D. An elderly man being treated for a peptic ulcer. -

A lactating woman (B) has the greatest need for additional protein intake. (A, C, and D) are all conditions that require protein, but do not have the increased metabolic prote in demands of lactation.

Correct Answer: B

A client is in the radiology department at 0900 when the prescription levofloxacin (Lev aquin) 500 mg IV q24h is scheduled to be administered. The client returns to the unit at 1300. What is the best intervention for the nurse to implement?

A. Contact the healthcare provider and complete a medication variance form.

B. Administer the Levaquin at 1300 and resume the 0900 schedule in the morning.

C. Notify the charge nurse and complete an incident report to explain the missed dose.

D. Give the missed dose at 1300 and change the schedule to administer daily at 1300. -

To ensure that a therapeutic level of medication is maintained, the nurse should admini ster the missed dose as soon as possible, and revise the administration schedule accordi ngly to prevent dangerously increasing the level of the medication in the bloodstream (D). The nurse should document the reason for the late dose, but (A and C) are not warra nted. (B) could result in increased blood levels of the drug.

Correct Answer: D

While instructing a male client's wife in the performance of passive range-of-motion exercises to his contracted shoulder, the nurse observes that she is holding hi s arm above and below the elbow. What nursing action should the nurse implement?

A. Acknowledge that she is supporting the arm correctly.

B. Encourage her to keep the joint covered to maintain warmth.

C. Reinforce the need to grip directly under the joint for better support.

D. Instruct her to grip directly over the joint for better motion. -
The wife is performing the passive ROM correctly, therefore the nurse should acknowl edge this fact (A). The joint that is being exercised should be uncovered (B) while the r est of the body should remain covered for warmth and privacy. (C and D) do not provi de adequate support to the joint while still allowing for joint movement.

Correct Answer: A

What is the most important reason for starting intravenous infusions in the upper extremiti es rather than the lower extremities of adults?

A. It is more difficult to find a superficial vein in the feet and ankles.

B. A decreased flow rate could result in the formation of a thrombosis.

C. A cannulated extremity is more difficult to move when the leg or foot is used.

D. Veins are located deep in the feet and ankles, resulting in a more painful procedure. -
Venous return is usually better in the upper extremities. Cannulation of the veins in the lower extremities increases the risk of thrombus formation (B) which, if dislodged, coul d be life-
threatening. Superficial veins are often very easy (A) to find in the feet and legs. Handli ng a leg or foot with an IV (C) is probably not any more difficult than

D. My blood level of low density lipoproteins needs to increase. -

Limiting saturated fat from animal food sources to no more than 4 ounces per week (C) is an important diet modification for lowering cholesterol. To be effective in reducing cholesterol, the client should exercise 30 minutes per day, or at least 4 to 6 times per we ek (A). Red meat and all proteins do not need to be eliminated (B) to lower cholesterol, but should be restricted to lean cuts of red meat and smaller portions (2-ounce servings). The low density lipoproteins (D) need to decrease rather than increase.

Correct Answer: C

The UAPs working on a chronic neuro unit ask the nurse to help them determine the safe st way to transfer an elderly client with left-sided weakness from the bed to the chair. What method describes the correct transfer pr ocedure for this client?

A. Place the chair at a right angle to the bed on the client's left side before moving.

B. Assist the client to a standing position, then place the right hand on the armrest.

C. Have the client place the left foot next to the chair and pivot to the left before sitting.

D. Move the chair parallel to the right side of the bed, and stand the client on the right f oot. - (D) uses the client's stronger side, the right side, for weight-bearing during the transfer, and is the safest approach to take. (A, B, and C) are unsafe methods of transfer and include the use of poor body mechanics by the caregiver.

Correct Answer: D

An unlicensed assistive personnel (UAP) places a client in a left lateral position prior to administering a soap suds enema. Which instruction should the nurse provide the UAP?

Correct Answer: B

The nurse observes that a male client has removed the covering from an ice pack ap
plied to his knee. What action should the nurse take first?

A. Observe the appearance of the skin under the ice pack.

B. Instruct the client regarding the need for the covering.

C. Reapply the covering after filling with fresh ice.

D. Ask the client how long the ice was applied to the skin. -
The first action taken by the nurse should be to assess the skin for any possible thermal injury (A). If no injury to the skin has occurred, the nurse can take the other actions (B, C, and D) as needed.

Correct Answer: A

The nurse mixes 50 mg of Nipride in 250 ml of D5W and plans to administer the soluti
on at a rate of 5 mcg/kg/min to a client weighing 182 pounds. Using a drip factor of 60 g
tt/ml, how many drops per minute should the client receive?

A. 31 gtt/min.

B. 62 gtt/min.

C. 93 gtt/min.

D. 124 gtt/min. -
(D) is the correct calculation: Convert lbs to kg: 182/2.2 = 82.73 kg. Determine the do
sage for this client: 5 mcg × 82.73 = 413.65 mcg/min. Determine how

Correct Answer: C

The healthcare provider prescribes furosemide (Lasix) 15 mg IV stat. On hand is Lasix 20 mg/2 ml. How many milliliters should the nurse administer?

A. 1 ml.

B. 1.5 ml.

C. 1.75 ml.

D. 2 ml. -

(B) is the correct calculation: Dosage on hand/amount on hand = Dosage desired/x amount. 20 mg : 2 ml = 15 mg : x . 20x = 30. x = 30/20; = 1½ or 1.5 ml.

Correct Answer: B

Heparin 20,000 units in 500 ml D5W at 50 ml/hour has been infusing for 5½ hours. How much heparin has the client received?

A. 11,000 units.

B. 13,000 units.

C. 15,000 units.

D. 17,000 units. -

(A) is the correct calculation: 20,000 units/500 ml = 40 units (the amount of units in one ml of fluid). 40 units/ml x 50 ml/hr = 2,000 units/hour (1,000 units in 1/2 hour). 5.5 x 2,000 = 11,000 (A). OR, multiply 5 x 2,000 and add the 1/2 hour amount of 1,000 to reach the same conclusion = 11,000 units.

Correct Answer: A

The healthcare provider prescribes morphine sulfate 4mg IM STAT. Morphine comes i n 8 mg per ml. How many ml should the nurse administer?

A. 0.5 ml.

B. 1 ml.

C. 1.5 ml.

D. 2 ml. -

Using ratio and proportion: 8mg: 1m

l :: 4mg:Xml

8X=4

X=0.5

Correct Answer: A

The nurse prepares a 1,000 ml IV of 5% dextrose and water to be infused over 8 hours. T he infusion set delivers 10 drops per milliliter. The nurse should regulate the IV to admin ister approximately how many drops per minute?

A. 80

B. 8

Which nutritional assessment data should the nurse collect to best reflect total muscle mas s in an adolescent?

A. Height in inches or centimeters.

B. Weight in kilograms or pounds.

C. Triceps skin fold thickness.

D. Upper arm circumference. -
Upper arm circumference (D) is an indirect measure of muscle mass. (A and B) do not distinguish between fat (adipose) and muscularity. (C) is a measure of body fat.

Correct Answer: D

An elderly resident of a long-term care facility is no longer able to perform self-care and is becoming progressively weaker. The resident previously requested that n o resuscitative efforts be performed, and the family requests hospice care. What acti on should the nurse implement first?

A. Reaffirm the client's desire for no resuscitative efforts.

B. Transfer the client to a hospice inpatient facility.

C. Prepare the family for the client's impending death.

D. Notify the healthcare provider of the family's request. -
The nurse should first communicate with the healthcare provider (D). Hospice care is p rovided for clients with a limited life expectancy, which must be identified by the health care provider. (A) is not

B. Continue asking the mother questions about the child.

C. Ask another nurse to interview the mother now.

D. Tell the mother politely to look at you when answering. - Eye contact is a culturally-influenced form of non-verbal communication. In some non-Western cultures, such as the Vietnamese culture, a client or family member may avoid eye contact as a form of respect, so the nurse should continue to ask the mother questions about the child (B). (A, C, and D) are not indicated.

Correct Answer: B

When conducting an admission assessment, the nurse should ask the client about the use of complimentary healing practices. Which statement is accurate regarding the use of these practices?

A. Complimentary healing practices interfere with the efficacy of the medical model of treatment.

B. Conventional medications are likely to interact with folk remedies and cause adverse effects.

C. Many complimentary healing practices can be used in conjunction with conventional practices.

D. Conventional medical practices will ultimately replace the use of complimentary healing practices. - Conventional approaches to health care can be depersonalizing and often fail to take into consideration all aspects of an individual, including body, mind, and spirit. Often complimentary healing practices can be used in conjunction with

Correct Answer: C

A female client asks the nurse to find someone who can translate into her native language her concerns about a treatment. Which action should the nurse take?

A. Explain that anyone who speaks her language can answer her questions.

B. Provide a translator only in an emergency situation.

C. Ask a family member or friend of the client to translate.

D. Request and document the name of the certified translator. -

A certified translator should be requested to ensure the exchanged information is reliable and unaltered. To adhere to legal requirements in some states, the name of the translator should be documented (D). Client information that is translated is private and protected under HIPAA rules, so (A) is not the best action. Although an emergency situation may require extenuating circumstances (B), a translator should be provided in most situations. Family members may skew information and not translate the exact information, so (C) is not preferred.

Correct Answer: D

The nurse is teaching a client with numerous allergies how to avoid allergens. Which instruction should be included in this teaching plan?

A. Avoid any types of sprays, powders, and perfumes.

B. Wearing a mask while cleaning will not help to avoid allergens.

80. While preparing to insert a rectal suppository in a male adult client, the nurse obs erves that the client is holding his breath while bearing down. What action should the nurse implement?

A. Advise the client to continue to bear down without holding his breath.

B. Gently insert the lubricated suppository four inches into the rectum.

C. Perform a digital exam to determine if a fecal impaction is present.

D. Instruct the client to take slow deep breaths and stop bearing down. -

During administration of a rectal suppository, the client is asked to take slow deep bre aths through the mouth to relax the anal sphincter (D). Bearing down (A) will push the suppository out of the rectum, so the suppository should not be inserted while the client is bearing down (B). Further data is needed before performing an invasive digital exam to check for fecal impaction (C).

Correct Answer: D

82. While the nurse is administering a bolus feeding to a client via nasogastric tube, the client begins to vomit. What action should the nurse implement first?

A. Discontinue the administration of the bolus feeding.

B. Auscultate the client's breath sounds bilaterally.

C. Elevate the head of the bed to a high Fowler's position.

D. Administer a PRN dose of a prescribed antiemetic. -

When a client receiving a tube feeding begins to vomit, the nurse should first stop the f eeding (A) to prevent further vomiting. (C) should then be implemented to reduce the ri sk of aspiration. After that, (B and D) can be implemented as indicated.

Correct Answer: A

84. Which client care requires the nurse to wear barrier gloves as required by the protocol for Standard Precautions?

A. Removing the empty food tray from a client with a urinary catheter.

B. Washing and combing the hair of a client with a fractured leg in traction.

C. Administering oral medications to a cooperative client with a wound infection.

D. Emptying the urinary catheter drainage bag for a client with Alzheimer's disease. -

Possible contact with body secretions, excretions, or broken skin is an indication for wearing barrier (nonsterile) gloves. Emptying a urine drainage bag requires the use of gloves (D). (A, B, and C) do not require gloves.

Correct Answer: D

85. What action should the nurse implement when adding sterile liquids to a sterile field?

A. Use an outdated sterile liquid if the bottle is sealed and has not been opened.

B. Consider the sterile field contaminated if it becomes wet during the procedure.

C. Remove the container cap and lay it with the inside facing down on the sterile field.

D. Hold the container high and pour the solution into a receptacle at the back of the steri le field. -

Wet or damp areas on a sterile field allow organisms to wick from the table surface and permeate into the sterile area, so the field is considered contaminated if it becomes wet (B). Outdated liquids may be contaminated and should be discarded, not used (A). The container's cap should be removed, placed facing up, and off the sterile field, not (C). T o prevent contamination of the sterile field, liquids should be held close (6 inches) to the receptacle when pouring to prevent splashing, and the receptacle should be placed near the front edge to avoid reaching over or across the sterile field (D).

Correct Answer: B

86.A healthcare provider is performing a sterile procedure at a client's bedside. Near the end of the procedure, the nurse observes the healthcare provider contaminate a sterile gl ove and the sterile field. What is the best action for the nurse to implement?

A. Report the healthcare provider for the violation in aseptic technique.

B. Allow the completion of the procedure.

C. Ask if the glove and sterile field are contaminated.

What do you do first if you commit a medication error? - Check the patient (take VS)

3 checks of safe medication administration -

1) Before you pour, mix, or draw up a medication

2) After you prepare the medication

3) At the bedside

Rights of medication - 1) Right drug

2) Right patient

3) Right dose

4) Right route

5) Right time

6) Right documentation

Others:

7) Right reason

8) Right to know

9) Right to refuse

What is the preferred IM site for infants? -

Vastus lateralis muscle What is the site of choice for IM injections? - -

Ventrogluteal muscle

-Landmarks are the greater trochanter, anterior superior iliac spine, and iliac crest

What supplements do pregnant women need to take? -

Folic acid, iron, calcium (vitamin D)

Normal creatinine levels - 0.5-1.2 mg/dL

A) Aspirating gastric contents to assure a pH value of 4 or less.

B) Hearing air pass in the stomach after injecting air into the tubing.

C) Examining a chest x-ray obtained after the tubing was inserted.

D) Checking the remaining length of tubing to ensure that the correct length was inserted. - C) Examining a chest x-ray obtained after the tubing was inserted

Both (A and B) are methods used to determine proper placement of the NG tubing. Howe ver, the best indicator that the tubing is properly placed is (C). (D) is not an indicator of p roper placement

The nurse is instructing a client with high cholesterol about diet and life style modificatio n. What comment from the client indicates that the teaching has been effective?

A) If I exercise at least two times weekly for one hour, I will lower my cholesterol.

B) I need to avoid eating proteins, including red meat.

C) I will limit my intake of beef to 4 ounces per week.

D) My blood level of low density lipoproteins needs to increase. -

C) I will limit my intake of beef to 4 ounces per week

Limiting saturated fat from animal food sources to no more than 4 ounces per week (C) i s an important diet modification for lowering cholesterol. To be effective in reducing c holesterol, the client should exercise 30 minutes per day, or at least 4 to 6 times per we ek (A). Red meat and all proteins do not need to be eliminated (B) to lower cholesterol, but should be restricted to lean cuts of red meat and smaller portions (2- ounce servings). The low density lipoproteins (D) need to decrease rather than increase

A resident in a skilled nursing facility for short-term rehabilitation after a hip replacement tells the nurse, "I don't want any more blood taken for those useless tests." Which narrative documentation should the nurse enter in t he client's medical record?

A) Healthcare provider notified of failure to collect specimens for prescribed blood studies.
B) Blood specimens not collected because client no longer wants blood tests performed.
C) Healthcare provider notified of client's refusal to have blood specimens collected for testing.
D) Client irritable, uncooperative, and refuses to have blood collected. Healthcare provider notified -
C) Healthcare provider notified of client's refusal to have blood specimens collect ed for testing

When a client refuses a treatment, the exact words of the client regarding the client's refusal of care should be documented in a narrative format (C). (A, B, and D) do not address the concepts of informatics and legal issues

While instructing a male client's wife in the performance of passive range-of-motion exercises to his contracted shoulder, the nurse observes that she is holding hi s arm above and below the elbow. What nursing action should the nurse implement?

A) Acknowledge that she is supporting the arm correctly.
B) Encourage her to keep the joint covered to maintain warmth.
C) Reinforce the need to grip directly under the joint for better support.
D) Instruct her to grip directly over the joint for better motion. -
A) Acknowledge that she is supporting the arm correctly

The wife is performing the passive ROM correctly, therefore the nurse should ackn owledge this fact (A). The joint that is being exercised should be uncovered (B)

while the rest of the body should remain covered for warmth and privacy. (C and D) do n ot provide adequate support to the joint while still allowing for joint movement

The nurse is caring for a client who is receiving 24-
hour total parenteral nutrition (TPN) via a central line at 54 ml/hr. When initially assessi ng the client, the nurse notes that the TPN solution has run out and the next TPN solutio n is not available. What immediate action should the nurse take?

A) Infuse normal saline at a keep vein open rate.
B) Discontinue the IV and flush the port with heparin.
C) Infuse 10 percent dextrose and water at 54 ml/hr
D) Obtain a stat blood glucose level and notify the healthcare provider. -
C) Infuse 10 percent dextrose and water at 54 ml/hr

TPN is discontinued gradually to allow the client to adjust to decreased levels of glucos e. Administering 10% dextrose in water at the prescribed rate (C) will keep the client fr om experiencing hypoglycemia until the next TPN solution is available. The client coul d experience a hypoglycemic reaction if the current level of glucose (A) is not maintain ed or if the TPN is discontinued abruptly (B). There is no reason to obtain a stat blood gl ucose level (D) and the healthcare provider cannot do anything about this situation

At the beginning of the shift, the nurse assesses a client who is admitted from the post-
anesthesia care unit (PACU). When should the nurse document the client's findings?

A) At the beginning, middle, and end of the shift.
B) After client priorities are identified for the development of the nursing care plan.
C) At the end of the shift so full attention can be given to the client's needs.

is a subjective experience and therefore the nurse has to ask the client directly instead of a ccepting statement of the family members.

While undergoing a soapsuds enema, the client reports abdominal cramping. What a ction should the nurse take?

1

Immediately stop the infusion.

2

Lower the height of the enema bag.

3

Advance the enema tubing 2 to 3 inches.

4

Clamp the tube for 2 minutes, then restart the infusion. - 2

Abdominal cramping during a soapsuds enema may be due to too rapid administration of the enema solution. Lowering the height of the enema bag slows the flow and allows t he bowel time to adapt to the distention without causing excessive discomfort. Stopping the infusion is not necessary. Advancing the enema tubing is not appropriate. Clamping the tube for several minutes then restarting the infusion may be attempted if slowing the infusion does not relieve the cramps.

During the initial physical assessment of a newly admitted client with a pressure ulcer, a nurse observes that the client's skin is dry and scaly. The nurse applies emollients and re inforces the dressing on the pressure ulcer. Legally, were the nurse's actions adequate?

1

The nurse also should have instituted a plan to increase activity.

2

The nurse provided supportive nursing care for the well-

being of the client. 3

A health care provider has prescribed isoniazid (Laniazid) for a client. Which instru ction should the nurse give the client about this medication?

1

Prolonged use can cause dark concentrated urine.

2

The medication is best absorbed when taken on an empty stomach.

3

Take the medication with aluminum hydroxide to minimize GI upset.

4

Drinking alcohol daily can cause drug-induced hepatitis - 4

Daily alcohol intake can cause drug induced hepatitis. Prolonged use does not cause dark concentrated urine. The client should take isoniazid with meals to decrease GI upset. Clients should avoid taking aluminum antacids at the same time as this medic ation because it impairs absorption.

To minimize the side effects of the vincristine (Oncovin) that a client is receiving, what d oes the nurse expect the dietary plan to include?

1

Low in fat

2

High in iron

3

High in fluids

4

Low in residue - 3

A common side effect of vincristine is a paralytic ileus that results in constipation. Preve ntative measures include high-

fiber foods and fluids that exceed minimum requirements. These will keep the stool bulk y and soft, thereby promoting evacuation.

When assessing a client with wrist restraints, the nurse observes that the fingers on the rig ht hand are blue. What action should the nurse implement first?

A. Loosen the right wrist restraint.

B. Apply a pulse oximeter to the right hand.

C. Compare hand color bilaterally.

D. Palpate the right radial pulse. -

The priority nursing action is to restore circulation by loosening the restraint (A), becau se blue fingers (cyanosis) indicates decreased circulation. (C and D) are also important nursing interventions, but do not have the priority of (A). Pulse oximetry (B) measures the saturation of hemoglobin with oxygen and is not indicated in situations where the c yanosis is related to mechanical compression (the restraints).

Correct Answer: A

The nurse is instructing a client with high cholesterol about diet and life style modificatio n. What comment from the client indicates that the teaching has been effective?

A. If I exercise at least two times weekly for one hour, I will lower my cholesterol.

B. I need to avoid eating proteins including red meat.

C. I will limit my intake of beef to 4 ounces per week.

D. My blood level of low density lipoproteins needs to increase. -

Limiting saturated fat from animal food sources to no more than 4 ounces per week (C) is an important diet modification for lowering cholesterol. To be effective in reducing cholesterol, the client should exercise 30 minutes per day, or at least 4 to 6 times per we ek (A). Red meat and all proteins do not need to be eliminated (B) to lower cholesterol, but should be restricted to lean cuts of red meat and smaller portions (2-ounce servings). The low density lipoproteins (D) need to decrease rather than increase.

Correct Answer: C

D. Eats anything and does not think diet makes a difference in health. -
Correct Answer: D

Which statement correctly identifies a written learning objective for a client with peripher
al vascular disease?
A. The nurse will provide client instruction for daily foot care.
B. The client will demonstrate proper trimming toenail technique.
C. Upon discharge, the client will list three ways to protect the feet from injury.
D. After instruction, the nurse will ensure the client understands foot care rationale. -
Correct Answer: C

A middle-
aged woman who enjoys being a teacher and mentor feels that she should pass down he
r legacy of knowledge and skills to the younger generation. According to Erikson, she is
involved in what developmental stage?
A. Generativity.
B. Ego integrity.
C. Identification.
D. Valuing wisdom. - Correct Answer: A

Which statement best describes durable power of attorney for health care?
A. The client signs a document that designates another person to make legally binding
healthcare decisions if client is unable to do so.
B. The healthcare decisions made by another person designated by the client are not
legally binding.
C. Instructions about actions to be taken in the event of a client's terminal or irreversible
condition are not legally binding.
D. Directions regarding care in the event of a terminal or irreversible condition must be
documented to ensure that they are legally binding. - Correct Answer: A

A. Pre-medicate the client with an analgesic.

B. Inform the client of the plan for moving to the chair.

C. Obtain and place a portable commode by the bed.

D. Ask the client to push the IV pole to the chair.

E. Clamp the indwelling catheter.

F. Assess the client's blood pressure. -

The nurse should plan to implement (A, B, D, and F). Pre-medicating the client with an analgesic (A) reduces the client's pain during mobilization and maximizes compliance. To ensure the client's cooperation and promote independence, the nurse should inform the client about the plan for moving to the chair (B) and encourage the client to participate by pushing the IV pole when walking to the chair (D). The nurse should assess the client's blood pressure (F) prior to mobilization, which can cause orthostatic hypotension. (C and E) are not indicated. Correct Answer: A, B, D, F

A client is demonstrating a positive Chvostek's sign. What action should the nurse take?

A. Observe the client's pupil size and response to light.

B. Ask the client about numbness or tingling in the hands.

C. Assess the client's serum potassium level.

D. Restrict dietary intake of calcium-rich foods. -

A positive Chvostek's sign is an indication of hypocalcemia, so the client should be assessed for the subjective symptoms of hypocalcemia, such as numbness or tingling of the hands (B) or feet. (A and C) are unrelated assessment data. (D) is contraindicated because the client is hypocalcemic and needs additional dietary calcium.

Correct Answer: B

When preparing to administer an intravenous medication through a central venous catheter, the nurse aspirates a blood return in one of the lumens of the triple lumen catheter. Which action should the nurse implement?

A. There is no reason to be so angry.

B. Why do I need to leave your room?

C. What is concerning you this morning?

D. Let me call the client advocate for you. - (C) is an open-ended question that encourages the client to discuss personal feelings. (A) devalues the client and hinders further communication. Acting defensively and asking why questions such as (B) are likely to elicit more anger and block communication. By deferring to the client advocate (D), the nurse fails to even address the client's feelings of anger and exasperation. Correct Answer: C

The nurse encounters resistance when inserting the tubing into a client's rectum for a tap water enema. What action should the nurse implement?

A. Withdraw the tube and apply additional lubricant to the tube.

B. Encourage the client to bear down and continue to insert the tube.

C. Remove the tube and check the client for a fecal impaction.

D. Ask the client to relax and run a small amount of fluid into the rectum. - If resistance is encountered during the initial insertion of an enema tube, the client should be instructed to relax while a small amount of solution runs through the tube into the rectum (D) to promote dilation. (A) is unlikely to resolve the problem. (B) may cause injury. (C) should not be implemented until other, less invasive actions, such as (D) have been taken.

Correct Answer: D

When assessing a client with a nursing diagnosis of fluid volume deficit, the nurse notes that the client's skin over the sternum "tents" when gently pinched. Which action should the nurse implement?

A. Confirm the finding by further assessing the client for jugular vein distention.

B. Offer the client high protein snacks between regularly scheduled mealtimes.

C. Continue the planned nursing interventions to restore the client's fluid volume.

imminent (D). Although culturally sensitive care should be observed throughout the clie nt's plan of care (A), this is not the priority at this time. Administration of oxygen may b e expected care, but a flow rate greater than 2 L/minute (B) is not palliative care. (C) may provide additional information, but is not necessary as death approaches.
Correct Answer: D

The nurse notes that a client consistently coughs while eating and drinking. Which nursin g diagnosis is most important for the nurse include in this client's plan of care?
A. Ineffective breathing pattern.
B. Impaired gas exchange.
C. Risk for aspiration.
D. Ineffective airway clearance. -
Coughing during or after meals is a manifestation of dysphagia, or difficulty swallowi ng, which places the client at risk for aspiration (C). Dysphagia can lead to aspiration pneumonia, but the client is not currently exhibiting any symptoms of breathing diffic ulty (A) or impaired gas exchange (B). Although (D) may be related to an ineffective c ough, the client's coughing is an effective response when solids or liquids are taken or ally.
Correct Answer: C

The nurse is digitally removing a fecal impaction for a client. The nurse should stop the procedure and take corrective action if which client reaction is noted?
A. Temperature increases from 98.8° to 99.0° F.
B. Pulse rate decreases from 78 to 52 beats/min.
C. Respiratory rate increases from 16 to 24 breaths/min.
D. Blood pressure increases from 110/84 to 118/88 mm/Hg. -
Parasympathetic reaction can occur as a result of digital stimulation of the anal sphinct er, which should be stopped if the client experiences a vagal response, such as bradyca rdia (B). (A, C, and D) do not warrant stopping the procedure.
Correct Answer: B

A. Stage 1 pressure sore draining sero-sanguineous drainage.

B. Pressure sore at bony prominence with exudate noted.

C. One-inch pressure sore draining serous fluid.

D. Pressure sore on heel with a small amount of purulent drainage. -

Serous drainage is clear watery plasma, so (C) provides accurate documentation based on the information provided. Information to stage this pressure score (A) is not provide d, and sero-

sanguineous drainage is pale and watery with a combination of plasma and red cells, a nd may be blood-

streaked. Exudate (B) is fluid such as pus and serum. Purulent drainage (D) is thick, ye llow, green, or brown indicating the presence of dead or living organisms and white blo od cells.

Correct Answer: C

A medication is prescribed to be given QID. What schedule should the nurse use to admin ister this prescription?

A. 0800, 1200, 1600, 2000

B. 800.

C. Every other day at 0800.

D. 0800, 1200, 1600, 2000, 0000, 0400. -

(A) provides the best schedule, because QID means four times per day. (B, C, and D) provide incorrect dosages.

Correct Answer: A

The nurse working in the emergency department is assessing four clients' ability to tolerat e pain. Which client is likely to tolerate a higher level of pain?

A. A 10-year-old who was burned by a camp fire earlier today.

B. A 70-year-old who has a postoperative infection from a surgery one week ago.

C. A 23-year-old woman who sprained her knee while bicycling.

D. A 55-year-old woman who has had moderate low back pain for three months. -

Experiences with the same type of pain that has successfully been relieved makes i

property of the hospital and cannot be removed (D), even with the client's permission (C). Next, the clinical instructor should be notified (B)so that all students can be educate d regarding copying and removing clinical records from the healthcare agency. The nurs ing supervisor (A) should also be alerted to ensure appropriate supervision of students a s well as protection of client information.

Correct Answer: D

An older female client with rheumatoid arthritis is complaining of severe joint pain that is caused by the weight of the linen on her legs. What action should the nurse impleme nt first?

A. Apply flannel pajamas to provide warmth.

B. Administer a PRN dose of ibuprofen.

C. Perform range of motion exercises in a warm tub.

D. Drape the sheets over the footboard of the bed. -

The nurse should first provide an immediate comfort measure to address the client's co mplaint about the linens and drape the linens over the footboard of the bed (D) instead o f tucking them under the mattress, which can add pressure perceived by the client as the source of her pain. (A, B, and C) may be components of the client's plan of care, but th e nurse should first address the client's complaint.

Correct Answer: D

A male client with venous incompetence stands up and his blood pressure subsequently dr ops. Which finding should the nurse identify as a compensatory response?

A. Bradycardia.

B. Increase in pulse rate.

C. Peripheral vasodilation.

D. Increase in cardiac output. -

When postural hypotension occurs, the body attempts to restore arterial pressure by sti mulating the baro-

receptors to increase the heart rate (B), not decrease it (A). Peripheral vasoconstriction, not dilation (C), of the veins and

E. Bedtime snack of crackers and milk. -

Potato chips (A) are high in sodium. Tuna (B) is high in protein. Bacon (C) and cracker s (E) are high in sodium. Only (D) is a meal that is in compliance with a low sodium, l ow protein diet.

Correct Answer: A, B, C, E

What intervention should the nurse include in the plan of care for a client who is being treated with an Unna's paste boot for leg ulcers due to chronic venous insufficiency?

A. Check capillary refill of toes on lower extremity with Unna's paste boot.

B. Apply dressing to wound area before applying the Unna's paste boot.

C. Wrap the leg from the knee down towards the foot.

D. Remove the Unna's paste boot q8h to assess wound healing. -

The Unna's paste boot becomes rigid after it dries, so it is important to check distally f or adequate circulation (A). Kerlix is often wrapped around the outside of the boot and an ace bandage may be used to cover both, but no bandage should be put under it (B). T he Unna's paste boot should be applied from the foot and wrapped towards the knee (C). The Unna's paste boot acts as a sterile dressing and should not be removed q8h. We ekly removal is reasonable (D).

Correct Answer: A

A 75-year-

old client who has a history of end stage renal failure and advanced lung cancer, recentl y had a stroke. Two days ago the healthcare provider discontinued the client's dialysis tr eatments, stating that death is inevitable, but the client is disoriented and will not sign a DNR directive. What is the priority nursing intervention?

A. Review the client's most recent laboratory reports.

B. Refer the client and family members for hospice care.

C. Notify the hospital ethics committee of the client situation.

D. Determine who is legally empowered to make decisions. -

When death is impending, it is essential for the nurse to determine who is legally empo wered to make decisions regarding the use of life-

resistant to relief measures, (C) may not be possible. Psychogenic pain (D) is a painful se nsation that is perceived but has no known cause.

Correct Answer: A

A male client arrives at the outpatient surgery center for a scheduled needle aspiration o f the knee. He tells the nurse that he has already given verbal consent for the procedure t o the healthcare provider. What action should the nurse implement?

A. Witness the client's signature on the consent form.

B. Verify the client's consent with the healthcare provider.

C. Notify the healthcare provider that the client is ready for the procedure.

D. Document that the client has given consent for the needle aspiration. -

Written informed consent is required prior to any invasive procedure. The healthcare provider must explain the procedure to the client, but the nurse can witness the client's signature on a consent form (A). (B) is not necessary since written consent must be obt ained. (C) is not correct because written consent has not been obtained. (D) must occur after written consent is obtained.

Correct Answer: A

In assessing a client's femoral pulse, the nurse must use deep palpation to feel the pulsation while the client is in a supine position. What action should the nurse im plement?

A. Elevate the head of the bed and attempt to palpate the site again.

B. Document the presence and volume of the pulse palpated.

C. Use a thigh cuff to measure the blood pressure in the leg.

D. Record the presence of pitting edema in the inguinal area. -

Deep palpation may be required to palpate the femoral pulse; and, when palpated, the nurse should document the presence and volume of the pulse (B). The site is best palp ated with the client supine; elevation of the head of the bed requires even deeper palpa tion (A). The use of

A. Continue gabapentin.

B. Discontinue ibuprofen.

C. Add aspirin to the protocol.

D. Add oral methadone to the protocol. -

Based on the WHO pain relief ladder, adjunct medications, such as gabapentin (Neuron tin), an antiseizure medication, may be used at any step for anxiety and pain manageme nt, so (A) should be implemented. Nonopiod analgesics, such as ibuprofen (A) and aspi rin (C) are Step 1 drugs. Step 2 and 3 include opioid narcotics (D), and to maintain free dom from pain, drugs should be given around the clock rather than by the client s PRN r equests.

Correct Answer: A

17. To obtain the most complete assessment data for a client with chronic pain, which information should the nurse obtain?

A. Can you describe where your pain is the most severe?

B. What is your pain intensity on a scale of 1 to 10?

C. Is your pain best described as aching, throbbing, or sharp?

D. Which activities during a routine day are impacted by your pain? -

A client with chronic pain is more likely to have adapted physiologically to vital sign c hanges, localization or intensity, so pain assessment should focus on any interference w ith daily activities (D), sleep, relationships with others, physical activity, and emotional well-

being. Exacerbation of acute symptoms, such as pain distribution, patterns, intensity, a nd descriptors illicit specific assessment findings, whereas (A, B, and C) are limiting, c losed-end questions, and can be answered with a yes, no, or a number.

Correct Answer: D

18.A male client with acquired immunodeficiency syndrome (AIDS) develops cryptococ cal meningitis and tells the nurse he does not want to be resuscitated if his breathing stops . What action should the nurse implement?

A. Document the client's request in the medical record.

the mother's coaxing. (D) is best done before going to the treatment room when the child feels less threatened.

Correct Answer: C

31. When making the bed of a client who needs a bed cradle, which action should the nurse include?

A. Teach the client to call for help before getting out of bed.

B. Keep both the upper and lower side rails in a raised position.

C. Keep the bed in the lowest position while changing the sheets.

D. Drape the top sheet and covers loosely over the bed cradle. -

A bed cradle is used to keep the top bedclothes off the client, so the nurse should drape the top sheet and covers loosely over the cradle (D). A client using a bed cradle may still be able to ambulate independently (A) and does not require raised side rails (B). (C) ca uses the nurse to use poor body mechanics.

Correct Answer: D

32.A male client has a nursing diagnosis of "Spiritual distress." What intervention is b est for the nurse to implement when caring for this client?

A. Use distraction techniques during times of spiritual stress and crisis.

B. Reassure the client that his faith will be regained with time and support.

C. Consult with the staff chaplain and ask that the chaplain visit with the client.

D. Use reflective listening techniques when the client expresses spiritual doubts. -

The most beneficial nursing intervention is to use nonjudgmental reflective listening t echniques, to allow the client to feel comfortable expressing his concerns (D). (A and B) are not therapeutic. The client should be consulted before implementing (C). Corre ct Answer: D

44.A client is admitted with a stage four pressure ulcer that has a black, hardened surfa ce and a light-
pink wound bed with a malodorous green drainage. Which dressing is best for the nurse to use first?

A. Hydrogel.

B. Exudate absorber.

C. Wet to moist dressing.

D. Transparent adhesive film. -

To provide moisture and loosen the necrotic tissue, the eschar should be covered first with wet to moist dressings (C), which are discontinued and then a hydrogel alginate ca n be placed in the prepared wound bed to prevent further damage of granulating any surr ounding tissue. Although a hydrogel (A) liquefies necrotic tissue of slough and rehydrat es the wound bed, it does not address wicking the purulent drainage from the wound. E xudate absorbers (B) provide a moist wound surface, absorb exudate, and support debri dement, but do not prepare the wound bed for proper healing. Transparent dressings (D) are used to protect against contamination and friction while maintaining a clean moist s urface.

Correct Answer: C

45.A 35-year-
old female client with cancer refuses to allow the nurse to insert an IV for a scheduled c hemotherapy treatment, and states that she is ready to go home to die. What interventio n should the nurse initiate?

A. Review the client's medical record for an advance directive.

B. Determine if a do-not-resuscitate prescription has been obtained.

C. Document that the client is being discharged against medical advice.

D. Evaluate the client's mental status for competence to refuse treatment. -

Competent clients have the right to refuse treatment, so the nurse should first ensure th at the client is competent (D). (A and C) are not necessary for a competent client to refu se treatment. The nurse cannot document (C) until the healthcare provider is notified of t

C. Encourage additional fluid intake.

D. Turn the client q2h. -

(D) will help to move and drain respiratory secretions and prevent pneumonia from o ccurring, so this intervention has the highest priority. Older adults often have an incre ased BP, and a PRN antihypertensive medication is usually prescribed for a BP over 140 systolic and 90 diastolic (A). Older adults often run a lower temperature, particul arly in the morning, and (B) does not have the priority of (D). Even though the client has adequate output, (C) might be encouraged because the urine is concentrated, but th is intervention does not have the priority of (D).

Correct Answer: D

51. The home health nurse visits an elderly female client who had a brain attack three months ago and is now able to ambulate with the assistance of a quad cane. Which a ssessment finding has the greatest implications for this client's care?

A. The husband, who is the caregiver, begins to weep when the nurse asks how he is doing.

B. The client tells the nurse that she does not have much of an appetite today.

C. The nurse notes that there are numerous scatter rugs throughout the house.

D. The client's pulse rate is 10 beats higher than it was at the last visit one week ago. -

Scatter rugs (C) pose a safety hazard because the client can trip on them when ambulat ing, so this finding has the greatest significance in planning this client's care. Psycholog ical support of the caregiver (A) is a less acute need than that of client safety. The nurse needs to obtain more information about (B), but this is not a safety issue. (D) is not a si gnificant increase, and additional assessment might provide information about the reaso n for the increase (anxiety, exercise, etc.).

Correct Answer: C

52. The nurse removes the dressing on a client's heel that is covering a pressure sore on e- inch in diameter and finds that there is straw-

colored drainage seeping from the wound. What description of this finding should the nurse include in the client's record?

prepared to take steps to relieve the pain (D). (A, B, and C) are having new experiences w ith pain.

Correct Answer: D

55.A 4-year-

old boy who is scheduled for a tonsillectomy and adenoidectomy asks the nurse, Will i t hurt to have my tonsils and adenoids taken out? Which response is best for the nurse to provide?

A. It may hurt a little because of the incision made in your throat.

B. It won't hurt because you're such a big boy.

C. It won't hurt because we put you to sleep.

D. It may hurt but we'll give you medicine to help you feel better. -

Answering questions simply and directly provides comfort for the preschool age child and builds confidence in the health care team (D). (A) uses language (i.e. 'inci sion') that could create anxiety for the child. Four-year-olds are in the Initiative vs. Guilt stage (Erikson's psychosocial development), and (B) c ontributes to guilt when the child hurts. (C) is not helpful because the child may associa te being put to sleep with the postoperative throat pain and then become fearful of goin g to sleep.

Correct Answer: D

56.A female nurse who sometimes tries to save time by putting medications in her unifor m pocket to deliver to clients, confides that after arriving home she found a hydrocodone (Vicoden) tablet in her pocket. Which possible outcome of this situation should be the nu rse's greatest concern?

A. Accused of diversion.

B. Reported for stealing.

C. Reported for a HIPAA violation.

D. Accused of unprofessional conduct. -

Even if this is only one incident, the nurse may be suspected of taking medications on a regular basis and the incident could be interpreted as diversion (A), or diverting narcoti

A. Solicit information on hospitalization from the insurance company.

91. The nurse is caring for a client who is weak from inactivity because of a 2-week hospitalization. In planning care for the client, the nurse should include which range of motion (ROM) exercises?

A. Passive ROM exercises to all joints on all extremities four times a day.

B. Active ROM exercises to both arms and legs two or three times a day.

C. Active ROM exercises with weights twice a day with 20 repetitions each.

D. Passive ROM exercises to the point of resistance and slightly beyond. -

Active, rather than passive, ROM is best to restore strength and (B) is an effective schedule. Passive ROM 4 times a day (A) is not as beneficial for the client as (B). With weights (C), the client may fatigue quickly and develop muscle soreness. ROM is not performed beyond the point of resistance or pain (D) because of the risk of damage to underlying structures.

Correct Answer: B