.

- **Option A:** Superficial partial-thickness: red, glistening, pain, absence of blisters, and brisk capillary refill. Not life-threatening and normally heals within a week, without scarring. Superficial burns (first degree) involve only the epidermis and are warm, painful, red, soft, and blanch when touched. Usually, there is no blistering. A typical example is a sunburn.
- **Option B:** Pale pink or mottled appearance with associated swelling and small blisters. A wet, shiny, and weeping surface is also a characteristic. Brisk capillary refill.
- **Option D:** Full-thickness: dry, white, or black, no blisters, absent capillary refill, and absent sensation. Requires surgical repair and grafting. Full-thickness burns (third degree) extend through both the epidermis and dermis and into the subcutaneous fat or deeper. These burns have little or no pain, can be white, brown, or charred, and feel firm and leathery to palpation with no blanching.

**75. Which action(s) should you delegate to the experienced nursing assistant when caring for a patient with a thrombotic stroke with residual left-sided weakness? Select all that apply.**

- A. Assist the patient to reposition every 2 hours.
- B. Reapply pneumatic compression boots.
- C. Remind the patient to perform active ROM.
- D. Check extremities for redness and edema.

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

The experienced nursing assistant would know how to reposition the patient and how to reapply compression boots and would remind the patient to perform activities he has been taught to perform.

- **Option D:** Assessing for redness and swelling (signs of deep venous thrombosis {DVT}) requires additional education and is still appropriate to the professional nurse.

**76. A family member expresses concern to a nurse about behavioral changes in an elderly aunt. Which would cause the nurse to suspect a cognitive impairment disorder?**

- A. Decreased interest in activities that she once enjoyed.
- B. Fearfulness of being alone at night.
- C. Increased complaints of physical ailments.
- D. Problems with preparing a meal or balancing her checkbook.

**Correct Answer: D. Problems with preparing a meal or balancing her checkbook.**

Making a meal and balancing a checkbook are higher-level cognitive functions that, when unable to be performed, may signal onset of a cognitive disorder. Dementia is a disorder that is characterized by

cognitive decline involving memory and at least 1 of the other domains, including personality, praxis, abstract thinking, language, executive functioning, complex attention, social and visuospatial skills. In addition to the noted decline, the severity must be significant enough to interfere with daily functionality. It is often a progressive disorder, and individuals often do not have insight into their deficits.

- **Option A:** Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease the ability to function at work and at home. Depression affects an estimated one in 15 adults (6.7%) in any given year. And one in six people (16.6%) will experience depression at some time in their life. Depression can occur at any time, but on average, first appears during the late teens to mid-20s.
- **Option B:** Autophobia is considered a situational phobia. This means that the situation of being alone or loneliness causes extreme distress. To be diagnosed with autophobia, the fear of being alone causes you so much anxiety that it interferes with daily routine.
- **Option C:** Somatic symptom disorder is characterized by an extreme focus on physical symptoms — such as pain or fatigue — that cause major emotional distress and problems functioning. The client may or may not have another diagnosed medical condition associated with these symptoms, but the reaction to the symptoms is not normal.

**77. The client with GERD complains of a chronic cough. The nurse understands that in a client with GERD this symptom may be indicative of which of the following conditions?**

- A. Development of laryngeal cancer.
- B. Irritation of the esophagus.
- C. Esophageal scar tissue formation.
- D. Aspiration of gastric contents.

**Correct Answer: D. Aspiration of gastric contents**

Clients with GERD can develop pulmonary symptoms such as coughing, wheezing, and dyspnea that are caused by the aspiration of gastric contents. It is frequently thought that GERD plays a big role in chronic cough; there are reports that 25% or more of chronic cough cases are associated with GERD.

- **Option A:** GERD does not predispose the client to the development of laryngeal cancer. The most intuitive theory is called the reflux theory, whereby reflux rises above the esophagus and upper esophageal sphincter, resulting in microaspiration as microdroplets land in the larynx or occasionally enter the bronchial tree, directly causing cough as a protective mechanism against reflux.
- **Option B:** Irritation of the esophagus can develop as a result of GERD. However, GERD is more likely to cause painful and difficult swallowing. In the reflux theory, because of the common embryologic origin of the respiratory tract and the digestive tract, a little bit of reflux in the esophagus can lead to an esophagobronchial reflex that causes cough.
- **Option C:** Esophageal scar tissue formation can develop as a result of GERD. GERD occurs in approximately 20% of Americans, and chronic cough is a very common problem, which patients with GERD are not immune to developing. Due to the baseline GERD rate of 20%, it is difficult to separate the presence of the disorder from the causative effect of the disorder.

**78. Which of the following drugs can cause severe hematologic disorders?**

- A. digoxin (Lanoxin)
- B. quinidine (Cardioquin)
- C. disopyramide (Norpace)
- D. procainamide (Pronestyl)

**Correct Answer: D. procainamide (Pronestyl)**

Pronestyl is known for this serious side effect. Associate Pronestyl with plasma — P and P. This drug is known for its hematologic side effects. Procainamide is known to cause certain blood dyscrasias. Procainamide has been known to cause bone marrow toxicity, leading to pancytopenia or agranulocytosis; this is usually due to hypersensitivity or varied immunologic mechanisms

- **Option A:** Digoxin comes from the foxgloves plant known as *Digitalis purpurea*. It is a cardiotonic glycoside and belongs to the digitalis class. It increases the force of contraction of the heart by reversibly inhibiting the activity of the myocardial Na-K ATPase pump, an enzyme that controls the movement of ions into the heart. Digoxin has vagomimetic effects on the AV node.
- **Option B:** Quinine is a derivative of the bark of the South American cinchona tree. Quinidine is a stereoisomer of quinine; it is a “class 1a antiarrhythmic drug” and also an antimalarial agent. Class 1a antiarrhythmic agents (for example – quinidine, procainamide, disopyramide, ajmaline) work by inhibiting the fast inward sodium current, depressing the phase 0 of the action potential hence dampening the excitability of cardiac muscles which in turn prolongs the action potential and decreases automaticity.
- **Option C:** Despite rarely used now for heart rhythm abnormalities because of the availability of newer drugs that provided better efficacy and favorable side effect profiles, disopyramide is still the drug of choice for vagally mediated atrial fibrillation such as sleep-induced or atrial fibrillation in athlete groups. The effectiveness of disopyramide in these conditions is due to its anticholinergic activity that abolished parasympathetic tone.

**79. The client with a benign lung tumor is treated in which of the following ways?**

- A. The tumor is removed, involving the least possible amount of tissue
- B. The tumor is left alone unless symptoms are present
- C. The tumor is treated with radiation only
- D. The tumor is treated with chemotherapy only

**Correct Answer: A. The tumor is removed, involving the least possible amount of tissue**

- **Option A:** The tumor is removed to prevent further compression of the lung tissue as the tumor grows, which could lead to respiratory decompensation.
- **Options B, C, and D:** If for some reason it can't be removed, then radiation or chemotherapy may be used to try to shrink the tumor.

**80. A mother asks the nurse how to handle her 5-year-old child, who recently started wetting the pants after being completely toilet trained. The child just started attending nursery school 2 days a week. Which principle should guide the nurse's response?**

- A. The child forgets previously learned skills
- B. The child experiences growth while regressing, regrouping, and then progressing
- C. The parents may refer less mature behaviors
- D. The child returns to a level of behavior that increases the sense of security.

**Correct Answer: D. The child returns to a level of behavior that increases the sense of security.**

The stress of starting nursery school may trigger a return to a level of successful behavior from earlier stages of development. Parents may notice a change in their child's bathroom behaviors. They'll want to observe if the child is going more frequently or having accidents.

- **Option A:** A child's skills remain intact, although increased stress may prevent the child from using these skills. When they're scared or nervous, they may actually feel sick or behave in ways that are not typical for them. That may be how they tell parents that something is bothering them.
- **Option B:** Growth occurs when the child does not regress. When talking about starting school, reassure the child that school is a fun and safe space. Offer a reminder that the child will get to meet new friends and participate in fun games and activities.
- **Option C:** Parents rarely desire less mature behaviors. Let the child know that it's normal to feel anxious about starting school. Acknowledging fears can be helpful. Providing the child with positive praise for coping with nervousness will help with building good coping skills.

**81. A nurse is working in the hematology ward and is administering a blood transfusion to a 40-year-old patient with chronic anemia due to a genetic condition. The patient, who is a biology teacher, is curious about the physiology of red blood cells and asks, "Considering the turnover and production of red blood cells in my body, how long does a typical red blood cell live?" Given the patient's background and the context, which of the following responses is accurate?**

- A. "The average lifespan of a red blood cell (RBC) is about 45 days, after which it is broken down."
- B. "Red blood cells typically survive for around 60 days in the circulatory system."
- C. "Most red blood cells have a life span of approximately 90 days before they are replaced."
- D. "A red blood cell generally has a lifespan of 120 days in the body."
- E. "The longevity of red blood cells can vary, but it's usually around 150 days."
- F. "Red blood cells continuously regenerate and can live indefinitely in the body."

**Correct Answer: D. "A red blood cell generally has a lifespan of 120 days in the body."**

Red blood cells (RBCs), or erythrocytes, have a typical life span of about 120 days in the human body. After this period, they are removed from the circulation and broken down in the spleen and liver. The components are then recycled to produce new RBCs in the bone marrow. This continuous process ensures that the body has an adequate supply of fresh RBCs to transport oxygen to tissues.

**82. Baroreceptors in the carotid artery walls and aorta respond to which of the following conditions?**

- A. Changes in blood pressure.
- B. Changes in arterial oxygen tension.
- C. Changes in arterial carbon dioxide tension.
- D. Changes in heart rate.

**Correct Answer: A. Changes in blood pressure.**

Baroreceptors located in the carotid arteries and aorta sense pulsatile pressure. Baroreceptors are a type of mechanoreceptor allowing for the relay of information derived from blood pressure within the autonomic nervous system. Information is then passed in rapid sequence to alter the total peripheral resistance and cardiac output maintaining blood pressure within a preset, normalized range.

- **Option B:** Peripheral chemoreceptors in the aorta and carotid arteries are primarily stimulated by oxygen. Peripheral chemoreceptors include the carotid and aortic bodies. The carotid bodies are located at the bifurcation of the common carotid arteries and send information to the respiratory center via cranial nerve IX, the glossopharyngeal nerve. The aortic bodies are situated within the aortic arch, and send information to the brain via cranial nerve X, the vagus nerve. While capable of sensing carbon dioxide and hydrogen ions, the peripheral sensory system primarily detects low arterial oxygen levels (hypoxemia).
- **Option C:** Chemoreceptors in the medulla are primarily stimulated by carbon dioxide. Carbon dioxide is a lipid-soluble molecule that freely diffuses across the blood-brain barrier and forms hydrogen ions within the cerebrospinal fluid. Chemoreceptors, in turn, respond to pH changes as they become more acidic and send sensory input to the brain to stimulate hyperventilation. The result is a slow and deep breathing pattern that helps eliminate carbon dioxide from the body.
- **Option D:** Decreases in pulsatile pressure cause a reflex increase in heart rate. Pulse pressure has been previously correlated with arterial compliance and with hemodynamic factors such as stroke volume and peak aortic blood flow. Left ventricular systolic dysfunction reduces stroke volume and therefore also PP and systolic BP.

**83. A client is admitted with a venous stasis leg ulcer. A nurse assesses the ulcer, expecting to note that the ulcer:**

- A. Has a pale colored base.
- B. Is deep, with even edges.
- C. Has little granulation tissue.
- D. Has brown pigmentation around it.

**Correct Answer: D. Has brown pigmentation around it.**

Venous leg ulcers, also called stasis ulcers, tend to be more superficial than arterial ulcers, and the ulcer bed is pink. The edges of the ulcer are uneven, and granulation tissue is evident. The skin has a brown pigmentation from the accumulation of metabolic waste products resulting from venous stasis. The client also exhibits peripheral edema.

- **Option A:** Necrotic-base ulcers have a black appearance and are non-viable, indicating a peripheral arterial disease or an infection. Fibrotic-base ulcers have a white to yellowish stringy appearance and tend to halt the formation of the granulation tissue. Granular-base ulcers have a beefy red appearance and indicate a positive healing potential.



- **Option B:** In the visual assessment of the wound, we are looking for any possible erythemas, edema, fluid discharges, crepitations, or abscess collections. Inspect wound edges for any possible formation of hyperkeratotic tissues which tends to halt the tissue healing. A hyperkeratotic border results from increased stress on the tissue; therefore, the focal pressure should be evaluated.
- **Option C:** This is due to tissue malnutrition, and thus an arterial problem. Quantitative measurements should be checked at every clinic visit. A comparison of the wound dimensions, including the width, length, and depth over time allows for the evaluation of the wound contracture. Ulceration discharge cultures can be obtained to target antibiotic therapy in the presence of an infection.

**84. When providing care to clients with varied cultural backgrounds, it is imperative for the nurse to recognize that:**

- A. Cultural considerations must be put aside if basic needs are in jeopardy.
- B. Generalizations about the behavior of a particular group may be inaccurate.
- C. Current health standards should determine the acceptability of cultural practices.
- D. Similar reactions to stress will occur when individuals have the same cultural background.

**Correct Answer: B. Generalizations about the behavior of a particular group may be inaccurate.**

Nurses can pay close attention to their own biases and how they react to people whose backgrounds and cultural experiences differ from their own. For example, a person who becomes conscious that they think of immigrants as illegal aliens achieves cultural awareness of that particular bias.

- **Option A:** Often, individual beliefs and values do not correspond to their behavior and actions. Nurses can work to acknowledge that this disconnect exists and view knowledge as an important element of developing cultural competence. Research has shown that people who score low on prejudice tests may still use labels such as “illegal alien.”
- **Option C:** Nurses put their awareness, attitude, and knowledge into practice by repeating culturally competent behaviors until they become integrated into their daily interactions. These behaviors include effective and respectful communication and body language. Among various cultures, nonverbal communication methods, such as gestures, can mean very different things.
- **Option D:** Once nurses tap into awareness, they can actively analyze their increased awareness and internal belief systems. Using the above example, the person can examine their background, beliefs, and values to understand their cultural bias regarding immigrants.

**85. The twelve-year-old boy has fractured his arm because of a fall from his bike. After the injury has been casted, the nurse knows it is most important to perform all of the following assessments on the area distal to the injury except:**

- A. capillary refill.
- B. radial and ulnar pulse.
- C. finger movement.
- D. skin integrity.

**Correct Answer: D. Skin integrity**

Capillary refill, pulses, and skin temperature and color are indicative of intact circulation and absence of compartment syndrome. Skin integrity is less important. Check the edges of the cast and all skin areas where the cast edges may cause pressure. If there are signs of edema or circulatory impairment, notify the charge nurse or physician immediately.

- **Option A:** Assess circulation by performing the blanching test and comparing the skin temperature and blanching reaction of the affected limb to that of the unaffected limb. Assess the presence of sensation in the affected limb by touching exposed areas of skin and instructing the patient to describe what he felt.
- **Option B:** Report any danger signs to the nursing staff immediately. Danger signs include pale, cold fingers or toes, tingling, numbness, increased pain, pressure spots, odor, or feeling that the cast has become too tight.
- **Option C:** Assess the motor ability of the affected limb by having the patient wiggle his fingers or toes. Lean down and smell the cast to detect odors indicating tissue damage. A musty or moldy odor at the surface of the cast may be the first indication that necrosis from pressure has developed underneath.