

# Kevin's Review - 85 NCLEX Practice Questions

**1. She tearfully tells the nurse “I can’t take it when she accuses me of stealing her things.” Which response by the nurse will be most therapeutic?**

- A. “Don’t take it personally. Your mother does not mean it.”
- B. “Have you tried discussing this with your mother?”
- C. “This must be difficult for you and your mother.”
- D. “Next time ask your mother where her things were last seen.”

**Correct Answer: C. “This must be difficult for you and your mother.”**

This reflects the feeling of the daughter that shows empathy. Provide client support. Offer support and empathy when a client expresses embarrassment at inability to remember people, events, and places. Interventions tend to focus on helping these patients and their family and caregivers cope and adapt to the condition, and furthermore, to help patients function independently within their context. Rehabilitation approaches need to be individualized and should focus on the specific deficit by developing compensatory strategies.

- **Option A:** Encourage expression of feelings. Encourage the client to express honest feelings in relation to loss of prior level of functioning; acknowledge the pain of loss; support the client through the process of grieving. Assist with memory deficit. Devise methods in assisting the client with memory deficit; these aids may assist the client to function more independently, thereby increasing self-esteem.
- **Option B:** This response does not encourage the verbalization of feelings. Encourage communication. Encourage client’s attempts to communicate; if verbalizations are not understandable, express to the client what you think he or she intended to say. Encourage the client to be as independent as possible in self-care activities; provide a written schedule of tasks to be performed.
- **Option D:** Giving advice does not encourage verbalization. Reminisce events with the client. Encourage reminiscence and discussion of life review; also encourage discussion of present-day events; sharing picture albums, if possible, is especially good. Encourage participation in group activities; caregiver may need to accompany client at first, until he or she feels secure that group members will be accepting, regardless of limitations in verbal communication.

**3. Jayson, 1-year-old child, has a staph skin infection. Her brother has also developed the same infection. Which behavior by the children is most likely to have caused the transmission of the organism?**

- A. Sharing pacifiers
- B. Coughing on each other
- C. Bathing together
- D. Eating off the same plate

**Correct Answer: C. Bathing together.**

Direct contact is the mode of transmission for staphylococcus. *S. aureus* are one the most common bacterial infections in humans and are the causative agents of multiple human infections, including bacteremia, infective endocarditis, skin and soft tissue infections (e.g., impetigo, folliculitis, furuncles, carbuncles, cellulitis, scalded skin syndrome, and others), osteomyelitis, septic arthritis, prosthetic device infections, pulmonary infections (e.g., pneumonia and empyema), gastroenteritis, meningitis,

toxic shock syndrome, and urinary tract infections.

- **Option A:** *S. aureus* does not normally cause infection on healthy skin, however, if it is allowed to enter the internal tissues or bloodstream, these bacteria may cause a variety of potentially serious infections. Depending on the strains involved and the site of infection, these bacteria can cause invasive infections and/or toxin-mediated diseases.
- **Option B:** *S. aureus* is not spread through droplets or airborne means. *Staphylococcus aureus* (including drug-resistant strains such as MRSA) are found on the skin and mucous membranes, and humans are the major reservoir for these organisms. It is estimated that up to half of all adults are colonized, and approximately 15% of the population persistently carry *S. aureus* in the anterior nares.
- **Option D:** Prevention of *S. aureus* infections remains challenging. Despite many efforts, a routine vaccination for *S. aureus* infections has remained elusive. As a result, efforts have relied on infection control methods such as hospital decontamination procedures, handwashing techniques, and MRSA transmission prevention guidelines.

**4. The doctor has prescribed Cortisone (cortisone) for a child with systemic lupus erythematosus. Which instruction should be given to the client?**

- A. Take the medication 30 minutes before eating
- B. Report changes in appetite and weight
- C. Wear sunglasses to prevent cataracts
- D. Schedule a time to take the influenza vaccine

**Correct Answer: D. Schedule a time to take the influenza vaccine**

- Option D: Long-term use of steroids can increase the risk of infection, the client taking steroid medication should receive an annual influenza vaccine (inactivated vaccine).
- Option A: The medication should be taken with food.
- Option B: Increased appetite and weight gain are expected side effects of the medication.
- Option C: Wearing sunglasses will not prevent cataracts.

**5. During the nursing history, which assessment data would the nurse expect the client scheduled for surgical correction of chronic open-angle glaucoma to report?**

- A. Seeing flashes of lights and floaters.
- B. Recent motor vehicle crash while changing lanes.
- C. Complaints of headaches, nausea, and redness of the eyes.
- D. Increasingly frequent episodes of double vision.

**Correct Answer: B. Recent motor vehicle crash while changing lanes.**

Typically, the client with chronic open-angle glaucoma experiences a gradual loss in peripheral vision leading to tunnel vision. Being involved in a motor vehicle crash while changing lanes suggests the disorder. The client may experience insidious blurring, decreased accommodation, mild aching eyes

and, eventually, halos around the lights as intraocular pressure increases.

- **Option A:** Flashes of light and floaters are characteristic of retinal detachment. Patients with a rhegmatogenous retinal detachment may present with a history of a large number of new-onset floaters. They may also have significant photopsia (flashes of light) in their vision.
- **Option C:** Nausea, headache, and eye redness are seen with an episode of acute (sudden) closed-angle closure. Acute angle-closure glaucoma presents as a sudden onset of severe unilateral eye pain or a headache associated with blurred vision, rainbow-colored halos around bright lights, nausea, and vomiting.
- **Option D:** Double vision occurs when one eye has a lens and the other is aphakic. When evaluating a diplopic patient, one has to first determine whether diplopia is monocular or binocular. While this has already been mentioned above, it is of paramount importance as skipping this step will lead to unnecessary investigations and anxiety for the patient.

**6. The nurse is monitoring a client receiving peritoneal dialysis and the nurse notes that a client's outflow is less than the inflow. Which of the following actions will the nurse take. Select all that apply.**

- A. Place the client in good body alignment.
- B. Check the level of the drainage bag.
- C. Contact the physician.
- D. Check the peritoneal dialysis system for kinks.
- E. Reposition the client to his or her side.

**Correct Answers: A, B, D, & E.**

Maintain a record of inflow and outflow volumes and cumulative fluid balance. In most cases, the amount drained should equal or exceed the amount instilled. A positive balance indicates a need of further evaluation.

- **Option A:** If outflow drainage is inadequate, the nurse attempts to stimulate outflow by changing the client's position. Assess the patency of catheter, noting difficulty in draining. Note the presence of fibrin strings and plugs. Slowing of flow rate and presence of fibrin suggests partial catheter occlusion requiring further evaluation and intervention.
- **Option B:** The drainage bag needs to be lower than the client's abdomen to enhance gravity drainage. Improper functioning of equipment may result in retained fluid in the abdomen and insufficient clearance of toxins.
- **Option C:** There is no reason to contact the physician. Evaluate development of tachypnea, dyspnea, increased respiratory effort. Drain dialysate, and notify the physician. Abdominal distension and diaphragmatic compression may cause respiratory distress.
- **Option D:** The connecting tubing and the peritoneal dialysis system is also checked for kinks or twisting and the clamps on the system are checked to ensure that they are open. Check tubing for kinks; note placement of bottles and bags. Anchor catheter so that adequate inflow/outflow is achieved.
- **Option E:** Turning the client to the other side or making sure that the client is in good body alignment may assist with outflow drainage. Turn from side to side, elevate the head of the bed, apply gentle pressure to the abdomen. May enhance outflow of fluid when the catheter is malpositioned and obstructed by the omentum.

**7. Which of the following actions is not appropriate in the care of a 2-month-old infant?**

- A. Place the infant on her back for naps and bedtime.
- B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.
- C. Talk to the infant frequently and make eye contact to encourage language development.
- D. Wait until at least 4 months to add infant cereals and strained fruits to the diet.

**Correct Answer: B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.**

Infants under 6 months may not be able to sleep for long periods because their stomachs are too small to hold adequate nourishment to take them through the night. After 6 months, it may be helpful to let babies put themselves back to sleep after waking during the night, but not prior to 6 months. By 6 months of age, most babies are physiologically capable of sleeping through the night and no longer require nighttime feedings. However, 25%-50% continue to awaken during the night. When it comes to waking during the night, the most important point to understand is that all babies wake briefly between four and six times. Babies who are able to soothe themselves back to sleep ("self-soothers") awaken briefly and go right back to sleep.

- **Option A:** Infants should always be placed on their backs to sleep. Research has shown a dramatic decrease in sudden infant death syndrome (SIDS) with back sleeping. Babies should always sleep Alone, on their Backs, in a Crib. Place your baby on his or her back for every sleep, night time and nap time. Do not put your baby to sleep on his side or tummy. Once your baby can roll from his back to tummy and tummy to back, your baby can stay in the sleep position that he assumes. But always place your baby to sleep on his back.
- **Option C:** Eye contact and verbal engagement with infants are important to language development. Establish a consistent bedtime routine that includes calm and enjoyable activities that you can stick with as your baby gets older. Examples include a bath and bedtime stories. The activities occurring closest to "lights out" should occur in the room where your baby sleeps. Also, avoid making bedtime feedings part of the bedtime routine after 6 months.
- **Option D:** The best diet for infants under 4 months of age is breast milk or infant formula. The American Academy of Pediatrics recommends exclusive breastfeeding for about 6 months, and then continuing breastfeeding while introducing complementary foods until the child is 12 months old or older. This provides the child with ideal nutrition and supports growth and development.

**8. The nurse is assessing a male client 24 hours following a cholecystectomy. The nurse noted that the T-tube has drained 750 mL of green-brown drainage since the surgery. Which nursing intervention is appropriate?**

- A. Clamp the T-tube
- B. Irrigate the T-tube
- C. Notify the physician
- D. Document the findings

**Correct Answer: D. Document the findings.**

Following cholecystectomy, drainage from the T-tube is initially bloody and then turns to a greenish-brown color. The drainage is measured as output. The amount of expected drainage will range from 500 to 1000 mL/day. The nurse would document the output. The fluid may appear bloody for the first day or 2. The color will eventually be golden yellow or greenish, depending on exactly where the catheter is inside the body.

- **Option A:** The doctor may order the t-tube to be clamped at times so bile can drain to the duodenum so fats can be digested during meal times. If choledocholithiasis persists, the T-tube can be clamped to promote stone passage. If signs or symptoms of cholangitis occur, the tube can be unclamped and repeat imaging is obtained.
- **Option B:** The client will need to flush the catheter with normal saline twice a day. If the doctor instructed to flush with less than 10 mL, squirt the extra saline out before connecting the syringe. Push the plunger of the syringe to push 1/3 of the normal saline into the catheter, and then pause. Push in another 1/3 of the normal saline, and pause again. Push in the rest of the normal saline into the catheter. Never pull back on the plunger.
- **Option C:** Notify the physician if the drainage is more than 500 mL/day. Watch for extremely thick, bad-smelling drainage with a fever or extremely bloody like bright red blood that looks fresh. Assess how well the patient tolerated the t-tube being clamped. If the patient develops abdominal pain, nausea, vomiting, etc. unclamp it and notify the physician.

**9. An elderly man is admitted to the hospital. He was alert and oriented during the admission interview. However, his family states that he becomes disruptive and disoriented around dinnertime. One night he was shouting furiously and didn't know where he was. He was sedated and the next morning he was fine. At dinnertime, the disruptive behavior returned. The client is diagnosed as having sundown syndrome. The client's son asks the nurse what causes sundown syndrome. The nurse's best response is that it is attributed to**

- A. An underlying depression
- B. Inadequate cerebral flow
- C. Changes in the sensory environment
- D. Fluctuating levels of oxygen exchange

**Correct Answer: C. Changes in the sensory environment**

Because the confusion occurs at sundown, the cause probably changes in the sensory environment. Sundown syndrome is related to environmental and sensory abnormalities that lead to acute confusion. The evaluation and management of altered mental status are broad and require careful history and physical examination to eliminate life-threatening situations. Changes in consciousness can be categorized into changes of arousal, the content of consciousness, or a combination of both. Arousal includes wakefulness and/or alertness and can be described as hypoactivity or hyperactivity, while changes in the content of consciousness can lead to changes in self-awareness, expression, language, and emotions

- **Option A:** An underlying depression does not cause sundown syndrome. Depression is characterized by personal withdrawal, slowed speech, or poor results of a cognitive test. Patients rarely have a rapid fluctuation of symptoms and are usually oriented and able to follow commands. When eliciting a history from a patient who presents for altered mental status, it is important to

obtain information both from the patient and from collateral sources (e.g., parents, children, friends, emergency management services, bystanders, the patient's primary physician). This information can provide more insight regarding the chronicity of the change, precipitating factors, exacerbating or relieving factors, and recent as well as chronic medical history.

- **Option B:** There is not sufficient evidence to suggest he has inadequate cerebral blood flow. Delirium is typically an acute confusional state, defined by impairment of attention or cognition that usually develops over hours to days. Some patients may experience rapid fluctuations between hypoactive and hyperactive states, that may be interjected with periods of intermittent lucidity. A nearly pathognomonic characteristic of delirium is sleep-wake cycle disruption, which leads to "sundowning," a phenomenon in which delirium becomes worse or more persistent at night
- **Option D:** Fluctuating levels of oxygen exchange do not cause sundown syndrome. The ascending reticular activating system is the anatomic structure that mediates arousal. Neurons of the ascending reticular activating system are located in the midbrain, pons, and medulla, and control arousal from sleep. Metabolic conditions, likely hypoglycemia or hypoxia, can decrease acetylcholine synthesis in the central nervous system, which correlates with the severity of delirium.

**10. The client admitted for alcohol detoxification develops increased tremors, irritability, hypertension, and fever. The nurse should be alert for impending:**

- A. Delirium tremens
- B. Korsakoff's syndrome
- C. Esophageal varices
- D. Wernicke's syndrome

**Correct Answer: A. Delirium tremens**

Delirium tremens is the most extreme central nervous system irritability due to withdrawal from alcohol. Delirium tremens was first recognized as a disorder attributed to excessive alcohol abuse in 1813. It is now commonly known to occur as early as 48 hours after abrupt cessation of alcohol in those with chronic abuse and can last up to 5 days. It has an anticipated mortality of up to 37% without appropriate treatment. It is crucial to identify early signs of withdrawal because it can become fatal.

- **Option B:** This refers to an amnesic syndrome associated with chronic alcoholism due to a deficiency in Vit. B. While there is no consensus for the actual definition of Korsakoff syndrome, it is generally agreed to be a chronic neuropsychiatric syndrome due to thiamine (vitamin B1) deficiency. Damage to multiple areas on the brain leads to amnesia and confusion. While classically associated with chronic alcohol use, Korsakoff syndrome can be the result of other processes that ultimately lead to thiamine deficiency. Korsakoff syndrome is most often seen in the context of chronic alcohol abuse and thought to be on the spectrum with Wernicke encephalopathy.
- **Option C:** This is a complication of liver cirrhosis which may be secondary to alcoholism. Esophageal varices are dilated submucosal distal esophageal veins connecting the portal and systemic circulations. This happens due to portal hypertension (most commonly a result of cirrhosis), resistance to portal blood flow, and increased portal venous blood inflow. The most common fatal complication of cirrhosis is variceal rupture; the severity of liver disease correlates with the presence of varices and risk of bleeding.
- **Option D:** This is a complication of alcoholism characterized by irregularities of eye movements and lack of coordination. Wernicke's syndrome, also known as Wernicke encephalopathy, is a neurological disease characterized by the clinical triad of confusion, the inability to coordinate voluntary movement (ataxia), and eye (ocular) abnormalities.

**11. All potassium-sparing diuretics:**

- A. Are required supplements during blood transfusion.
- B. Enhance aldosterone action.
- C. Cause hypokalemia.
- D. Are weak diuretics.

**Correct Answer: D. Are weak diuretics.**

Potassium-sparing diuretics are not potent diuretics when used alone. They are used as adjunctive therapy with other diuretics to minimize potassium loss. Potassium-sparing diuretics, which include amiloride (Midamor), spironolactone (Aldactone), and eplerenone (Inspra), avoid the potential problem of potassium loss. But the opposite problem can occur. If potassium levels become too high, it can cause dangerous heart rhythm problems and even cardiac arrest.

- **Option A:** Potassium-sparing diuretics given during blood transfusions tend to cause hyperkalemia because potassium is present in the transfusion.
- **Option B:** These drugs block aldosterone's effects. Potassium-sparing diuretics, which include amiloride (Midamor), spironolactone (Aldactone), and eplerenone (Inspra), avoid the potential problem of potassium loss. But the opposite problem can occur. If potassium levels become too high, it can cause dangerous heart rhythm problems and even cardiac arrest.
- **Option C:** These drugs cause hyperkalemia, not hypokalemia. People with high blood pressure or heart failure are often advised to limit how much salt or sodium they consume. One way to do that is to use salt substitutes, but these products are high in potassium—a quarter teaspoon of one brand contains about 800 mg of potassium. So, people who take potassium-sparing diuretics should avoid these products.

**12. The pain of a duodenal ulcer can be distinguished from that of a gastric ulcer by which of the following characteristics?**

- A. Early satiety
- B. Pain on eating
- C. Dull upper epigastric pain
- D. Pain on an empty stomach

**Correct Answer: D. Pain on an empty stomach**

Pain on an empty stomach is relieved by taking foods or antacids. The location of the disease can also be differentiated based on symptoms. The pain associated with duodenal ulcers improves after meals, while the pain associated with gastric ulcers generally intensifies after meals. The other symptoms are those of a gastric ulcer.

- **Option A:** Early satiety is seen in gastric ulcers. The mechanism by which *H. pylori* predisposes individuals is unclear. However, the thinking is that *H. pylori* colonization and persistent inflammation lead to the weakening of the mucosal surface layer causing it to be vulnerable to exposure to gastric acid.

- **Option B:** The typical presentation of a patient with gastric ulcers is epigastric pain that is worse with eating. It often correlates with mild nausea and early satiety. They often describe this pain as a sharp or burning type of pain that typically doesn't radiate.
- **Option C:** The most common finding on the physical exam is epigastric tenderness. These symptoms may continue for weeks or months before patients seek medical help. Patients may present with upper GI bleeding.

**13. Which stage of development is most unstable and challenging regarding the development of personal identity?**

- A. Adolescence
- B. Toddlerhood
- C. Middle Childhood
- D. Young adulthood

**Correct Answer: A. Adolescence**

Although it occurs throughout one's lifetime, identity development is considered to be the primary psychosocial task of adolescence or as described by Erickson on identity versus identity confusion. Individuals in this stage start to integrate their values, abilities, inner drives, and past experiences into who they are as persons.

- **Option B:** Toddlers at their age focus on developing their physical, emotional, cognitive, language, and motor skills. Gaining a sense of personal control over the world is important at this stage of development. Children at this age are becoming increasingly independent and want to gain more control over what they do and how they do it.
- **Option C:** Middle childhood is a stage where children learn skills that will help them build social relationships that will prepare them for adolescence. A child's social world expands considerably as they enter school and gain new friendships with peers. Through social interactions, children begin to develop a sense of pride in their accomplishments and abilities.
- **Option D:** Young adulthood would focus on building intimate and loving relationships with other people. Romantic and sexual relationships can be an important part of this stage of life, but intimacy is more about having close, loving relationships. It includes romantic partners, but it can also encompass close, enduring friendships with people outside of the family.

**14. Aubrey thinks about primary nursing as a system to deliver care. Which of the following activities is not done by a primary nurse?**

- A. Collaborates with the physician.
- B. Provides care to a group of patients together with a group of nurses.
- C. Provides care for 5-6 patients during their hospital stay.
- D. Performs comprehensive initial assessment.

**Correct Answer: B. Provides care to a group of patients together with a group of nurses.**

This function is done in team nursing where the nurse is a member of a team that provides care for a group of patients. Primary care nursing is when a single nurse is identified as the point of contact and primary caregiver for a patient during his or her particular hospital stay or other episodes of care. As



envisioned by staff nurses at the University of Minnesota in 1969, the primary care nursing team is composed of that lead nurse, who directly supervises the engagement of a licensed practical nurse and/or nursing assistant in that patient's care.

- **Option A:** Further, the primary care nurse acts as a care partner, serving as a communications liaison between the patient and his or her doctor and other care team members. (In many facilities and systems, the position of nurse practitioner has been created to fulfill this role.)
- **Option C:** The primary nursing model is hailed by proponents as creating a better bond and trust relationship between patients and caregivers, thanks to that single-source relationship. They say that the patient's care is elevated by having that single nurse overseeing its delivery and that its structure empowers the nurse to utilize managerial abilities as well as deploy their best bedside care.
- **Option D:** Primary health care (PHC) is a principle-based, comprehensive approach. It focuses on the way services are delivered, from birth to death, across the continuum of care in all settings.

**15. You are supervising a student nurse who is performing tracheostomy care for a patient. For which action by the student should you intervene?**

- A. Suctioning the tracheostomy tube before performing tracheostomy care
- B. Removing old dressings and cleaning off excess secretions
- C. Removing the inner cannula and cleaning using universal precautions
- D. Replacing the inner cannula and cleaning the stoma site.
- E. Changing the soiled tracheostomy ties and securing the tube in place.

**Correct Answer: C. Removing the inner cannula and cleaning using universal precautions**

When tracheostomy care is performed, a sterile field is set up and sterile technique is used. Standard precautions such as washing hands must also be maintained but are not enough when performing tracheostomy care. The presence of a tracheostomy tube provides direct access to the lungs for organisms, so sterile technique is used to prevent infection. All of the other steps are correct and appropriate.

- **Option A:** Suctioning of the tracheostomy tube is necessary to remove mucus, maintain a patent airway, and avoid tracheostomy tube blockages. The frequency of suctioning varies and is based on individual patient assessment. It is recommended that the episode of suctioning (including passing the catheter and suctioning the tracheostomy tube) is completed within 5-10 seconds.
- **Option B:** The tracheal stoma in the immediate post-operative period requires regular assessment and wound management including once daily dressing change following cleaning of the stoma area or more frequently if required.
- **Option D:** Care of the stoma is commenced in the immediate postoperative period, and is ongoing. Clean stoma with cotton wool applicator sticks moistened with 0.9% sodium chloride. Use each cotton wool applicator stick once only taking it from one side of the stoma opening to the other and then discard in waste.
- **Option E:** The frequency of a tracheostomy tube changes is determined by the Respiratory and ENT teams except in an emergency situation. This can vary depending on the patient's individual needs and tracheostomy tube type. It is imperative that the first tracheostomy tube change is performed with both nursing and medical staff who are competent in tracheostomy management and the tracheostomy kit is available at the bedside.

**16. A 20-year-old client was diagnosed with dependent personality disorder. Which behavior is not most likely to be evidence of ineffective individual coping?**

- A. Recurrent self-destructive behavior.
- B. Avoiding relationships.
- C. Showing interest in solitary activities.
- D. Inability to make choices and decisions without advice.

**Correct Answer: D. Inability to make choices and decision without advice**

Individuals with dependent personality disorder typically show indecisiveness, submissiveness, and clinging behavior so that others will make decisions with them. Dependent personality disorder (DPD) is a type of anxious personality disorder. People with DPD often feel helpless, submissive or incapable of taking care of themselves. They may have trouble making simple decisions. But, with help, someone with a dependent personality can learn self-confidence and self-reliance.

- **Option A:** Self-destructive behaviors are those that are bound to harm you physically or mentally. It may be unintentional. Or, it may be that you know exactly what you're doing, but the urge is too strong to control. It may be due to earlier life experiences. It can also be related to a mental health condition, such as depression or anxiety. Self-destructive behavior is when you do something that's sure to cause self-harm, whether it's emotional or physical.
- **Option B:** People with DPD have an overwhelming need to have others take care of them. Often, a person with DPD relies on people close to them for their emotional or physical needs. Others may describe them as needy or clingy. People with DPD may believe they can't take care of themselves. They may have trouble making everyday decisions, such as what to wear, without others' reassurance.
- **Option C:** Dependent personality belongs to a group of anxious or fearful disorders that also includes avoidant personality — painfully shy, inhibited, and withdrawn. But it also has characteristics in common with histrionic personality — self-dramatizing, suggestible, seductive, and constantly starved for attention.

**17. Referencing the image below, what is the name of the structure marked #16.**

- A. Loop of henle
- B. Renal medulla
- C. Renal calyx
- D. Renal blood vessels
- E. Renal capsule
- F. Renal vein
- G. Renal nerve
- H. Renal artery
- I. Renal pelvis
- J. Renal pyramid

**Correct answer: #16 is the Option E. renal capsule.**

The renal capsule is a thin, tough membrane that envelops the outer surface of the kidney. It provides structural support, protection from trauma and injuries, and helps maintain the kidney's shape.

**18. Which of the following will Nurse Dory use when communicating with a client who has cognitive impairment?**

- A. Complete explanations with multiple details.
- B. Pictures or gestures instead of words.
- C. Stimulating words and phrases to capture the client's attention.
- D. Short words and simple sentences.

**Correct Answer: D. Short words and simple sentences.**

Short words and simple sentences minimize client confusion and enhance communication. Assess the patient's ability to speak, language deficit, cognitive or sensory impairment, presence of aphasia, dysarthria, aphonia, dyslalia, or apraxia. Presence of psychosis, and/or other neurologic disorders affecting speech. This identifies problem areas and speech patterns to help establish a plan of care.

- **Option A:** Use simple, direct questions requiring one-word answers. Repeat and reword questions if misunderstanding occurs. This promotes self-confidence of the patient who is able to achieve some degree of speech or communication. Encourage the patient to breathe prior to speaking, pause between words, and use the tongue, lips, and jaw to speak. Encourage the patient to control the length and rate of phrases, over articulate words, and separate syllables, emphasizing consonants.
- **Option B:** Although pictures and gestures may be helpful, they would not substitute for verbal communication. When communicating with the patient, face the patient and maintain eye contact, speaking slowly and enunciating clearly in a moderate or low-pitched tone. Clarity, brevity, and time provided for responses promote the opportunity for successful speech by allowing patient time to receive and process the information.
- **Option C:** Complete explanations with multiple details and stimulating words and phrases would increase confusion in a client with short attention span and difficulty with comprehension. Remove competing stimuli, and provide a calm, unhurried atmosphere for communication. This reduces unnecessary noise and distraction and allows patient time to decrease frustration.

**19. Even though the nurse may obtain the client's signature on a form, obtaining informed consent is the responsibility of the:**

- A. Client
- B. Physician
- C. Student nurse
- D. Supervising nurse

**Correct Answer: B. Physician**

It is the obligation of the provider to make it clear that the patient is participating in the decision-making process and avoid making the patient feel forced to agree to the provider. The provider must make a recommendation and provide their reasoning for said recommendation.

- **Option A:** Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.
- **Option C:** Members of the healthcare team, such as nurses and patient care assistants, should also be educated about all potential adverse reactions so that they are able to identify them and notify a provider so that any immediate intervention that is needed can be performed in a timely manner.
- **Option D:** Members of the healthcare team involved with the care of a patient should also be informed about procedures and interventions as they may be used as witnesses in obtaining informed consent. They would be able to evaluate whether all necessary information was given to the patient and provide any information the provider obtaining informed consent may have forgotten.

**20. The nurse is reviewing the physician's orders for a client with Meniere's disease. Which diet will most likely be prescribed?**

- A. Low-cholesterol diet
- B. Low-sodium diet
- C. Low-carbohydrate diet
- D. Low-fat diet

**Correct Answer: B. Low-sodium diet.**

Dietary changes such as salt and fluid restrictions that reduce the amount of endolymphatic fluid sometimes are prescribed. Foods with high sugar or salt content cause water retention, which can worsen symptoms of Meniere's disease. Sugar prompts an insulin response from the body, and insulin retains sodium. Sodium causes the body to retain water.

- **Option A:** It is unnecessary to place the client on a low cholesterol diet. Water retention makes Meniere's disease worse, but this doesn't mean the client should stop drinking fluids. It's more important that he avoids fluids that contain large amounts of sugar and salt, such as soda or concentrated juices, which makes one retain water.
- **Option C:** Carbohydrates should not be decreased from the client's diet. People with Meniere's disease should aim for less than 2,300 mg of sodium each day, according to the Mayo Clinic. Intake should be spread evenly throughout the day. Much more than that will cause water retention.
- **Option D:** Caffeine, not fat, should be avoided because it's a stimulant and can make tinnitus louder. Caffeine and alcohol also interfere with the body's ability to regulate fluid levels, which can make the inner ear worse, causing headaches, pressure, and vertigo.

**21. A male client is color blind. The nurse understands that this client has a problem with:**

- A. Rods.
- B. Cones.
- C. Lens.
- D. Aqueous humor.

**Correct Answer: B. Cones.**

Cones provide daylight color vision, and their stimulation is interpreted as color. If one or more types of cones are absent or defective, color blindness occurs. Very few individuals are truly color blind, but instead, see a disrupted range of colors. The most common forms are protanopia and deuteranopia, conditions arising from loss of function of one of the cones, leading to dichromic vision.

- **Option A:** Rods are sensitive to low levels of illumination but can't discriminate color. Rods are the cells primarily responsible for scotopic vision, or low-light vision. Rods are the more abundant cell-type of the retina and reach their maximum density approximately 15 to 20 degrees from the fovea, a small depression in the retina of the eye where visual acuity is highest. There are approximately 90 million rod cells in the human retina.
- **Option C:** The lens is responsible for focusing images. The lens is the adjustable component of the refractive system: its shape is altered by the contraction or relaxation of the ciliary muscle to focus on objects that are near or far.
- **Option D:** Aqueous humor is a clear watery fluid and isn't involved in color perception. Aqueous humor is a low viscosity fluid secreted from plasma components by the ciliary body into the posterior chamber of the eye. The humor then travels to the anterior chamber and proceeds to drain into the systemic cardiovascular circulation by an incompletely understood mechanism. Aqueous humor circulation forms the basis of intraocular pressure (IOP), which is associated with glaucoma; this is how the synthesis, circulation, and drainage of aqueous humor become clinically significant.

**22. When ventricular fibrillation occurs in a CCU, the first person reaching the client should:**

- A. Administer oxygen.
- B. Defibrillate the client.
- C. Initiate CPR.
- D. Administer sodium bicarbonate intravenously.

**Correct Answer: B. Defibrillate the client**

Ventricular fibrillation is a death-producing dysrhythmia and, once identified, must be terminated immediately by precordial shock (defibrillation). This is usually a standing physician's order in a CCU. Pulseless VT and VF are both shockable rhythms, and once the staff identifies the rhythm as VF, patients should be shocked immediately with 120 to 200 joules on a biphasic defibrillator or 360 joules using a monophasic.

- **Option A:** Professionals should undertake cause-specific measures such as securing the airway, correcting electrolytes, administering fluids, decompressing pneumothorax, draining tamponade while resuscitating the patient. Once the patient attains return of spontaneous circulation (ROSC), physicians should begin a definitive evaluation for coronary artery disease.
- **Option C:** Due to the high mortality rate and extreme acuity of the condition, VF patients warrant immediate attention. Healthcare professionals should immediately initiate guideline-directed management as per Advanced Cardiac Life Support (ACLS) protocol. There is a lower likelihood of survival if the healthcare professional deviates from the ACLS guidelines. All patients with cardiac arrest should have an initial assessment while receiving quality CPR.
- **Option D:** Administer epinephrine and amiodarone as per ACLS protocol in patients sustaining VF rhythm regardless of receiving 3 shocks. Amiodarone significantly improves survival to hospital

admission without affecting survival to hospital discharge.

**23. A 45-year-old male patient who recently underwent a kidney transplant is being monitored in the post-operative period. During a routine check-up, the patient reports feeling generally unwell and expresses discomfort in the area of the transplant. The nurse is vigilant for signs of organ rejection. Which of the following assessments would most strongly prompt the nurse to suspect organ rejection?**

- A. Sudden weight loss
- B. Polyuria
- C. Hypertension
- D. Shock

**Correct Answer: C. Hypertension**

Hypertension, along with fever, and tenderness over the grafted kidney, reflects acute rejection.

**24. A 58-year-old man is going to have chemotherapy for lung cancer. He asks the nurse how the chemotherapeutic drugs will work. The most accurate explanation the nurse can give is which of the following?**

- A. "Cancer cells are susceptible to drug toxins."
- B. "Chemotherapy affects all rapidly dividing cells."
- C. "Chemotherapy encourages cancer cells to divide."
- D. "The molecular structure of the DNA is altered."

**Correct Answer: B. "Chemotherapy affects all rapidly dividing cells."**

- **Option B:** There are many mechanisms of action for chemotherapeutic agents, but most affect the rapidly dividing cells—both cancerous and noncancerous. Cancer cells are characterized by rapid cell division.
- **Option A:** All cells are susceptible to drug toxins, but not all chemotherapeutic agents are toxins.
- **Options C and D:** Chemotherapy slows cell division. Not all chemotherapeutic agents affect the molecular structure.

**25. A client has been pronounced brain dead. Which findings would the nurse assess? Select all that apply.**

- A. Decerebrate posturing
- B. Dilated nonreactive pupils
- C. Deep tendon reflexes
- D. Absent corneal reflex

**Correct Answer: B, C, & D**

A client who is brain dead typically demonstrates nonreactive dilated pupils and nonreactive or absent corneal and gag reflexes. The client may still have spinal reflexes such as deep tendon and Babinski reflexes in brain death. Decerebrate or decorticate posturing would not be seen.

- **Option A:** The physiology of brain death is similar regardless of the etiology. Inadequate tissue oxygenation leads to a progressive cascade of further edema, increasing intracranial pressure, a further decrease in cerebral perfusion and eventual herniation, or complete cessation of blood flow and aseptic necrosis of brain tissue.
- **Option B:** Coma should be evaluated by ensuring a lack of responsiveness to noxious stimuli; no eye or motor reflex should be present in response to stimuli. Additionally, the cause of coma should be identified by neuroimaging, history, and physical examination or laboratory testing.
- **Option C:** Once the decision to proceed with the brain death determination has been made, three conditions must be present: coma, the absence of brainstem reflexes, and apnea. Loss of response to central pain occurs in brain death. Central pain assessment can be by the application of noxious stimuli to certain areas as the supraorbital notch, the angle of the jaw, upper trapezius, the anterior axillary fold, and the sternum. Neither eye response nor motor reflexes are detectable in brain death.
- **Option D:** The following brainstem reflexes should be tested in the physical examination of a patient deemed for brain death evaluation. They all must be absent for a patient to be diagnosed as brain dead: the pupillary reflex to light—must be fixed at a mid-position; usually, around 4 mm and must not respond to light.

**26. When chloride concentration drops below 95 mEq/L, reabsorption of which of the following electrolytes increases proportionally?**

- A. Hydrogen
- B. Potassium
- C. Sodium
- D. Bicarbonate

**Correct Answer: D. Bicarbonate**

When chloride concentrations drop below 95 mEq/L, bicarbonate reabsorption increases proportionally, causing metabolic alkalosis. Other choices are cations, chloride is an anion; a cation must always exchange for a cation in order to maintain electrical neutrality.

- **Option A:** Hydrogen is used within the kidneys as an antiporter energy gradient to retain a multitude of other elements. Of interest here, sodium is reabsorbed through an exchange for hydrogen in the renal collecting ducts under the influence of aldosterone.
- **Option B:** Anytime that hydrogen ions are shifted intracellularly, this imbalance in the buffer system has a relative increase in bicarbonate. Processes that drive hydrogen intracellularly include hypokalemia.
- **Option C:** Severe vomiting may lead to the most disproportionate loss of chloride compared to sodium since gastric chloride content is greater than 100 mEq/L and gastric sodium content is relatively low (20 to 30 mEq/L). In individuals with protracted vomiting or nasogastric suction, the serum sodium concentration may be only mildly depressed (130 mEq/L), whereas the serum chloride concentration is usually markedly lowered (80 to 90 mEq/L).

**27. The nurse is assessing an infant with developmental dysplasia of the hip. Which finding would the nurse anticipate?**

- A. Unequal leg length
- B. Limited adduction
- C. Diminished femoral pulses
- D. Symmetrical gluteal folds

**Correct Answer: A. Unequal leg length**

Shortening of a leg is a sign of developmental dysplasia of the hip. The hip is a “ball-and-socket” joint. In a normal hip, the ball at the upper end of the thigh bone (femur) fits firmly into the socket, which is part of the large pelvis bone. In babies and children with developmental dysplasia (dislocation) of the hip (DDH), the hip joint has not formed normally. The ball is loose in the socket and may be easy to dislocate.

- **Option B:** Limited adduction is not a sign of developmental dysplasia. In all cases of DDH, the socket (acetabulum) is shallow, meaning that the ball of the thighbone (femur) cannot firmly fit into the socket. Sometimes, the ligaments that help to hold the joint in place are stretched. The degree of hip looseness, or instability, varies among children with DDH.
- **Option C:** Femoral pulses in a client with developmental dysplasia of the hip are normal.
- **Option D:** Asymmetric gluteal folds with uneven gluteal creases are associated with developmental hip dysplasia.

**28. A 40-year-old paraplegic must perform intermittent catheterization of the bladder. Which of the following instructions should be given?**

- A. “Clean the meatus from back to front.”
- B. “Measure the quantity of urine.”
- C. “Gently rotate the catheter during removal.”
- D. “Clean the meatus with soap and water.”

**Correct Answer: D. “Clean the meatus with soap and water.”**

Intermittent catheterization may be performed chronically with a clean technique, using soap and water to clean the urinary meatus. Cleanse the perineal area and keep dry. Provide catheter care as appropriate. Decreases risk of skin irritation or breakdown and development of ascending infection.

- **Option A:** The meatus is always cleaned from front to back in a woman, or in expanding circles working outward from the meatus in a man. Observe for cloudy or bloody urine, foul odor. Dipstick urine as indicated. Signs of urinary tract or kidney infection that can potentiate sepsis. Multistrip dipsticks can provide a quick determination of pH, nitrite, and leukocyte esterase suggesting the presence of infection.
- **Option B:** It isn’t necessary to measure the urine. The nurse may measure residual urine via post void catheterization or ultrasound. Helpful in detecting the presence of urinary retention and effectiveness of the bladder training program. Note: Use of ultrasound is noninvasive, reducing the risk of colonization of the bladder.



- **Option C:** The catheter doesn't need to be rotated during removal. Keep the bladder deflated by means of an indwelling catheter initially. Begin intermittent catheterization program when appropriate. Intermittent catheterization may be implemented to reduce complications usually associated with long-term use of indwelling catheters.

**29. In the United States, the first programs for training nurses were affiliated with:**

- A. The military
- B. General hospitals
- C. Civil service
- D. Religious orders

**Correct Answer: D. Religious orders**

When the Civil War broke out, the Army used nurses who had already been trained in religious orders. Nursing started with religious orders. The Hindu faith was the first to write about nursing. In the United States, all training for nurses was affiliated with religious orders until after the Civil War.

- **Option A:** Although the Army did provide some training, it occurred later than in the religious orders. Most people think of the nursing profession as beginning with the work of Florence Nightingale, an upper class British woman who captured the public imagination when she led a group of female nurses to the Crimea in October of 1854 to deliver nursing service to British soldiers.
- **Option B:** Although nurses were trained in hospitals, the training and the hospitals were affiliated with religious orders. Upon her return to England, Nightingale successfully established nurse education programs in a number of British hospitals. These schools were organized around a specific set of ideas about how nurses should be educated, developed by Nightingale often referred to as the "Nightingale Principles."
- **Option C:** Civil service was not mentioned in Chapter 1 and was not a factor in the early 1800s. While Nightingale's work was groundbreaking in that she confirmed that a corps of educated women, informed about health and the ways to promote it, could improve the care of patients based on a set of particular principles, she was not the first to put these principles into action.

**30. In the sympto-thermal method, the parameters being monitored to determine if the woman is fertile or infertile are:**

- A. Temperature, cervical mucus, cervical consistency
- B. Release of ovum, temperature, and vagina
- C. Temperature and wetness
- D. Temperature, endometrial secretion, mucus

**Correct Answer: A. Temperature, cervical mucus, cervical consistency**

The 3 parameters measured/monitored which will indicate that the woman has ovulated are- a temperature increase of about 0.2-0.4 degrees centigrade, a softness of the cervix and cervical mucus that looks like the white of an egg which makes the woman feel "wet".

- **Option B:** The symptothermal method is a combination of methods. The two most commonly used are the BBT method and the cervical mucus method. The Marquette method combines BBT and cervical mucus tracking with use of an electronic hormonal fertility monitor. The monitor detects hormones in urine to confirm fertile days. It can be purchased online or at a pharmacy.
- **Option C:** The symptothermal method combines calendar calculations, basal body temperature charting, and cervical mucus monitoring.
- **Option D:** Cervical secretions are the foundation for this method, and the other techniques provide a “double-check.” Women may use other signs (e.g., consistency and position of the cervix) or symptoms (e.g., breast tenderness, ovulatory pain) to aid in the identification of the fertile period.

**31. A client is admitted to the labor and delivery unit. The nurse performs a vaginal exam and determines that the client’s cervix is 5 cm dilated with 75% effacement. Based on the nurse’s assessment the client is in which phase of labor?**

- A. Active
- B. Latent
- C. Transition
- D. Early

**Correct Answer: A. Active**

The active phase of labor occurs when the client is dilated 4–7cm. Active labor with more rapid cervical dilation generally starts around 6 centimeters of dilation. During the active phase, the cervix typically dilates at a rate of 1.2 to 1.5 centimeters per hour. Multiparas, or women with a history of prior vaginal delivery, tend to demonstrate more rapid cervical dilation. The absence of cervical change for greater than 4 hours in the presence of adequate contractions or six hours with inadequate contractions is considered the arrest of labor and may warrant clinical intervention.

- **Option B:** The latent phase is commonly defined as the 0 to 6 cm, while the active phase commences from 6 cm to full cervical dilation. The presenting fetal part also begins the process of engagement into the pelvis during the first stage. Throughout the first stage of labor, serial cervical exams are done to determine the position of the fetus, cervical dilation, and cervical effacement.
- **Option C:** The transition phase of labor is 8–10cm in dilation. The second stage of labor commences with complete cervical dilation to 10 centimeters and ends with the delivery of the neonate. This was also defined as the pelvic division phase by Friedman. After cervical dilation is complete, the fetus descends into the vaginal canal with or without maternal pushing efforts.
- **Option D:** The latent or early phase of labor is from 1cm to 3cm in dilation. During the latent phase, the cervix dilates slowly to approximately 6 centimeters. The latent phase is generally considerably longer and less predictable with regard to the rate of cervical change than is observed in the active phase. A normal latent phase can last up to 20 hours and 14 hours in nulliparous and multiparous women respectively, without being considered prolonged.

**32. The client is concerned about his coming discharge, manifested by being unusually sad. Which is the most therapeutic approach by the nurse?**

- A. “You are much better than when you were admitted so there’s no reason to worry.”

- B. "What would you like to do now that you're about to go home?"
- C. "You seem to have concerns about going home."
- D. "Aren't you glad that you're going home soon?"

**Correct Answer: C. "You seem to have concerns about going home."**

This statement reflects how the client feels. Showing empathy can encourage the client to talk which is important as an alternative more adaptive way of coping with stressors. Patients often ask nurses for advice about what they should do about particular problems or in specific situations. Nurses can ask patients what they think they should do, which encourages patients to be accountable for their own actions and helps them come up with solutions themselves.

- **Option A:** Giving false reassurance is not therapeutic. It's frequently useful for nurses to summarize what patients have said after the fact. This demonstrates to patients that the nurse was listening and allows the nurse to document conversations. Ending a summary with a phrase like "Does that sound correct?" gives patients explicit permission to make corrections if they're necessary.
- **Option B:** While this technique explores plans after discharge, it does not focus on the expression of feelings. Sometimes during a conversation, patients mention something particularly important. When this happens, nurses can focus on their statement, prompting patients to discuss it further. Patients don't always have an objective perspective on what is relevant to their case; as impartial observers, nurses can more easily pick out the topics to focus on.
- **Option D:** This close-ended question does not encourage verbalization of feelings. Therapeutic communication is often most effective when patients direct the flow of conversation and decide what to talk about. To that end, giving patients a broad opening such as "What's on your mind today?" or "What would you like to talk about?" can be a good way to allow patients an opportunity to discuss what's on their mind.

### **33. In an individual with Sjögren's syndrome, nursing care should focus on:**

- A. Moisture replacement.
- B. Electrolyte balance.
- C. Nutritional supplementation.
- D. Arrhythmia management.

**Correct Answer: A. Moisture replacement.**

Sjogren's syndrome is an autoimmune disorder leading to progressive loss of lubrication of the skin, GI tract, ears, nose, and vagina. Moisture replacement is the mainstay of therapy.

- **Option B:** Electrolyte balance is not the priority problem in Sjogren's syndrome. Electrolyte abnormalities, particularly hypokalemia, must be considered in patients presenting with generalized weakness.
- **Option C:** Though malnutrition may occur as a result of Sjogren's syndrome effect on the GI tract, it isn't the predominant problem. An estimated 90% of people with Sjogren's syndrome have problems related to eating, enough to cause malnutrition.
- **Option D:** Arrhythmias aren't a problem associated with Sjogren's syndrome. However, there is a new study that showed a significantly increased risk of heart attack in patients with Sjogren's syndrome, particularly in the first year following diagnosis.

**34. With peripheral arterial insufficiency, leg pain during rest can be reduced by:**

- A. Elevating the limb above heart level.
- B. Lowering the limb so it is dependent.
- C. Massaging the limb after application of cold compresses.
- D. Placing the limb in a plane horizontal to the body.

**Correct Answer: B. Lowering the limb so it is dependent**

The cornerstone of treatment of PAD is exercise to improve peripheral circulation, walking economy, cardiopulmonary function, and functional capacity. The data to support the efficacy of supervised exercise in improving claudication are robust with the length of the program influencing the magnitude of increase in maximal walking distance of up to 150% (range 74% to 230%).

- **Option A:** Functional benefits (increased walking speed, distance, duration, and decreased symptoms) accrue gradually and can occur in as early as 4 to 8 weeks, but greater benefit is conferred with programs of 6 months or longer. Typical improvements in walking distance include more than 100% increase in peak exercise performance and self-reported physical function. Longer walking interventions achieve greater benefit. However, most studies have been of short duration, 3 to 6 months, with few longer than 12 months.
- **Option C:** Exercise recommendations have been extrapolated from clinical trials in patients with PAD. Based on these studies, walking is the most effective mode of exercise. Although resistance training does confer some benefit, it has been shown to be less effective than walking in improving walking distance in patients with PAD. Recently, pole striding exercise has been demonstrated to increase cardiovascular fitness, improve symptoms and quality of life in a small group of PAD patients.
- **Option D:** Exercise intensity is based on the workload achieved during a treadmill test that elicited claudication pain within 3 to 5 minutes of walking. Once this workload has been determined, the patient is asked to walk at this set workload until claudication of moderate intensity. Once this point is reached the patient is allowed to rest (standing or sitting) until pain subsides. The exercise-rest-exercise pattern is repeated for the duration of the exercise session.

**35. The nurse instructs a primipara about safety considerations for the neonate. The nurse determines that the client does not understand the instructions when she says:**

- A. "All neonates should be in an approved car seat when in an automobile."
- B. "It's acceptable to prop the infant's bottle once in a while."
- C. "Pillows should not be used in the infant's crib."
- D. "Infants should never be left unattended on an unguarded surface."

**Correct Answer: B. "It's acceptable to prop the infant's bottle once in a while."**

- **Option B:** It is not advisable to prop or leave the bottle in the baby's mouth. This can increase the baby's risk of choking, ear infections, and tooth decay. There is also the very real risk that babies simply end up consuming too much milk if it keeps flowing.

**36. Antidepressants generally exert influence by:**

- A. Increasing the reuptake of norepinephrine
- B. Altering the action of the cyproprotein (MAO)
- C. Changing the availability of dopamine
- D. Changing the availability of select neurotransmitters

**Correct Answer: D. Changing the availability of select neurotransmitters**

This choice best describes the effect of antidepressants in general. All currently licensed antidepressants are believed to work by increasing the neurotransmitters serotonin or norepinephrine, or both, in the synapse. The mechanisms to increase these neurotransmitters vary, though antidepressant drugs target reuptake by the nerve terminals.

- **Option A:** Selective serotonin reuptake inhibitors (SSRIs) work by inhibiting 5-HT reuptake by the presynaptic cleft in a synapse, thus increasing available serotonin levels. Serotonin and norepinephrine reuptake inhibitors (SNRIs) block serotonin reuptake, like SSRIs, however, they also block norepinephrine reuptake in the synapse.
- **Option B:** Monoamine oxidase inhibitors (MAOIs), work by inhibiting the monoamine oxidase enzyme, which catabolizes serotonin, norepinephrine, and dopamine. Another antidepressant drug that does not work by blocking reuptake is mirtazapine. Mirtazapine works by blocking alpha-2 adrenergic receptors on the cell bodies and nerve terminals, promoting the release of norepinephrine into the synapse.
- **Option C:** Another atypical antidepressant, agomelatine, works by agonizing melatonin receptors MT1 and MT2 while antagonizing serotonergic 5-HT<sub>2C</sub> receptors, promoting dopamine and norepinephrine release. Serotonin modulators, like nefazodone, may work by down-regulating postsynaptic serotonin 5-HT<sub>2A</sub> receptors.

**37. When deciding on what time of day to give medications, the nurse pays the closest attention to the client's habits regarding:**

- A. Eating
- B. Sleeping
- C. Elimination
- D. Activity

**Correct Answer: A. Eating**

Eating is the most important of these because food in the stomach must be a consideration. When a medicine is prescribed on an empty stomach, it is done to ensure the most effective absorption. The changes in the gut with food restrict and therefore affect the effectiveness of these particular medicines. In some cases, elements of food like iron or calcium might bind to chemical structures in medicine.

- **Option B:** Acute exposure to drugs of abuse disrupts sleep by affecting sleep latency, duration, and quality [1]. With chronic administration, sleep disruption becomes more severe, and during abstinence, insomnia with a negative effect prevails, which drives drug craving and contributes to impulsivity and relapse.
- **Option C:** All drugs are eventually eliminated from the body. They may be eliminated after being chemically altered (metabolized), or they may be eliminated intact. Most drugs, particularly

water-soluble drugs and their metabolites, are eliminated largely by the kidneys in urine. Therefore, drug dosing depends largely on kidney function. Some drugs are eliminated by excretion in the bile (a greenish-yellow fluid secreted by the liver and stored in the gallbladder)

- **Option D:** One important area that has been understudied to date is the relationship between medication use and both the rehabilitation process and habitual physical activity in people. Most people have more than one disease (referred to as multimorbidity) and hence take multiple medications. Just as some diseases may interfere with the ability to undertake physical activity (eg, arthritis, heart failure, or lung disease), it is plausible that some medications may either enhance or interfere with the ability to undertake physical activity or rehabilitation.

**38. Which of the following nursing interventions would be most helpful in making the respiratory effort of a client with metastatic lung cancer more efficient?**

- A. Teaching the client diaphragmatic breathing techniques
- B. Administering cough suppressants as ordered
- C. Teaching and encouraging pursed-lip breathing
- D. Placing the client in a low semi-Fowlers position

**Correct Answer: C. Teaching and encouraging pursed-lip breathing**

- **Option C:** For clients with obstructive versus restrictive disorders, extending exhalation through pursed-lip breathing will make the respiratory effort more efficient. The usual position of choice for this client is the upright position, leaning slightly forward to allow greater lung expansion.
- **Option A:** Teaching diaphragmatic breathing techniques will be more helpful to the client with a restrictive disorder.
- **Option B:** Administering cough suppressants will not help the respiratory effort.
- **Option D:** A low semi-Fowler's position does not encourage lung expansion. Lung expansion is enhanced in the upright position.

**39. If the labor period lasts only for 3 hours, the nurse should suspect that the following conditions may occur. Select all that apply.**

- A. Laceration of cervix
- B. Laceration of perineum
- C. Cranial hematoma in the fetus
- D. Fetal anoxia

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

All the above conditions can occur following precipitate labor and delivery of the fetus because there was little time for the baby to adapt to the passageway. If the presentation is cephalic, the fetal head serves as the main part of the fetus that pushes through the birth canal which can lead to cranial hematoma, and possible compression of the cord may occur which can lead to less blood and oxygen to the fetus (hypoxia).

- **Option A:** The maternal passageway (cervix, vaginal canal, and perineum) did not have enough time to stretch which can lead to a laceration.
- **Option B:** Fetal anoxia may occur from inadequate oxygenation of the mother, low maternal blood pressure, or abnormalities in the uterus, placenta, or umbilical cord that result in inadequate blood flow to the fetus. After birth, anoxia may result from blood loss, shock, or inadequate respiration.
- **Option C:** Fetal intracranial hemorrhage is generally diagnosed in the late second trimester as an asymmetric echogenic mass within the ventricles, mostly associated with some degree of ventriculomegaly. Causes to be considered include drug use (warfarin, cocaine), alloimmune thrombocytopenia, coagulation disorders, or trauma.
- **Option D:** Anoxia occurs when the infant undergoes a total lack of oxygen. If the brain is deprived of oxygen for even a brief period of time, the infant's brain is not getting enough oxygen to function smoothly and will begin to malfunction.

**40. When a female client with an indwelling urinary (Foley) catheter insists on walking to the hospital lobby to visit with family members, nurse Rose teaches how to do this without compromising the catheter. Which client action indicates an accurate understanding of this information?**

- A. The client sets the drainage bag on the floor while sitting down.
- B. The client keeps the drainage bag below the bladder at all times.
- C. The client clamps the catheter drainage tubing while visiting with the family.
- D. The client loops the drainage tubing below its point of entry into the drainage bag.

**Correct Answer: B. The client keeps the drainage bag below the bladder at all times.**

To maintain effective drainage, the client should keep the drainage bag below the bladder; this allows the urine to flow by gravity from the bladder to the drainage bag. Make sure that the patient maintains a generous fluid intake. This helps prevent infection and irrigates the catheter naturally by increasing urinary output.

- **Option A:** The client shouldn't lay the drainage bag on the floor because it could become grossly contaminated. Teach the patient the importance of personal hygiene, especially the importance of careful cleaning after having bowel movements and thorough washing of hands frequently.
- **Option C:** The client shouldn't clamp the catheter drainage tubing because this impedes the flow of urine. Plan to change indwelling catheters only as necessary. The usual length of time between catheter changes varies and can be anywhere from 5 days to 2 weeks. The less often a catheter is changed, the less the likelihood that an infection will develop.
- **Option D:** To promote drainage, the client may loop the drainage tubing above — not below — its point of entry into the drainage bag. Report any signs of infection promptly. These include a burning sensation and irritation at the meatus, cloudy urine, a strong odor to the urine, an elevated temperature, and chills.

**41. A patient with a history of congestive heart failure arrives at the clinic complaining of dyspnea. Which of the following actions is the first the nurse should perform?**

- A. Ask the patient to lie down on the exam table.

- B. Draw blood for chemistry panel and arterial blood gas (ABG).
- C. Send the patient for a chest x-ray.
- D. Check blood pressure.

**Correct Answer: D. Check blood pressure**

A patient with congestive heart failure and dyspnea may have pulmonary edema, which can cause severe hypertension. Therefore, taking the patient's blood pressure should be the first action.

- **Option A:** Lying flat on the exam table would likely worsen the dyspnea, and the patient may not tolerate it.
- **Option B:** Blood draws for chemistry and ABG will be required, but not prior to the blood pressure assessment.
- **Option C:** A chest X-ray may be ordered by the physician after priority nursing care.

**42. During the lecture, the clinical instructor tells the students that 50% to 60% of daily calories should come from carbohydrates. What should the nurse say about the types of carbohydrates that can be eaten?**

- A. Try to limit simple sugars to between 10% and 20% of daily calories.
- B. Simple carbohydrates are absorbed more rapidly than complex carbohydrates.
- C. Simple sugars cause a rapid spike in glucose levels and should be avoided.
- D. Simple sugars should never be consumed by someone with diabetes.

**Correct Answer: A. Try to limit simple sugars to between 10% and 20% of daily calories.**

It is recommended that carbohydrates provide 50% to 60% of the daily calories. Approximately 40% to 50% should be from complex carbohydrates. The remaining 10% to 20% of carbohydrates could be from simple sugars.

- **Option B:** Because sugars provide no nutrition aside from energy (hence why they are often referred to as empty calories), people looking to lose weight will also benefit from eliminating sources of added sugar from their diet.
- **Option C:** Simple carbohydrates are called simple sugars. Sugars are found in a variety of natural food sources including fruit, vegetables, and milk, and give food a sweet taste. But they also raise blood glucose levels quickly.
- **Option D:** The NHS advises adults to consume less than 70g a day of sugar for men and under 50g of sugar a day for women. However, people with diabetes will benefit from better blood glucose levels if sugar intake can be limited to lower levels.

**43. While performing a neurodevelopmental assessment on a 3-month-old infant, which of the following characteristics would be expected?**

- A. A strong Moro reflex.
- B. A strong parachute reflex.
- C. Rolling from front to back.



D. Lifting of head and chest when prone.

**Correct Answer: D. Lifting of head and chest when prone**

A 3-month-old infant should be able to lift the head and chest when prone.

- **Option A:** The Moro reflex typically diminishes or subsides by 3 months. The Moro reflex is a normal primitive, infantile reflex. The Moro reflex is an involuntary protective motor response against abrupt disruption of body balance or extremely sudden stimulation.
- **Option B:** The parachute reflex appears at 9 months. This reflex occurs in slightly older infants when the child is held upright and the baby's body is rotated quickly to face forward (as in falling). The baby will extend his arms forward as if to break a fall, even though this reflex appears long before the baby walks.
- **Option C:** Rolling from front to back usually is accomplished at about 5 months.

**44. Which of the following phrases would be found in a report of a qualitative study?**

- A. "The hypothesis of this study is?"
- B. "Perceived pain was measured using the Abbott pain scale?"
- C. "The control group received no instruction?"
- D. "Subjects were asked to relate their perceptions of pain?"

**Correct Answer: D. "Subjects were asked to relate their perceptions of pain?"**

Data collected were perceptions of pain, not numeric data. Other options are found in a report of a quantitative study. Qualitative research involves collecting and analyzing non-numerical data (e.g., text, video, or audio) to understand concepts, opinions, or experiences. It can be used to gather in-depth insights into a problem or generate new ideas for research.

- **Option A:** Quantitative research is the process of collecting and analyzing numerical data. It can be used to find patterns and averages, make predictions, test causal relationships, and generalize results to wider populations.
- **Option B:** Qualitative research is the opposite of quantitative research, which involves collecting and analyzing numerical data for statistical analysis. Quantitative research is widely used in the natural and social sciences: biology, chemistry, psychology, economics, sociology, marketing, etc.
- **Option C:** To collect quantitative data, the researcher will often need to use operational definitions that translate abstract concepts (e.g., mood) into observable and quantifiable measures (e.g., self-ratings of feelings and energy levels).

**45. A nurse is caring for a client with diabetic ketoacidosis and documents that the client is experiencing Kussmaul's respirations. Based on this documentation, which of the following did the nurse most likely observe? Select all that apply.**

- A. Respirations that cease for several seconds
- B. Respirations that are regular but abnormally slow
- C. Respirations that are labored and increased in-depth and rate

D. Respirations that are abnormally deep, regular, and increased in rate

E. Respirations are rapid and shallow but as acidosis worsens, breathing gradually becomes deep, labored, and gasping

**Correct Answer: D & E.**

Kussmaul's respiration is a deep and labored breathing pattern often associated with severe metabolic acidosis, particularly diabetic ketoacidosis (DKA) but also kidney failure. It is a form of hyperventilation. It results from stimulation of the respiratory center in the brain stem by low serum pH.

- **Option A:** In apnea, respirations cease for several seconds. Apnea is the absence of breathing. This signals a life-threatening situation in which the patient will quickly succumb unless rescue breathing is instituted immediately.
- **Option B:** In bradypnea, respirations are regular but abnormally slow. Bradypnea is a respiratory rate that is lower than normal for age.
- **Option C:** In hyperpnea, respirations are labored and increased in depth and rate. Hyperpnea is increased volume with or without an increased rate of breathing. Blood gasses are normal.
- **Option D:** They are abnormally deep, regular, and increased in rate. As classically described, Kussmaul respirations are a deep, sighing respiratory pattern. Dr. Kussmaul actually described it as "air hunger." Kussmaul's respiratory pattern occurs due to increased tidal volume with or without an increased respiratory rate.
- **Option E:** In metabolic acidosis, breathing is first rapid and shallow but as acidosis worsens, breathing gradually becomes deep, labored, and gasping. This is probably the most important of the abnormal respiratory patterns.

**46. A child is admitted to the hospital with a diagnosis of Wilms tumor, stage II. Which of the following statements most accurately describes this stage?**

A. The tumor is less than 3 cm. in size and requires no chemotherapy.

B. The tumor did not extend beyond the kidney and was completely resected.

C. The tumor extended beyond the kidney but was completely resected.

D. The tumor has spread into the abdominal cavity and cannot be resected.

**Correct Answer: C. The tumor extended beyond the kidney but was completely resected.**

Stage II, the tumor extends beyond the kidney but is completely resected. Stage II would be a tumor that has grown outside the kidney to some degree, such as into surrounding fatty tissue. Usually, the tumor would be completely removable by surgery, and regional lymph nodes are negative. About 20% of all Wilms tumors are at this stage.

- **Option A:** This is not included in the staging of Wilms tumor. Imaging is particularly important in surgical planning. Surgical risk factors include larger tumor size, contralateral tumor extension, and displacement of the great vessels which typically result in longer surgical times, increased blood loss, and higher complication rates.
- **Option B:** This described stage I: the tumor is limited to the kidney and completely resected. Stage I indicates the tumor was completely contained within the kidney without any breaks or spillage outside the renal capsule and no vascular invasion. This stage accounts for 40% to 45% of all Wilms tumors.

- **Option D:** This described stage IV, hematogenous metastasis has occurred with spread beyond the abdomen. Stage IV tumors are those that have spread through the vascular system to distant organs such as the lungs, liver, brain, or bones, or to distant lymph nodes. These account for about 10% of all Wilms tumors.

**47. During the admission assessment on a client with chronic bilateral glaucoma, which statement by the client would the nurse anticipate since it is associated with this problem?**

- A. "I have constant blurred vision."
- B. "I can't see on my left side."
- C. "I have to turn my head to see my room."
- D. "I have specks floating in my eyes."

**Correct Answer: C. "I have to turn my head to see my room."**

Intraocular pressure becomes elevated which slowly produces a progressive loss of the peripheral visual field in the affected eye along with rainbow halos around lights. Intraocular pressure becomes elevated from the microscopic obstruction of the trabecular meshwork. If left untreated or undetected blindness results in the affected eye.

- **Option A:** Central vision is one of the most common signs of glaucoma. The fluid inside the eye, called aqueous humor, usually flows out of the eye through a mesh-like channel. If this channel gets blocked, the liquid builds up. Sometimes, experts don't know what causes this blockage. But it can be inherited, meaning it's passed from parents to children.
- **Option B:** The peripheral field of vision is most often lost in a client with glaucoma. The increased pressure in the eye, called intraocular pressure, can damage the optic nerve, which sends images to the brain. If the damage worsens, glaucoma can cause permanent vision loss or even total blindness within a few years.
- **Option D:** Patchy blind spots in the peripheral or central vision of both eyes is a symptom of open-angle glaucoma. It is caused by the drainage channels in the eye becoming gradually clogged over time.

**48. A nurse is caring for a patient who has had hip replacement. The nurse should be most concerned about which of the following findings?**

- A. Complaints of pain during repositioning.
- B. Scant bloody discharge on the surgical dressing.
- C. Complaints of pain following physical therapy.
- D. Temperature of 101.8 F (38.7 C).

**Correct Answer: D. Temperature of 101.8 F (38.7 C).**

Post-surgical nursing assessment after hip replacement should be principally concerned with the risk of neurovascular complications and the development of infection. A temperature of 101.8 F (38.7 C) postoperatively is higher than the low grade that is to be expected and should raise concern. The THA postoperative wound complication spectrum ranges from superficial surgical infections (SSIs) such as cellulitis, superficial dehiscence, and/or delayed wound healing, to deep infections resulting in

full-thickness necrosis. Deep infections result in returns to the operating room for irrigation, debridement (incision and drainage) and depending on the timing of the infection, may require explanation of THA components.

- **Option A:** Joint replacement surgery relieves the pain and stiffness of arthritis for most people. Some people may still have some symptoms of arthritis. For most people, surgery usually provides enough relief of symptoms for most people. Loosening of the new joint over time can cause pain, and sometimes another surgery is needed to fix the problem.
- **Option B:** A small amount of bloody drainage on the surgical dressing is a result of normal healing, normal to lose blood during and after hip or knee replacement surgery. Some people need a blood transfusion during surgery or during their recovery period in the hospital. Some surgeries require you to donate blood before surgery. Much of the bleeding during surgery comes from the bone that has been cut. A bruise may occur if blood collects around the new joint or under the skin after surgery.
- **Option C:** Some pain following physical therapy is to be expected and can be managed with analgesics. As in its counterpart TKA procedure, aseptic loosening is the result of a confluence of steps involving particulate debris formation, prosthesis micromotion, and macrophage-activated osteolysis. Treatment requires serial imaging and radiographs and/or CT imaging for preoperative planning. Persistent pain requires revision THA surgery.

**49. A 35-year-old female has intense fear of riding an elevator. She claims “As if I will die inside.” The client is suffering from:**

- A. Agoraphobia
- B. Social phobia
- C. Claustrophobia
- D. Xenophobia

**Correct Answer: C. Claustrophobia**

Claustrophobia is fear of closed space. Claustrophobia is a type of specific phobia, where one has a fear of closed spaces. Examples of closed spaces are engine rooms, MRI machines, elevators, etc. Those with specific phobias generally will report avoidance behaviors regarding the particular object or situation that triggers their fear. The fear can be expressed as a danger of harm, disgust, or experience of the physical symptoms in a phobic scenario. physical symptoms include, but are not limited to, difficulty breathing, trembling, sweating, tachycardia, dry mouth, and chest pain. Emotional symptoms include, but are not limited to, feeling overwhelming anxiety or fear, fear of losing control, feeling an intense need to leave the situation, the understanding of the fear as irrational, but an inability to overcome it.

- **Option A:** Agoraphobia is fear of open space or being a situation where escape is difficult. Agoraphobia is the anxiety that occurs when one is in a public or crowded place, from which a potential escape is difficult, or help may not be readily available. It is characterized by the fear that a panic attack or panic-like symptoms may occur in these situations. Individuals with agoraphobia, therefore, strive to avoid such situations or locations. In the currently-used DSM-5, agoraphobia is considered a distinct diagnosis that can occur independently of other diagnoses, such as generalized anxiety disorder or panic disorder. In the DSM-5, it is defined as “marked fear or anxiety about actual or anticipated exposure of public spaces, with the symptoms of fear or anxiety occurring most of the time in at least two of five common, different situations.”

- **Option B:** Social phobia is fear of performing in the presence of others in a way that will be humiliating or embarrassing. Social anxiety disorder (SAD) is characterized by excessive fear of embarrassment, humiliation, or rejection when exposed to possible negative evaluation by others when engaged in a public performance or social interactions. It is also known as social phobia. With the publication of DSM-5, the diagnostic criteria for SAD have been broadened from previous editions to include fear of acting in a way or show anxiety symptoms that offend others or lead to rejection in addition to fear of humiliation or embarrassment. Additionally, the latest edition of DSM removed the generalized subtype and added the “performance only” specifier.
- **Option D:** Xenophobia is fear of strangers. Xenophobia, or fear of strangers, is a broad term that may be applied to any fear of someone who is different from us. Hostility towards outsiders is often a reaction to fear. It typically involves the belief that there is a conflict between an individual’s ingroup and an outgroup. Xenophobia often overlaps with forms of prejudice including racism and homophobia, but there are important distinctions. Where racism, homophobia, and other forms of discrimination are based on specific characteristics, xenophobia is usually rooted in the perception that members of the outgroup are foreign to the ingroup community.

**50. While caring for a client, the nurse notes a pulsating mass in the client’s periumbilical area. Which of the following assessments is appropriate for the nurse to perform?**

- A. Measure the length of the mass.
- B. Auscultate the mass.
- C. Percuss the mass.
- D. Palpate the mass.

**Correct Answer: B. Auscultate the mass.**

Auscultate the mass. Auscultation of the abdomen and finding a bruit will confirm the presence of an abdominal aneurysm and will form the basis of information given to the provider. Occasionally, an overlying mass (pancreas or stomach) may be mistaken for an AAA. An abdominal bruit is nonspecific for an unruptured aneurysm, but the presence of an abdominal bruit or the lateral propagation of the aortic pulse wave can offer subtle clues and maybe more frequently found than a pulsatile mass.

- **Option A:** In one study, 38% of AAA cases were detected on the basis of physical examination findings, whereas 62% were detected incidentally on radiologic studies obtained for other reasons. Femoral/popliteal pulses and pedal (dorsalis pedis or posterior tibial) pulses should be palpated to determine if an associated aneurysm (femoral/popliteal) or occlusive disease exists. Flank ecchymosis (Grey Turner sign) represents retroperitoneal hemorrhage.
- **Option C:** Do not percuss the abdominal mass. The presence of a pulsatile abdominal mass is virtually diagnostic of an AAA but is found in fewer than 50% of cases. It is more likely to be noted with a ruptured aneurysm.
- **Option D:** The mass should not be palpated because of the risk of rupture. Most clinically significant AAAs are palpable upon routine physical examination; however, the sensitivity of palpation depends on the experience of the examiner, the size of the aneurysm, and the size of the patient.

**51. A natural body defense that plays an active role in preventing infection is:**

- A. Yawning
- B. Body hair
- C. Hiccupping
- D. Rapid eye movements

**Correct Answer: B. Body hair**

Hair on or within body areas, such as the nose, traps and holds particles that contain microorganisms. One of the body's most important physical barriers is the skin barrier, which is composed of three layers of closely packed cells. The thin upper layer is called the epidermis. A second, thicker layer, called the dermis, contains hair follicles, sweat glands, nerves, and blood vessels. A layer of fatty tissue called the hypodermis lies beneath the dermis and contains blood and lymph vessels

- **Option A:** Evidence suggests that drowsiness is the most common stimulus of yawn. Boredom occurs when the main source of stimulation in a person's environment is no longer able to sustain their attention. This induces drowsiness by stimulating the sleep generating system. At this moment, the mind has to make an effort to maintain contact with the external environment.
- **Option C:** Hiccupping does not prevent microorganisms from entering or leaving the body. As they breathe out, the diaphragm pushes up to expel the air. When a person has hiccups, the diaphragm contracts and pulls down, drawing in air between breaths. Immediately after this, the windpipe closes for a moment to prevent more air from entering the lungs. Hiccups often come after eating or drinking too much or too quickly.
- **Option D:** Rapid eye movement marks the stage of sleep during which dreaming occurs. Rapid eye movement (REM) is the stage of sleep characterized by rapid saccadic movements of the eyes. During this stage, the activity of the brain's neurons is quite similar to that during waking hours. Most of the vividly recalled dreams occur during REM sleep.

**52. A client with a vancomycin-resistant enterococcus (VRE) infection is admitted to the medical unit. Which action can be delegated to a nursing assistant who is assisting with the client's care?**

- A. Monitor the results of the laboratory culture and sensitivity test.
- B. Educate the client and family members on ways to prevent transmission of VRE.
- C. Implement contact precautions when handling the client.
- D. Collaborate with other departments when the client is transported for the ordered test.

**Correct Answer: C. Implement contact precautions when handling the client.**

All hospital personnel who care for the client are responsible for the correct implementation of contact precautions.

- **Options A, B, and D:** The other options should be carried out by a licensed nurse.

**53. The client is having an arteriogram. During the procedure, the client tells the nurse, "I'm feeling really hot." Which response would be best?**

- A. "You are having an allergic reaction. I will get an order for Benadryl."
- B. "That feeling of warmth is normal when the dye is injected."

- C. "That feeling of warmth indicates that the clots in the coronary vessels are dissolving."
- D. "I will tell your doctor and let him explain to you the reason for the hot feeling that you are experiencing."

**Correct Answer: Answer: B. "That feeling of warmth is normal when the dye is injected."**

It is normal for the client to have a warm sensation when dye is injected. The client may have some discomfort from a needle stick. He/she may feel symptoms such as flushing in the face or other parts of the body when the dye is injected. The exact symptoms will depend on the part of the body being examined.

- **Option A:** An area of the groin or the artery in the wrist or hand will be cleaned for the procedure. The client will be given a mild sedative and pain medication to keep them comfortable throughout the procedure. The Radiologist will numb the insertion site and a very small tube called a catheter will be inserted into the vessel. A rapid sequence of X-rays is taken when the dye is injected into the vessel. Each time the contrast is injected, the client may experience a sensation of warmth.
- **Option C:** Warmth does not indicate that clots are dissolving. If the angiogram reveals a narrowed vessel, a balloon angioplasty or stent placement may be performed at the same time. When the procedure is completed, the catheter will be removed, and pressure will be held on the entry site for 10-20 minutes to stop any bleeding. The client may have a compression device applied to stop the bleeding from the angiogram site. This device may stay in place for 1-1 ½ hours.
- **Option D:** This statement indicates that the nurse believes that the hot feeling is abnormal, so it is incorrect. Once the angiogram is completed the client may be on bedrest for 4-6 hours or until he has recovered from sedation. The client will be allowed to eat and will be encouraged to drink fluids to flush the contrast dye from the system. During this time, the catheter insertion site will be watched closely, and blood pressure and pulse will be monitored.

**54. The most serious adverse effect of Alprostadil (Prostin VR pediatric injection) administration in neonates is:**

- A. Bleeding tendencies.
- B. Apnea.
- C. Hypotension.
- D. Pyrexia.

**Correct Answer: B. Apnea.**

All items are adverse reactions of the drug. However, apnea appearing during the first hour of drug infusion occurs in 10-12 percent of neonates with congenital heart defects. Clinicians deciding to utilize alprostadil must be prepared to intubate and mechanically ventilate the infant. Careful monitoring for apnea or respiratory depression is mandatory. In some institutions, elective intubation occurs prior to the initiation of the medication.

- **Option A:** Alprostadil inhibits platelet aggregation and therefore can increase the risk of bleeding. Use intravenous alprostadil cautiously in patients with bleeding tendencies or receiving anticoagulant therapy. Additionally, caution should be used in patients at risk of coagulopathy.
- **Option C:** Alprostadil is known to cause hemodynamic instability causing hypotension/hypertension, and flushing. It is advisable to monitor blood pressure, heart rate, and temperature before and after the use of the drug.

- **Option D:** Alprostadil is a prostaglandin used to maintain patent ductus arteriosus in neonates with ductus arteriosus dependent congenital heart malformations. Alprostadil administration results in fever in ~14% of treated neonates. The occurrence of fever in this setting often leads to extensive investigations to identify the source of fever, as well as to empiric antibiotic therapy and the postponement of cardiac surgery. These measures can lead to several neonatal complications.

**55. Cristina undergoes a biopsy of a suspicious lesion. The biopsy report classifies the lesion according to the TNM staging system as follows: TIS, N0, M0. What does this classification mean?**

- A. No evidence of primary tumor, no abnormal regional lymph nodes, and no evidence of distant metastasis.
- B. Carcinoma in situ, no abnormal regional lymph nodes, and no evidence of distant metastasis.
- C. Can't assess tumor or regional lymph nodes and no evidence of metastasis.
- D. Carcinoma in situ, no demonstrable metastasis of the regional lymph nodes, and ascending degrees of distant metastasis.

**Correct Answer: B. Carcinoma in situ, no abnormal regional lymph nodes, and no evidence of distant metastasis**

TIS, N0, M0 denotes carcinoma in situ, no abnormal regional lymph nodes, and no evidence of distant metastasis.

- **Option A:** No evidence of primary tumor, no abnormal regional lymph nodes, and no evidence of distant metastasis is classified as T0, N0, M0.
- **Option C:** If the tumor and regional lymph nodes can't be assessed and no evidence of metastasis exists, the lesion is classified as TX, NX, M0.
- **Option D:** A progressive increase in tumor size, no demonstrable metastases of the regional lymph nodes, and ascending degrees of distant metastasis is classified as T1, T2, T3, or T4; N0; and M1, M2, or M3.

**56. A 45-year-old marathon runner comes to a health clinic for a routine checkup before participating in an upcoming running event. The patient's medical history is unremarkable and he denies any complaints or recent illnesses. The healthcare provider decides to perform a complete blood count (CBC) to ensure there are no underlying conditions that might affect the patient's performance or health during the event. The results of the CBC show that the formed elements in the patient's blood sample predominantly consist of a specific cell type known for its vital role in oxygen transport throughout the body, ensuring the tissues receive the necessary oxygen for metabolic activities. Based on this information, which of the following cell types is most likely to be predominant in this patient's blood sample?**

- A. Albumins
- B. Globulins
- C. Leukocytes (white blood cells)



D. Erythrocytes (red blood cells)

E. Thrombocytes (platelets)

**Correct Answer: D. Erythrocytes (red blood cells)**

Erythrocytes, or red blood cells, are the most common cell type among the formed elements in the blood and are essential for transporting oxygen from the lungs to tissues throughout the body. They contain hemoglobin, a molecule that binds oxygen and is crucial for aerobic respiration in the tissues, making them the primary cell type involved in oxygen transport.

- **Option A:** Albumins are proteins found in the plasma, not cells. They play a role in maintaining oncotic pressure but do not transport oxygen.
- **Option B:** Like albumins, globulins are proteins found in the plasma that function in the immune response and transport of various substances, but they are not cells and do not have a primary role in oxygen transport.
- **Options C:** Leukocytes are involved in the immune response and defending the body against infections. They do not play a role in oxygen transport.
- **Option E:** Thrombocytes or platelets are involved in hemostasis and help prevent bleeding by forming clots at the site of vascular injury. They do not have a role in oxygen transport.

**57. The nurse correctly teaches a client taking the Benzodiazepine Oxazepam (Serax) to avoid excessive intake of:**

A. Cheese

B. Coffee

C. Sugar

D. Shellfish

**Correct Answer: B. Coffee**

Coffee contains caffeine, which has a stimulating effect on the central nervous system that will counteract the effect of the anti-anxiety medication oxazepam. None of the remaining foods is contraindicated. These drugs may act as depressants to the CNS, specifically inhibiting respiratory drive. Therefore, careful monitoring of all vitals, especially blood pressure and respiratory rate, should be performed after the administration of benzodiazepines. Waveform capnography, if available, should be seriously considered to monitor respiratory status.

- **Option A:** The FDA strongly reminds providers that extreme care should be taken when administering benzodiazepines with other central nervous system depressants such as alcohol, barbiturates, and opioids. The activated charcoal administration is contraindicated in benzodiazepine (BZ) ingestion toxicity/overdose. This is due primarily to altered mental status commonly associated with BZ overdose, which lends itself to aspiration of the activated charcoal.
- **Option C:** Flumazenil is a GABA-A receptor antagonist, acting to reverse the sedative effects of benzodiazepines. Flumazenil functions through competitive inhibition of the alpha-gamma subunit of the GABA-A receptor. Administration of flumazenil should be carried out judiciously, as it may precipitate withdrawal seizures. Of note, one multi-center trial found that patients with excessive benzodiazepine ingestion could become “re-sedated” after flumazenil began to wear off.
- **Option D:** Contraindications include known hypersensitivity to benzodiazepines and angle-closure glaucoma. Glaucoma occurs when the intraocular pressure rises, thereby causing compression of the optic nerve near the posterior surface of the eye. This compression of the lamina cribrosa can

lead to axonal damage with subsequent disruption of anterograde and retrograde axonal transport. This results in numerous issues, including ocular pain, nausea/vomiting, blurred vision, an intraocular pressure greater than 21 mmHg, edema of the corneal epithelium, and non-reactive pupils.

**58. A nurse is teaching a client with pancreatitis about following a low-fat diet. The nurse develops a list of high-fat foods to avoid and includes which food on the item list?**

- A. Chocolate milk
- B. Broccoli
- C. Apple
- D. Salmon

**Correct Answer: A. Chocolate milk**

Chocolate milk is a high-fat food. The pancreas helps with fat digestion, so foods with more fat make the pancreas work harder. Registered dietitian Deborah Gerszberg recommends that people with chronic pancreatitis limit their intake of refined carbohydrates, such as white bread and high sugar foods. Refined carbohydrates can lead to the pancreas releasing large amounts of insulin. Foods that are high in sugar can also raise triglycerides.

- **Option B:** Vegetables are low in fat because they do not come from animal sources. Vegetables, beans, lentils, and whole grains are beneficial because of their fiber content. Eating more fiber can lower the chances of having gallstones or elevated levels of fats in the blood called triglycerides. Both of those conditions are common causes of acute pancreatitis.
- **Option C:** Fruits are low in fat because they do not come from animal sources. Fruits are recommended for people with pancreatitis because they tend to be naturally low in fat, which eases the amount of work the pancreas needs to do to aid digestion.
- **Option D:** Salmon is naturally lower in fat. Many types of fish, such as salmon, lake trout, tuna, and herring, provide healthy omega-3 fat. But avoid fish canned in oil, such as sardines in olive oil. Bake, broil, or grill meats, poultry, or fish instead of frying them in butter or fat.

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

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

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

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

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

**60. The nurse calculates a body mass index (BMI) of 18 for a young adult woman who comes to the physician's office for a college physical. This patient is considered:**

- A. Obese
- B. Overweight
- C. Average
- D. Underweight

**Correct Answer: D. Underweight**

For adults, BMI should range between 20 and 25. Body mass index (BMI) is a person's weight in kilograms divided by the square of height in meters. BMI is an inexpensive and easy screening method for the weight category—underweight, healthy weight, overweight, and obesity.

- **Option A:** BMI greater than 30 is considered obese. For adults 20 years old and older, BMI is interpreted using standard weight status categories. These categories are the same for men and women of all body types and ages.
- **Option B:** BMI 25 to 29.9 is overweight. The prevalence of adult BMI greater than or equal to 30 kg/m<sup>2</sup> (obese status) has greatly increased since the 1970s. Recently, however, this trend has leveled off, except for older women. Obesity has continued to increase in adult women who are 60 years and older.
- **Option C:** BMI less than 20 is considered underweight. BMI can be a screening tool, but it does not diagnose the body fatness or health of an individual. To determine if BMI is a health risk, a healthcare provider performs further assessments. Such assessments include skinfold thickness measurements, evaluations of diet, physical activity, and family history.

**61. Mitomycin (Mutamycin) is prescribed to a client with colorectal cancer. All of which are the routes of administration, except?**

- A. Oral
- B. Intravenous
- C. Intravesical

D. Intraarterial

**Correct Answer: A. Oral**

Mitomycin (Mutamycin) is an antitumor antibiotic used in the treatment of anal, bladder, breast, cervical, colorectal, head and neck, and non-small cell lung cancer.

- **Option A:** There is no pill form of this medication.
- **Options B, C, & D:** These are the routes of medication.

**62. The nurse is reviewing the laboratory result of a client receiving digoxin (Lanoxin) and notes that the result is 2.5 ng/mL. The nurse plans to do which of the following?**

- A. Give the next dose.
- B. Notify the physician.
- C. Check the client's pulse rate.
- D. Increase the next dose as ordered.

**Correct Answer: B. Notify the physician.**

The normal value therapeutic range for digoxin is 0.5 to 2 ng/mL. A level of 2.5 ng/mL indicates toxicity. The nurse should immediately inform the physician, who may give further instructions about holding the next doses of digoxin. Digoxin toxicity can present acutely after an overdose or chronically, as is often seen in patients on digoxin that develop acute kidney injury. Approximately 1% of CHF patients treated with digoxin develop toxicity. Additionally, 1% of adverse drug effects in patients greater than age 40 are due to digoxin toxicity; the incidence rises to greater than 3% in patients over age 85.

- **Option A:** Clinical staff should monitor the plasma digoxin level at least 6 hours or 12 hours post-administration of the last loading dose as this is the time to achieve steady-state levels. Recommended thresholds of therapeutic serum digoxin levels are between 0.5 to 2 ng/dl.
- **Option C:** The physician must request regular electrocardiograms and bloodwork to assess for renal function, and electrolytes require close monitoring. No more than 2 ml of the drug should be injected at the same site. The injection should be made deep into the muscle, and the overlying area massaged post-injection. Intravenous injections are metabolized more efficiently than intramuscular injections and are the preferred route, as only about 80% of the drug is absorbed in intramuscular injections as compared to intravenous dosing.
- **Option D:** Digoxin has a narrow therapeutic index. The recommended serum levels stand between 0.8 to 2 ng/mL. When measuring a digoxin serum level, it is essential to draw blood at least 6 to 8 hours after the last dose. The toxicity increases as the serum drug levels increase above 2.0 ng/mL.

**63. A 75-year-old client is admitted to the hospital with the diagnosis of dementia of the Alzheimer's type and depression. The symptom that is unrelated to depression would be?**

- A. Apathetic response to the environment.
- B. "I don't know" answer to questions.

- C. Shallow of labile affect.
- D. Neglect of personal hygiene.

**Correct Answer: C. Shallow of labile affect**

With depression, there is little or no emotional involvement therefore little alteration in affect. The common features of all the depressive disorders are sadness, emptiness, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.

- **Option A:** Depression (major depressive disorder) is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities you once enjoyed. It can lead to a variety of emotional and physical problems and can decrease your ability to function at work and at home.
- **Option B:** A dysphoric mood state may be expressed by patients as sadness, heaviness, numbness, or sometimes irritability and mood swings. They often report a loss of interest or pleasure in their usual activities, difficulty concentrating, or loss of energy and motivation. Their thinking is often negative, frequently with feelings of worthlessness, hopelessness, or helplessness.
- **Option D:** Depression—also called “clinical depression” or a “depressive disorder”—is a mood disorder that causes distressing symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, symptoms must be present most of the day, nearly every day for at least 2 weeks.

**64. When a client with chronic obstructive pulmonary disease is taking theophylline also receives ciprofloxacin (Cipro), which of the following interactions would occur?**

- A. Cipro Toxicity
- B. Ineffectiveness of ciprofloxacin
- C. Theophylline toxicity
- D. Ineffective theophylline

**Correct Answer: C. Theophylline toxicity**

Theophylline toxicity may occur because the action of theophylline is increased when given with Ciprofloxacin. Theophylline has an extremely narrow therapeutic window. Theophylline toxicity occurs when serum theophylline levels surpass the levels in the therapeutic range. This can occur by intentional overdose or unintentionally when metabolism and/or clearance of theophylline is altered due to certain physiological stressors.

- **Option A:** There is no such thing as Cipro toxicity. Toxic doses of theophylline can be as low as 7.5 mg/kg. When taken orally, 80% to 100% of theophylline is absorbed in the gastrointestinal tract. Peak serum levels can occur from 30 to 120 minutes for immediate release formulations. Sustained-release formulations have peak levels between 6 and 10 hours.
- **Option B:** One mechanism is that theophylline blocks adenosine receptors, which has both therapeutic and toxic effects such as bronchodilation, tachycardia, cardiac arrhythmias, seizures, and cerebral vasoconstriction. At larger doses, theophylline inhibits phosphodiesterase causing increased cyclic adenosine monophosphate resulting in increased levels of adrenergic activation and catecholamine release.

- **Option D:** In theophylline toxicity, epinephrine levels can be 4- to 8-times higher than normal, and norepinephrine concentrations can be 4- to 10-times higher than normal. Increased catecholamine concentrations have a variety of adverse effects such as cardiac arrhythmias, metabolic acidosis, hyperglycemia, and hypokalemia. Chronic theophylline toxicity can occur when there is an accumulation of the drug due to metabolism being overwhelmed or inhibited. It can also occur when clearance is decreased.

**65. Which of the following factors might result in a decreased supply of breastmilk in a postpartum (PP) mother?**

- A. Supplemental feedings with formula
- B. Maternal diet high in vitamin C
- C. An alcoholic drink
- D. Frequent feedings

**Correct Answer: A. Supplemental feedings with formula**

Routine formula supplementation may interfere with establishing an adequate milk volume because decreased stimulation to the mother's nipples affects hormonal levels and milk production. Especially in the first couple of weeks, supplementing with formula tricks the breasts into producing less milk. "In the early weeks, the breasts' capacity for milk production is calibrated in response to the amount of milk that is removed," says lactation consultant Diana West. "If less milk is removed, the breasts assume that less milk is needed, so the capacity is set at a lower point." When the baby is given formula supplements, she naturally eats less at the breast, and the breasts respond by making less milk. If supplementation is necessary, pumping as well as breastfeeding can help to promote a higher volume of milk production.

- **Option B:** A high diet in Vit C does not decrease the supply of breastmilk in the mother. Another cause is the use of birth control. Many mothers who breastfeed and take birth control pills find their milk production doesn't change, but for some, any form of hormonal birth control (the pill, patch or injections) can cause a significant drop in their milk. This is more likely to happen if they start using these contraceptives before the baby is four months old, but it can happen later as well. The first step to increasing the milk supply again is to stop the medication, but talk to a doctor before doing so and be prepared to change birth control methods. Some mothers also need extra help (such as prescription medication, herbal supplements, and/or pumping) to boost milk production.
- **Option C:** Alcohol levels are usually highest in breast milk 30-60 minutes after an alcoholic beverage is consumed, and can be generally detected in breast milk for about 2-3 hours per drink after it is consumed. However, the length of time alcohol can be detected in breast milk will increase the more alcohol a mother consumes. For example, alcohol from 1 drink can be detected in breast milk for about 2-3 hours, alcohol from 2 drinks can be detected for about 4-5 hours, and alcohol from 3 drinks can be detected for about 6-8 hours, and so on.
- **Option D:** The breasts make milk continuously, but the rate at which milk is made depends on how empty they are. The woman will make more milk when her breasts are close to empty and less milk when they are already filled up. When the baby is feeding infrequently, because the mother has put him on a three- or four-hour schedule for example, or because she is giving him a pacifier to stretch out the time between feedings, the breasts are fuller for longer periods of time. That means milk production slows down. When babies are breastfed in response to their cues, they tend to have shorter, frequent feedings and this means the breasts are emptier most of the time and so they continue to produce plenty of milk.

**66. The nurse is caring for a client that is hearing impaired. Which of the following approaches will facilitate communication?**

- A. Speak frequently.
- B. Speak loudly.
- C. Speak directly into the impaired ear.
- D. Speak in a normal tone.

**Correct Answer: D. Speak in a normal tone.**

Speaking in a normal tone to the client with impaired hearing and not shouting are important. The nurse should talk directly to the client while facing the client and speak clearly. If the client does not seem to understand what is said, the nurse should express it differently. Moving closer to the client and toward the better ear may facilitate communication, but the nurse should avoid talking directly into the impaired ear.

- **Option A:** When speaking with a patient who has a hearing impairment it's important to face him directly and make sure you have his attention. Identifying hospitalized patients who have a hearing impairment to others (for example, with a bracelet, a bed tag, or a flag on the chart) and posting communication strategies (with the patient's consent) may ease frustration and minimize miscommunication.
- **Option B:** When speaking with a patient who has a hearing impairment it's important to speak at a normal volume while clearly enunciating (but without using exaggerated lip movements). Remind patients to listen actively. However, many people with hearing impairment find it tiring to keep paying attention, so provide adequate time. Training in word recognition has also been shown to result in some improvements in older adults with hearing impairment.
- **Option C:** When speaking with a patient who has a hearing impairment it's important not to cover the mouth with a hand. When a patient has a hearing impairment, a combination of adaptive techniques, environmental modifications, and assistive devices (including hearing aids) is necessary to ensure effective communication.

**68. Upon Sam's admission for acute psychiatric hospitalization, Nurse Jona documents the following: Client refuses to bathe or dress, remains in the room most of the day, speaks infrequently to peers or staff. Which nursing diagnosis would be the priority at this time?**

- A. Anxiety
- B. Decisional conflict
- C. Self-care deficit
- D. Social isolation

**Correct Answer: D. Social isolation**

These behaviors indicate the client's withdrawal from others and possible fear or mistrust of relationships. If a client is found to be very paranoid, solitary or one-on-one activities that require concentration are appropriate. The client is free to choose his level of interaction; however, concentration can help minimize distressing paranoid thoughts or voices. If a client is unable to respond verbally or in a coherent manner, spend a frequent, short period with clients. An interested presence

can provide a sense of being worthwhile.

- **Option A:** Keep the client in an environment as free of stimuli (loud noises, crowding) as possible. The client might respond to noises and crowding with agitation, anxiety, and increased inability to concentrate on outside events. Identify with client symptoms he experiences when he or she begins to feel anxious around others. Increased anxiety can intensify agitation, aggressiveness, and suspiciousness.
- **Option B:** There is no indication of a Decisional conflict in the information provided. Structure times each day to include planned times for brief interactions and activities with the client on a one-on-one basis; helps the client to develop a sense of safety in a non-threatening environment. If the client is very withdrawn, one-on-one activities with a “safe” person initially should be planned. Learn to feel safe with one person, then gradually might participate in a structured group activity.
- **Option C:** Although the client refuses to bathe or dress, Self-care deficit would not be the priority nursing diagnosis in this situation. Try to incorporate the strengths and interests the client had when not as impaired into the activities planned. Increase the likelihood of client’s participation and enjoyment. Remember to give acknowledgment and recognition for positive steps the client takes in increasing social skills and appropriate interactions with others. Recognition and appreciation go a long way to sustaining and increasing a specific behavior.

**69. In preparing a female client for electroconvulsive therapy (ECT), Nurse Michelle knows that succinylcholine (Anectine) will be administered for which therapeutic effect?**

- A. Short-acting anesthesia
- B. Decreased oral and respiratory secretions
- C. Skeletal muscle paralysis
- D. Analgesia

**Correct Answer: C. Skeletal muscle paralysis**

Anectine is a depolarizing muscle relaxant causing paralysis. It is used to reduce the intensity of muscle contractions during the convulsive stage, thereby reducing the risk of bone fractures or dislocation. A nerve stimulator is utilized to monitor succinylcholine, a depolarizing muscle relaxant used to reduce tonic-clonic contractions during the procedure. As an alternative to EMG, a blood pressure cuff is inflated on the patient's ankle to prevent succinylcholine from entering the foot, allowing a visual monitor of seizure activity with measurement of tonic-clonic contractions.

- **Option A:** ECT utilizes general anesthesia. Anesthetic induction medications used include barbiturates such as thiopental and methohexital and nonbarbiturate agents such as propofol and etomidate. Seizure-induced by ECT should last longer than 30 seconds. Methohexital is the most commonly used induction agent due to its quick onset, effectiveness, low cost, and minimal effect on seizure duration. Propofol and thiopental have been shown to reduce seizure duration. Etomidate has correlations with myoclonus and increased seizure duration.
- **Option B:** Administration of an anticholinergic medication before ECT may prevent arrhythmias such as bradycardia or asystole and excessive oral secretions. To induce cerebral vasoconstriction via hypocarbia, the patient is often hyperventilated via bag valve mask before delivery of the electrical stimulus to increase seizure intensity.
- **Option D:** In a patient with numerous missed seizures, anesthetic induction agents such as etomidate or ketamine may be useful as they exhibit less anticonvulsant effects as compared to



methohexital. While caffeine had been previously administered to prolong seizures, it is no longer the recommendation due to its uncertain safety profile for this purpose.

**70. Nurse Gina understands that her client Glenda who is bulimic feels shame and guilt over binge eating and purging. This disorder is therefore considered:**

- A. Ego-distorting
- B. Ego-dystonic
- C. Ego-enhancing
- D. Ego-syntonic

**Correct Answer: B. Ego-dystonic**

An ego-dystonic disorder is one in which the client views behaviors or symptoms as incongruent with self-image and therefore feels guilt, shame, and distress about the symptoms. Ego-dystonic refers to thoughts, impulses, and behaviors that are felt to be repugnant, distressing, unacceptable or inconsistent with one's self-concept.

- **Option A:** To say that the ego is distorted is simply to say that the mental apparatus is in a state of disordered function, and we cannot pursue this matter fruitfully unless we know exactly what part or layer of the ego is distorted and how and when and why, and with what other psychic reactions the ego-distortion is associated.
- **Option C:** Ego enhancement has been offered as the psychological mechanism that drives differences in judgments about effects on self and others. Findings indicate that although ego enhancement does not appear to directly influence either third-person perception or its relationship to support for government control, it does play a moderating role in regulating the relationship between perceived effects and support for controls, especially in the case of perceived effects on others.
- **Option D:** An ego-syntonic disorder is one which the client views behaviors as congruent with her self-image (as in anorexia nervosa). Ego-syntonic refers to instincts or ideas that are acceptable to the self; that are compatible with one's values and ways of thinking. They are consistent with one's fundamental personality and beliefs.

**71. When developing a plan of care for the client with stress incontinence, the nurse should take into consideration that stress incontinence is best defined as the involuntary loss of urine associated with:**

- A. A strong urge to urinate.
- B. Overdistention of the bladder.
- C. Activities that increase abdominal pressure.
- D. Obstruction of the urethra.

**Correct Answer: C. Activities that increase abdominal pressure**

Stress incontinence is the involuntary loss of urine during such activities as coughing, sneezing, laughing, or physical exertion. These activities increase abdominal and detrusor pressure. Precipitating activities include coughing, laughing, sneezing, straining, or exercising. The patient may initially present with urinary complaints of dysuria, frequency, and urgency.

- **Option A:** A strong urge to urinate is associated with urge incontinence. Urge incontinence is a type of urinary incontinence in adults, which involves sudden compelling urges to void and results in involuntary leakage of urine. This is a serious and debilitating condition and has a social stigma attached to it. To avoid the huge socioeconomic burden and high morbidity associated with this condition, early diagnosis, treatment, and referral concepts must be widely practiced among clinicians.
- **Option B:** Overdistention of the bladder can lead to overflow incontinence. Overflow urinary incontinence is the involuntary leakage of urine from an overdistended bladder due to impaired detrusor contractility and/or bladder outlet obstruction. Neurologic diseases such as spinal cord injuries, multiple sclerosis, and diabetes can impair detrusor function.
- **Option D:** Obstruction of the urethra can lead to urinary retention. Obstructive uropathy is a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional. The back-up of urine into the unilateral or bilateral kidneys, depending on the location of the obstruction, causes hydronephrosis.

**72. She tries to design an organizational structure that allows communication to flow in all directions and involves workers in decision-making. Which form of organizational structure is this?**

- A. Centralized
- B. Decentralized
- C. Matrix
- D. Informal

**Correct Answer: B. Decentralized**

Decentralized structures allow the staff to make decisions on matters pertaining to their practice and communicate in downward, upward, lateral and diagonal flow. Decentralization is a type of organizational structure in which daily operations and decision-making responsibilities are delegated by top management to middle and lower-level managers.

- **Option A:** Centralized management is the organizational structure where a small handful of individuals make most of the decisions in a company. More centralized management is usually seen in highly competitive industries, where companies specialize in similar products to their competition.
- **Option C:** A matrix organizational structure is a workplace format in which employees report to two or more managers rather than one manager overseeing every aspect of a project. For example, an employee may have a primary manager they report to as well as one or more project managers they work under.
- **Option D:** The informal organization is the interlocking social structure that governs how people work together in practice. It is the aggregate of behaviors, interactions, norms, and personal/professional connections through which work gets done and relationships are built among people.

**73. Which of the following is the nurse's legal responsibility when applying restraints?**

- A. Document the patient's behavior.

- B. Document the type of restraint used.
- C. Obtain a written order from the physician except in an emergency, when the patient must be protected from injury to himself or others.
- D. All of the above.

**Correct Answer: D. All of the above**

When applying restraints, the nurse must document the type of behavior that prompted her to use them, document the type of restraints used, and obtain a physician's written order for the restraints. Nurses are accountable for providing, facilitating, advocating and promoting the best possible patient care and to take action when patient safety and well-being are compromised, including when deciding to apply restraints.

- **Option A:** Restraint use should be continually assessed by the health care team and reduced or discontinued as soon as possible. After the discontinuing restraints, interprofessional teams should debrief with the patient, patient's family, or substitute decision maker to discuss intervention, previous interventions and alternatives to restraints.
- **Option B:** There are three types of restraints: physical, chemical and environmental. Physical restraints limit a patient's movement. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement. Environmental restraints control a patient's mobility.
- **Option C:** With any intervention, such as restraint use, nurses need to ensure they actively involve the patient, patient's family, substitute decision-makers and the broader health care team. Nurses are also accountable for documenting nursing care provided, including assessment, planning, intervention and evaluation. In emergency situations, nurses may apply restraints without consent when a serious threat of harm to the patient or others exists and only after all alternative interventions were unsuccessful.

**74. During a group therapy session in the psychiatric unit, a client constantly interrupts with impulsive behavior and exaggerated stories that cast her as a hero or princess. She also manipulates the group with attention-seeking behaviors, such as sexual comments and angry outbursts. The nurse realizes that these behaviors are typical of:**

- A. Paranoid personality disorder
- B. Avoidant personality disorder
- C. Histrionic personality disorder
- D. Borderline personality disorder

**Correct Answer: C. Histrionic personality disorder**

This client's behaviors are typical of histrionic personality disorder, which is marked by excessive emotionality and attention seeking. The client constantly seeks and demands attention, approval, or praise; may be seductive in behavior, appearance, or conversation; and is uncomfortable except when she is the center of attention. Histrionic personality disorder, or dramatic personality disorder, is a psychiatric disorder distinguished by a pattern of exaggerated emotionality and attention-seeking behaviors. Histrionic personality disorder falls within the "Cluster B" of personality disorders.

- **Option A:** Typically, a client with paranoid personality disorder is suspicious, cold, hostile, and argumentative. Paranoid personality disorder (PPD) is one of a group of conditions called "Cluster

A” personality disorders which involve odd or eccentric ways of thinking. People with PPD also suffer from paranoia, an unrelenting mistrust and suspicion of others, even when there is no reason to be suspicious.

- **Option B:** Avoidant personality disorder is characterized by anxiety, fear, and social isolation. Avoidant personality disorder (AVPD) is an enduring pattern of behavior related to social inhibition, feelings of inadequacy, and sensitivity to rejection that causes problems in work situations and relationships. The disorder is characterized by extreme shyness and sensitivity to criticism from others and is known as a Cluster C personality disorder or one that involves anxious and fearful personality disorders.
- **Option D:** Borderline personality disorder is characterized by impulsive, unpredictable behavior and unstable, intense interpersonal relationships. Borderline personality disorder (BPD) is a serious psychological condition that’s characterized by unstable moods and emotions, relationships, and behavior. It’s one of several personality disorders recognized by the American Psychiatric Association (APA).

**75. A male client is having tonic-clonic seizures. What should the nurse do first?**

- A. Elevate the head of the bed.
- B. Restrain the client’s arms and legs.
- C. Place a tongue blade in the client’s mouth.
- D. Take measures to prevent injury.

**Correct Answer: D. Take measures to prevent injury.**

Protecting the client from injury is the immediate priority during a seizure. Do not leave the patient during and after a seizure to promote safety measures. Maintain in lying position, flat surface; turn head to side during seizure activity. Helps in the drainage of secretions; prevents the tongue from obstructing the airway. Loosen clothing from neck or chest and abdominal areas to aid in breathing or chest expansion.

- **Option A:** Elevating the head of the bed would have no effect on the client’s condition or safety. Support the head, place on soft areas or assist to the floor if out of bed. Supporting the extremities lessens the risk of physical injury when the patient lacks voluntary muscle control.
- **Option B:** Restraining the client’s arms and legs could cause injury. Do not attempt to restrain. If the attempt is made to restrain the patient during a seizure, erratic movements may increase, and the patient may injure himself or others.
- **Option C:** Placing a tongue blade or other object in the client’s mouth could damage the teeth. Turn head to side and suction airway as indicated. Insert plastic bite blocks only if the jaw relaxed. Helps maintain airway patency and reduces the risk of oral trauma but should not be “forced” or inserted when teeth are clenched because dental and soft-tissue damage may result. Note: Wooden tongue blades should not be used because they may splinter and break in the patient’s mouth.

**76. Which of the following health promotion activities should the nurse include in the discharge teaching plan for a client with asthma?**

- A. Incorporate physical exercise as tolerated into the treatment plan.

- B. Monitor peak flow numbers after meals and at bedtime.
- C. Eliminate stressors in the work and home environment.
- D. Use sedatives to ensure uninterrupted sleep at night.

**Correct Answer: A. Incorporate physical exercise as tolerated into the treatment plan.**

Physical exercise is beneficial and should be incorporated as tolerated into the client's schedule. Peak flow numbers should be monitored daily, usually in the morning (before taking medication). Encourage breathing exercises and controlled breathing and relaxation. Prevents attack before it begins and increases ventilation.

- **Option B:** Peak flow does not need to be monitored after each meal. Monitor peaked expiratory flow rates and forced expiratory volume as taken by the respiratory therapist. The severity of the exacerbation can be measured objectively by monitoring these values. The peak expiratory flow rate is the maximum flow rate that can be generated during a forced expiratory maneuver with fully inflated lungs.
- **Option C:** Stressors in the client's life should be modified but cannot be totally eliminated. Instruct folks to modify the home environment to reduce dust, exposure to pets and indoor plants, foods (peanut, egg), changing of filters.
- **Option D:** Although adequate sleep is important, it is not recommended that sedatives be routinely taken to induce sleep. Schedule and provide rest periods in a calm peaceful environment. Promotes adequate rest and decreases stimuli.

**77. The client has just had surgery to create an ileostomy. The nurse assesses the client in the immediate post-op period for which of the following most frequent complications of this type of surgery?**

- A. Intestinal obstruction
- B. Fluid and electrolyte imbalance
- C. Malabsorption of fat
- D. Folate deficiency

**Correct Answer: B. Fluid and electrolyte imbalance**

A major complication that occurs most frequently following an ileostomy is fluid and electrolyte imbalance. The client requires constant monitoring of intake and output to prevent this from happening. Losses require replacement by intravenous infusion until the client can tolerate a diet orally. Monitor I&O; carefully, measure liquid stool. Weigh regularly. This provides direct indicators of fluid balance. Greatest fluid losses occur with an ileostomy, but they generally do not exceed 500–800 mL/day.

- **Option A:** Intestinal obstruction is a less frequent complication. Small bowel obstruction is a recognized complication of ileostomy. Small bowel obstruction may occur because of too small trephine in the anterior abdominal wall, a twisted loop, small bowel adhesions in the area around the ileostomy, intraperitoneal adhesions, or an acute parastomal hernia.
- **Option C:** Fat malabsorption is a complication that could occur later in the postoperative period. Suggest the patient with ileostomy limit prunes, dates, stewed apricots, strawberries, grapes, bananas, cabbage family, beans, and avoid foods high in cellulose, e.g., peanuts. These products increase ileal effluent. Digestion of cellulose requires colon bacteria that are no longer present.

- **Option D:** Folate deficiency is a complication that could occur later in the postoperative period. Vitamin B12 plays an important role in keeping the brain and nervous system healthy. This decrease is thought to occur because the part of the intestine removed during the procedure is responsible for absorbing some vitamin B12 from the food you eat.

**78. Which of the following statements involving Type II diabetes mellitus is correct?**

- A. It involves inefficient insulin production.
- B. It involves cessation of Insulin production by the beta cells of the pancreas.
- C. It involves increased insulin receptor responsiveness.
- D. It involves the infant client.

**Correct Answer: A. It involves inefficient insulin production.**

In type II diabetes mellitus, insulin is produced in insufficient amounts along with reduced insulin receptor responsiveness. T2DM involves a more insidious onset where an imbalance between insulin levels and insulin sensitivity causes a functional deficit of insulin. Insulin resistance is multifactorial but commonly develops from obesity and aging.

- **Option B:** In type II diabetes mellitus, the beta cells do produce insulin but in inadequate amounts. A patient with DM has the potential for hyperglycemia. The pathology of DM can be unclear since several factors can often contribute to the disease. Hyperglycemia alone can impair pancreatic beta-cell function and contributes to impaired insulin secretion. Consequentially, there is a vicious cycle of hyperglycemia leading to the impaired metabolic state. Blood glucose levels above 180 mg/dL are often considered hyperglycemic in this context, though because of the variety of mechanisms, there is no clear cutoff point.
- **Option C:** There is decreased rather than increased insulin responsiveness. Insulin resistance is attributable to excess fatty acids and proinflammatory cytokines, which leads to impaired glucose transport and increases fat breakdown. Since there is an inadequate response or production of insulin, the body responds by inappropriately increasing glucagon, thus further contributing to hyperglycemia. While insulin resistance is a component of T2DM, the full extent of the disease results when the patient has inadequate production of insulin to compensate for their insulin resistance.
- **Option D:** T1DM presents in children or adolescents, while T2DM is thought to affect middle-aged and older adults who have prolonged hyperglycemia due to poor lifestyle and dietary choices. The pathogenesis for T1DM and T2DM is drastically different, and therefore each type has various etiologies, presentations, and treatments.

**79. A newly admitted client diagnosed with Hodgkin's disease undergoes an excisional cervical lymph node biopsy under local anesthesia. What does the nurse assess first after the procedure?**

- A. Vital signs
- B. Incision site
- C. Airway
- D. Level of consciousness

**Correct Answer: C. Airway**

Assessing for an open airway is the priority. The procedure involves the neck, the anesthesia may have affected the swallowing reflex or the inflammation may have closed in on the airway leading to ineffective air exchange. When the numbness wears off, the throat may feel scratchy for several days. After the test, the cough reflex will return in 1 to 2 hours. Then the client may eat and drink normally.

- **Option A:** The vital signs should be assessed after the procedure, but this may come after assessing the airway first. Infection is relatively rare and can be treated with antibiotics. Numbness can occur if the biopsy is done near nerves. Any numbness typically disappears within a couple of months.
- **Option B:** The incision site should be assessed regularly, but this would not be the priority after the procedure. The patient should contact the physician if any redness, increased swelling, or increased pain develops at the surgery site. Patients may shower or bathe normally. The patient may get water on the incision. If there are stitches, they may get wet. If there is a plastic bandage over the incision, the patient may get this wet.
- **Option D:** The client has only undergone local anesthesia, his level of consciousness should not be a cause of concern. Pain and tenderness can last for a few days after a biopsy. Once the client gets home, he should keep the biopsy site clean and dry at all times. The doctor may ask the client to avoid showers or baths for a couple of days after the surgery.

**80. A toddler has recently been diagnosed with cerebral palsy. Which of the following information should the nurse provide to the parents? Note: More than one answer may be correct. Select all that apply.**

- A. Regular developmental screening is important to avoid secondary developmental delays.
- B. Cerebral palsy is caused by injury to the upper motor neurons and results in motor dysfunction, as well as possible ocular and speech difficulties.
- C. Developmental milestones may be slightly delayed but usually will require no additional intervention.
- D. Parent support groups are helpful for sharing strategies and managing health care issues. E. Outdoor activities are prohibited for the child.
- E. Outdoor activities are prohibited for the child.

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

Delayed developmental milestones are characteristic of cerebral palsy, so regular screening and intervention is essential. Because of injury to upper motor neurons, children may have ocular and speech difficulties. Parent support groups help families to share and cope.

- **Option A:** Encourage age-related play and other activities that strengthen gross and fine motor development, sensory and cognitive development such as letting the child put green balls on the left basket and red balls on the right. These activities enhance growth and development and provide needed stimulation for the child.
- **Option B:** Learn patient needs and pay attention to nonverbal cues. The nurse should set aside enough time to attend to all of the details of patient care. Care measures may take longer to complete in the presence of a communication deficit. Provide an alternative means of communication. Alternative forms such as flashcards, whiteboards, hand signs, or a picture board allow the client to express oneself if speaking is difficult to obtain.

- **Option C:** Physical therapy and other interventions can minimize the extent of the delay in developmental milestones. Facilitate activities in using fine and gross motor skills (such as giving a ball on hand to encourage throwing, holding a spoon). Perform range-of-motion exercises every 4 hours for the child unable to move body parts. Children with cerebral palsy have a decreased range of motion (ROM) due to limited mobility and the presence of spasticity. ROM exercises promote movement and minimize the risk of contractures.
- **Option D:** Encourage the parent to express the impact of their child's condition on the family. Assess the coping ability of the family. This will determine how much support and guidance the family may need. Educate the family on different skills needed to manage the child's care (such as physical rehabilitation, proper nutrition, medication administration, ROM exercises, seizure management).
- **Option E:** Outdoor activities, such as bird watching, playing in the playground, or amusement park rides, are not prohibited for the child with cerebral palsy. Most of the activities of daily living and play exercises hasten physical development. Helps the parents to vent their feelings/concerns.

**81. The Hodgkin's disease patient described in the question above undergoes a lymph node biopsy for definitive diagnosis. If the diagnosis of Hodgkin's disease were correct, which of the following cells would the pathologist expect to find?**

- A. Reed-Sternberg cells.
- B. Lymphoblastic cells.
- C. Gaucher's cells.
- D. Rieder's cells

**Correct Answer: A. Reed-Sternberg cells**

A definitive diagnosis of Hodgkin's disease is made if Reed-Sternberg cells are found on pathologic examination of the excised lymph node. Four features characterize Hodgkin lymphomas. They commonly arise in the cervical lymph nodes; the disease is more common in young adults; there are scattered large mononuclear Hodgkin and multinucleated cells (Reed-Sternberg) intermixed in a background of a mixture of non-neoplastic inflammatory cells; finally, T lymphocytes are often observed surrounding the characteristic neoplastic cells.

- **Option B:** Lymphoblasts are immature cells found in the bone marrow of patients with acute lymphoblastic leukemia. Lymphoblast is an immature white blood cell that gives rise to a type of immune cell known as a lymphocyte. The nucleus contains moderately fine chromatin (readily stainable nuclear material) and has a well-defined nuclear membrane. There are one or two nucleoli, and the cytoplasm is small or moderate in amount. Lymphoblasts that grow and divide uncontrollably cause a type of cancer known as acute lymphoblastic leukemia.
- **Option C:** Gaucher's cells are large storage cells found in patients with Gaucher's disease. The Gaucher cell results from the accumulation of excessive glucocerebroside in cells of the monocyte-macrophage system. It is characterized ultrastructurally by the presence of cytoplasmic inclusions which consist of tubule-like structures measuring 130 to 150 Ao in diameter.
- **Option D:** Rieder's cells are myeloblasts found in patients with acute myelogenous leukemia. They are abnormal myeloblasts in which the nucleus may be widely or deeply indented or may actually be a bilobate or multilobate structure; frequently observed in acute leukemia.



**82. As a competent nurse, you are aware that vasodilators are used mainly to treat:**

- A. Diabetes
- B. Hypertension
- C. Atrial fibrillation
- D. Hypotension

**Correct Answer: B. Hypertension**

Vasodilators are used to treat hypertension. Vasodilators are useful in treating a variety of medical conditions, most commonly systemic hypertension. Other diseases include myocardial infarction (both ST-segment elevation and non-ST-segment elevation), angina, heart failure, stroke, chronic kidney disease, preeclampsia, hypertensive emergency.

- **Option A:** They are not used to treat diabetes. Since T1DM is a disease primarily due to the absence of insulin, insulin administration through daily injections, or an insulin pump, is the mainstay of treatment. In T2DM, diet and exercise may be adequate treatments, especially initially. Other therapies may target insulin sensitivity or increase insulin secretion by the pancreas. The specific subclasses for drugs include biguanides (metformin), sulfonylureas, meglitinides, alpha-glucosidase inhibitors, thiazolidinediones, glucagon like-peptide-1 agonist, dipeptidyl peptidase IV inhibitors, selective, amylinomimetics, and sodium-glucose transporter-2 inhibitors.
- **Option C:** Atrial fibrillation is not treated with vasodilators. If there is evidence of rapid ventricular response, a beta-blocker or calcium-channel blocker should be commenced for rate control. These options can be used in the intravenous (IV) form for rapid response. Usually, a bolus is administered to the patient and then started on a drip if symptoms do not resolve.
- **Option D:** Vasodilators are not used to treat hypotension. Asymptomatic hypotension should not receive drastic interventions. However, if symptoms are present, the treatment of hypotension should focus on reversing the underlying etiology.

**83. A client is having frequent premature ventricular contractions. A nurse would place a priority on the assessment of which of the following items?**

- A. Blood pressure and peripheral perfusion.
- B. Sensation of palpitations.
- C. Causative factors such as caffeine.
- D. Precipitating factors such as infection.

**Correct Answer: A. Blood pressure and peripheral perfusion.**

Premature ventricular contractions can cause hemodynamic compromise. The shortened ventricular filling time with the ectopic beats leads to decreased stroke volume and, if frequent enough, to decreased cardiac output. Physical examination findings would reveal an irregular heart rhythm upon auscultation if the patient is experiencing PVCs during the examination. In some patients, cannon A waves may cause chest or neck discomfort. Otherwise, there would not be any direct physical examination findings. A prolonged run of PVCs can result in hypotension.

- **Option B:** The client may be asymptomatic or may feel palpitations. A thorough history should include any associated symptoms with the palpitations, the patient's medical history, medication,

and supplement usage as well as a detailed social history. It is crucial to inquire about any illicit drug use in those who frequently experience PVCs.

- **Option C:** Common known etiologies include excess caffeine consumption, excess catecholamines, high levels of anxiety, and electrolyte abnormalities. Specific electrolyte changes found in those who experience PVCs are low blood potassium, low blood magnesium, and high blood calcium. Alcohol, tobacco, and illicit drugs are also associated with PVCs as are stimulant-based medications. Patients suffering from sleep deprivation also experience PVCs.
- **Option D:** PVCs can be caused by cardiac disorders or by any number of physiological stressors, such as infection, illness, surgery, or trauma, and by the intake of caffeine, alcohol, or nicotine. There are numerous cardiac and non-cardiac pathologies that are causative of PVCs. Examples include cardiomyopathy, mitral valve prolapse, and myocardial infarction. Any structural heart disease that alters conduction pathways due to tissue alterations can cause PVCs. Non-cardiac examples are hyperthyroidism, anemia, and even hypertension.

**84. Which of the following diagnostic tests should be performed annually over age 50 to screen for colon cancer?**

- A. Abdominal CT scan
- B. Abdominal x-ray
- C. Colonoscopy
- D. Fecal occult blood test

**Correct Answer: D. Fecal occult blood test**

Surface blood vessels of polyps and cancers are fragile and often bleed with the passage of stools. A fecal occult blood test is used to find blood in the feces, or stool, which can be a sign of polyps or cancer. A positive test, meaning that blood is found in the feces, can be from causes other than a colon polyp or cancer, including bleeding in the stomach or upper GI tract and even eating rare meat or other foods. There are 2 types of tests: guaiac (FOBT) and immunochemical (FIT). Polyps and cancers do not bleed continually, so FOBT must be done on several stool samples each year and should be repeated every year. Even then, this screening test provides a fairly small reduction in deaths from colorectal cancer, around 30% if done yearly and 18% if done every other year.

- **Option A:** Abdominal CT scan can help establish tumor size and metastasis. Ct colonography, sometimes called virtual colonoscopy, is a screening method being studied in some centers. It requires interpretation by a skilled radiologist to provide the best results. A radiologist is a doctor who specializes in obtaining and interpreting medical images. CT colonography may be an alternative for people who cannot have a standard colonoscopy due to the risk of anesthesia, which is medication to block the awareness of pain, or if a person has a blockage in the colon that prevents a full examination.
- **Option B:** Abdominal x-ray is a commonly performed diagnostic x-ray examination that produces images of the organs in the abdominal cavity including the stomach, liver, intestines, and spleen. When an abdominal x-ray is performed to provide pictures of the kidneys, ureters, and bladder, it's called a KUB x-ray.
- **Option C:** A colonoscopy can help locate a tumor as well as polyps, which can be removed before they become malignant. A colonoscopy allows the doctor to look inside the entire rectum and colon while a patient is sedated. A flexible, lighted tube called a colonoscope is inserted into the rectum and the entire colon to look for polyps or cancer. During this procedure, a doctor can remove polyps or other tissue for examination. The removal of polyps can also prevent colorectal cancer.

**85. A nurse is preparing to assess the uterine fundus of a client in the immediate postpartum period. When the nurse locates the fundus, she notes that the uterus feels soft and boggy. Which of the following nursing interventions would be most appropriate initially?**

- A. Massage the fundus until it is firm.
- B. Elevate the mother's legs.
- C. Push on the uterus to assist in expressing clots.
- D. Encourage the mother to void.

**Correct Answer: A. Massage the fundus until it is firm.**

If the uterus is not contracted firmly, the first intervention is to massage the fundus until it is firm and to express clots that may have accumulated in the uterus. Uterine atony refers to the corpus uteri myometrial cells inadequate contraction in response to endogenous oxytocin that is released in the course of delivery. Risk factors for uterine atony include prolonged labor, precipitous labor, uterine distension (multi-fetal gestation, polyhydramnios, fetal macrosomia), fibroid uterus, chorioamnionitis, indicated magnesium sulfate infusions, and prolonged use of oxytocin.

- **Option B:** Elevating the mother's legs will not manage the uterine atony. Ineffective uterine contraction, either focally or diffusely, is additionally associated with a diverse range of etiologies including retained placental tissue, placental disorders (such as morbidly adherent placenta, placenta previa, and abruptio placentae), coagulopathy (increased fibrin degradation products) and uterine inversion.
- **Option C:** Pushing on an uncontracted uterus can invert the uterus and cause massive hemorrhage. It leads to postpartum hemorrhage as delivery of the placenta leaves disrupted spiral arteries which are uniquely void of musculature and dependent on contractions to mechanically squeeze them into a hemostatic state. Uterine atony is a principal cause of postpartum hemorrhage, an obstetric emergency. Globally, this is one of the top 5 causes of maternal mortality.
- **Option D:** Encouraging the client to void will not assist in managing uterine atony. If the uterus does not remain contracted as a result of the uterine massage, the problem may be distended bladder and the nurse should assist the mother to urinate, but this would not be the initial action. Contraction of the myometrium that mechanically compresses the blood vessels supplying the placental bed provides the principal mechanism uterine hemostasis after delivery of the fetus, and the placenta is concluded. The process is complemented by local decidual hemostatic factors such as tissue factor type-1 plasminogen activator inhibitor as well as by systemic coagulation factors such as platelets, circulating clotting factors.