Decreasing anxiety is correct. The nurse should include that hydroxyzine is an effective antianxiety agent and is used to decrease anxiety in surgical clients as well as in persons with moderate anxiety.

Controlling emesis is correct. The nurse should include that hydroxyzine is an effective antiemetic and is used to control nausea and vomiting in pre- and postoperative clients.

Relaxing skeletal muscles is incorrect. The nurse should recognize benzodiazepines, such as diazepam (Valium), are used to produce skeletal muscle relaxation.

Preventing surgical site infections is incorrect. The nurse should instruct the client that antibiotics administered prior to surgery are used to diminish the risk of surgical site infections; hydroxyzine, an antiemetic, does not have any effect on bacteria.

Reducing the amount of narcotics needed for pain relief is correct. Hydroxyzine increases the effects of narcotic pain medications. The nurse should instruct the client that when it is used for surgical clients, narcotic requirements may be significantly reduced.

5. A nurse is reinforcing teaching with a client who has type 2 diabetes mellitus. The nurse determines that teaching has been effective when the client identifies which of the following manifestations of hypoglycemia? (Select all that apply.)

INCORRECT

1) Polyuria

2) Blurry vision

3) Tachycardia

INCORRECT

4) Polydipsia

5) Sweating

Answer Rationale:

Polyuria is incorrect. Hyperglycemia causes polyuria.

Blurry vision is correct. Manifestations of hypoglycemia include blurry vision, tremors, anxiety, irritability, headache, and hypotension.

Tachycardia is correct. Manifestations of hypoglycemia include tachycardia, tremors, anxiety, irritability, headache, and hypotension.

Polydipsia is incorrect. Hyperglycemia causes polydipsia.

Sweating is correct. Manifestations of hypoglycemia include sweating, tremors, anxiety, irritability, headache, and hypotension.

6. A nurse is collecting data from a client who has an exacerbation of gout. Which of the following findings should the nurse expect? (Select all that apply.)

1) Edema

1) Cranial enlargement

2) Skeletal pain

3) Waddling gait

INCORRECT

4) Cold extremities

INCORRECT

5) Muscle weakness

Answer Rationale:

Cranial enlargement is correct. When the skull is involved, Paget's disease causes thickening and enlargement of the skull bones and enlargement of the cranium.**Skeletal pain is correct.** Paget's disease causes pain and tenderness over the affected bones.**Waddling gait is correct.** When the legs are involved, Paget's disease causes bowing of the legs and a waddling gait.**Cold extremities is incorrect.** Paget's disease causes warmth over the affected bones.**Muscle weakness is incorrect.** The nurse should expect muscle weakness for a client who has osteomalacia.

24. An occupational health nurse is instructing workers at an industrial facility about emergency procedures to follow in the event of a traumatic amputation. Which of the following guidelines should the nurse include about preserving the amputated part for possible surgical reattachment? (Select all that apply.)

1) Wrap the part in sterile gauze.

INCORRECT

2) Place the severed end of the part directly into crushed ice.

3) Put the severed part in a plastic bag.

INCORRECT

4) Scrub the severed part with antibacterial solution.

5) Prevent the severed part from coming in contact with water.

Answer Rationale:

Wrap the part in sterile gauze is correct. The person at the scene should wrap the severed part in sterile gauze or a clean cloth, and soak it with saline solution, if available.**Place the severed end of the part directly into crushed ice is incorrect.** The person at the scene should not allow direct contact between the part and ice.**Put the severed part in a plastic bag is correct.** The person at the scene should place the severed part in a sealed, waterproof plastic bag and then put the bag in ice water.**Scrub the severed part with antibacterial solution is incorrect.** The person on the scene should only rinse the amputated part if needed to remove visible debris.**Prevent the severed part from coming in contact with water.** The person at the scene should not allow the severed part to become wet but should keep it dry.

25. A nurse in a provider's office is reinforcing teaching with a client about the risk factors for osteoarthritis. Which of the following information should the nurse include? (Select all that apply.)

INCORRECT

1) Bacterial infections

INCORRECT

2) Use of diuretic medications

3) Aging

4) Obesity

5) Heredity

Answer Rationale:

Bacteria is incorrect. Bacterial infections can lead to infectious arthritis or rheumatoid arthritis, but it is not a risk factor for osteoarthritis.

Diuretics is incorrect. Diuretic therapy is a possible risk factor for gout, but not for osteoarthritis.

Aging is correct. Aging is a risk factor for osteoarthritis, as the joints bear the load of the body's weight over time.

Obesity is correct. Obesity is a risk factor for osteoarthritis, as it increases the load of the body's weight over time.

Heredity is correct. There is a genetic component to the development of osteoarthritis.

26. A nurse in a provider's office is reinforcing teaching with a female client about risk factors for osteoporosis. Which of the following factors should the nurse include in the teaching? (Select all that apply.)

1) Sedentary lifestyle

INCORRECT

2) Obesity

3) Aging

4) Excessive caffeine

INCORRECT

5) Hormone therapy

Answer Rationale:

Sedentary lifestyle is correct. Immobility depletes bone.

Obesity is incorrect. Women who are obese have a greater capacity for storing estrogen to help maintain acceptable levels of calcium.

Aging is correct. Women lose bone due to estrogen depletion after menopause.

Caffeine intake is correct. Excessive caffeine intake causes calcium loss in the urine.

Hormone therapy is incorrect. Estrogen protects women from developing osteoporosis.

through the lower extremities. One means of doing this is through exercising the lower extremities using quadriceps and gluteal sets as well as ankle flexion and extension.**Measure thighs is correct.** The nurse should recognize the manifestations of a DVT include redness, swelling, warmth and pain of the affected extremity. Measuring calf and thigh diameters daily will assist in the identification of a DVT should one develop.**Massage calves is incorrect.** The nurse should recognize that massage is contraindicated in a client who is at risk for DVT development. Massage can cause small thrombi to break loose from the vein wall and move through the circulatory system, potentially resulting in complications such as a stroke, myocardial infarction, or pulmonary embolism.

40. A nurse is contributing to the plan of care for a client who has a spinal cord injury and paralysis. Which of the following actions should the nurse include in the plan to decrease the client's risk of skin breakdown? (Select all that apply.)

INCORRECT

1) Massage erythematous bony prominences.

INCORRECT

2) Implement turning schedule every 4 hr.

3) Use pillows to keep heels off the bed surface.

INCORRECT

4) Keep environmental humidity less than 30%.

5) Minimize skin exposure to moisture.

Answer Rationale:

Massage erythematous bony prominences is incorrect. The nurse should avoid massaging erythematous bony prominences, which would cause further skin breakdown.

Implement turning schedule every 4 hr is incorrect. The nurse should implement a turning schedule to prevent skin breakdown. This includes turning the client every 2 hr while in bed and repositioning hourly if the client is up in a chair.

Use pillows to keep heels off the bed surface is correct. The nurse should pad all bony prominences and use devices such as pillows to keep the heels off the bed surface and prevent skin breakdown.

Keep environmental humidity less than 30% is incorrect. The nurse should manage humidity in the client's room and keep the humidity above 40%. Humidity less than 40% is drying to the skin and increases the risk of skin breakdown.

Minimize skin exposure to moisture is correct. The nurse should include actions to minimize exposure of the skin to moisture from sweating, wound drainage or incontinence as this causes maceration of the skin which leads to skin breakdown.

41. A nurse is contributing to the plan of care for a client who has a seizure disorder. Which of the following interventions should the nurse include in the plan? (Select all that apply.)

1) Provide a suction setup at the bedside.

3) Pain relieved by narcotics

INCORRECT

4) Capillary refill 1 second

5) Altered sensation of the toes

Answer Rationale:

Cool skin is correct. The nurse should identify pallor as a possible manifestation of compartment syndrome.

Absence of pulse is correct. The nurse should identify pulselessness as a possible manifestation of compartment syndrome.

Pain that is relieved by narcotics is incorrect. The nurse should expect pain that is beyond the expected level for the client's condition and is unrelieved by narcotics as a possible manifestation of compartment syndrome.

Capillary refill 1 second is incorrect. The nurse should expect a client who has compartment syndrome to have delayed capillary refill (2 seconds or greater).

Altered sensation of the toes is correct. The nurse should identify paresthesias as a possible manifestation of compartment syndrome.

55. A nurse is assisting with a presentation at a community center about knee disorders and injuries. The nurse should include which of the following as risk factors for developing osteoarthritis? (Select all that apply.)

1) Obesity

2) Family history of osteoarthritis

INCORRECT

3) Calcium deficiency

4) Aging

5) Regular, strenuous exercise

Answer Rationale:

Obesity is correct. Obesity is a risk factor for osteoarthritis, as it increases the load of the body's weight over time.

Family history of osteoarthritis is correct. A client can have a genetic predisposition for developing osteoarthritis.

Calcium deficiency is incorrect. Too little calcium leads to osteoporosis, rather than osteoarthritis.

Aging is correct. Aging is a risk factor for osteoarthritis, as the joints bear the load of the body's weight over time.

Regular, strenuous exercise is correct. Strenuous exercise and repetitive motion can result in osteoarthritis.

will die if dialysis is not initiated. The client's glomerular filtration rate (GFR) is used to determine the severity of kidney damage. The GFR is expected to be greater than 90 mL/min. Chronic kidney disease (CKD) is comprised of five stages: Stage 1, minimal kidney damage with normal GFR; Stage 2, mild kidney damage with mildly decreased GFR; Stage 3, moderate kidney damage with a moderate decrease in GFR; Stage 4, severe kidney damage with a severe decrease in GFR; and Stage 5, kidney failure and end-stage kidney disease with little or no glomerular filtration and renal replacement therapy required. Glomerular filtration rate is an indicator of renal function and is checked to evaluate how well the kidneys are working. Because ESKD is irreversible, it is not necessary to check the GFR prior to dialysis because the GFR level in these clients is elevated and will remain that way unless a renal transplantation is performed.

Administer a sedative is incorrect. The client is awake during hemodialysis and is a painless procedure for the client. Therefore, a sedative is not needed.

Check the graft site for a palpable thrill is correct. Hemodialysis requires access to the client's blood by way of a graft, arteriovenous (AV) fistula, or central venous access device. The nurse should check patency of the access site (presence of bruit, palpable thrill, distal pulses, and circulation). This ensures vascular flow and proper functioning of the graft prior to the dialysis procedure. If a thrill is not found, this can indicate the graft has clotted and hemodialysis will not be possible. This would need to be reported to the provider. Measures to protect the graft include avoiding taking blood pressure, administering injections, performing venipuncture, or inserting IV lines on an extremity with an access site.

61. A nurse is reinforcing teaching with a client regarding reduction of risk factors for coronary artery disease. Which of the following statements by the client indicates an understanding of the teaching? (Select all that apply.)

1) "I must stop smoking."

INCORRECT

2) "I should lower my HDL cholesterol level."

INCORRECT

3) "I will stop consuming alcohol."

4) "I need to monitor my weight."

5) "I am limiting my intake of fast foods."

Answer Rationale:

"I must stop smoking." is correct. Smoking places the client at three to four times higher risk for developing coronary disease, but the benefits of stopping smoking occur almost immediately.

"I should lower my HDL cholesterol level." is incorrect. The nurse should remind the client that this type of cholesterol is beneficial to removing bad cholesterol from the body.

"I will stop consuming alcohol." is incorrect. The client should limit alcohol consumption to 2 drinks per day for men and 1 drink per day for women.

"I need to monitor my weight." is correct. Obesity, or an increase in weight, is a significant factor in developing coronary artery disease. Weight management is vital to

nurse should instruct the client to sit in a semi-Fowler's or sitting position to promote expansion of the diaphragm and thoracic region.

Take a deep breath between each attempt to cough is incorrect. The nurse should instruct the client to take two deep breaths, then inhale deeply. After holding the breath several seconds, the clients should cough two to three times consecutively to promote mucus expulsion from the lungs.

73. A nurse is caring for a client who is in Buck's traction. Which of the following actions should the nurse take? (Select all that apply.)

1) Monitor peripheral pulses in the affected extremity.

INCORRECT

2) Position weights against the foot of the bed.

INCORRECT

3) Adjust the prescribed weights every shift.

4) Examine the skin under the traction splint.

5) Assess the temperature of the affected extremity.

Answer Rationale:

Monitor peripheral pulses in the affected extremity is correct. The fracture and the traction device can compromise circulation to the extremity, so checking peripheral pulses is necessary to evaluate tissue perfusion.

Position weights against the foot of the bed is incorrect. The weights should hang freely away from the foot of bed to promote proper traction and healing.

Adjust the prescribed weights every shift is incorrect. Once the weights are in place, the nurse should not adjust or remove them unless the provider prescribes changes.

Examine the skin under the traction splint is correct. The nurse should monitor the client's skin integrity because immobility can reduce sensation in the extremity. The client might not feel any breakdown in the skin.

Assess the temperature of the affected extremity is correct. The fracture and the traction device can compromise circulation to the extremity, so checking the temperature is necessary to evaluate tissue perfusion.