

phenols, hormones, electrolytes, accumulate in the blood. In the early stage of renal insufficiency, polyuria results from the inability of the kidneys to concentrate urine and contribute to nocturia (B). (A, C, and D) are more common in the later stages of renal failure.

16. A client with heart disease is on a continuous telemetry monitor and has developed sinus bradycardia. In determining the possible cause of the bradycardia, the nurse assesses the client's medication record. Which medication is most likely the cause of the bradycardia?

- A) Propranolol (Inderal).
- B) Captopril (Capoten).
- C) Furosemide (Lasix).
- D) Dobutamine (Dobutrex). - **CORRECT ANSWER A) Propranolol (Inderal).**

Rationale: Inderal (A) is a beta adrenergic blocking agent, which causes decreased heart rate and decreased contractility. Neither (B), an ACE inhibitor, nor (C), a loop diuretic, causes bradycardia. (D) is a sympathomimetic, direct acting cardiac stimulant, which would increase the heart rate.

17. A client has been taking oral corticosteroids for the past five days because of seasonal allergies. Which assessment finding is of most concern to the nurse?

- A) White blood count of 10,000/mm³.
- B) Serum glucose of 115 mg/dl.
- C) Purulent sputum.
- D) Excessive hunger. - **CORRECT ANSWER C) Purulent sputum.**

Rationale: Steroids cause immunosuppression, and a purulent sputum (C) is an indication of infection, so this symptom is of greatest concern. Oral steroids may increase (A) and often cause (D). (B) may remain normal, borderline, or increase while taking oral steroids.

18. A female client receiving IV vasopressin (Pitressin) for esophageal varice rupture reports to the nurse that she feels substernal tightness and pressure across her chest. Which PRN protocol should the nurse initiate?

- A) Start an IV nitroglycerin infusion.
- B) Nasogastric lavage with cool saline.
- C) Increase the vasopressin infusion.
- D) Prepare for endotracheal intubation. - **CORRECT ANSWER A) Start an IV nitroglycerin infusion.**

Rationale: Vasopressin is used to promote vasoconstriction, thereby reducing bleeding. Vasoconstriction of the coronary arteries can lead to angina and myocardial infarction, and should be counteracted by IV nitroglycerin per prescribed protocol (A). (B) will not

D) Financial resources available for the equipment. - CORRECT ANSWER C)
Willingness of the client to learn the injection sites.

Rationale: If a client is incapable or does not want to learn, it is unlikely that learning will occur, so motivation is the first factor the nurse should assess before teaching (C). To determine learning needs, the nurse should assess (A), but this is not the most important factor for the nurse to assess. (B and D) are factors to consider, but not as vital as (C).

22. The nurse is caring for a client who has taken a large quantity of furosemide (Lasix) to promote weight loss. The nurse anticipates the finding of which acid-base imbalance?

- A) PO₂ of 78 mm Hg
- B) HCO₃ of 34 mEq/L
- C) PCO₂ of 56 mm Hg
- D) pH of 7.31 - CORRECT ANSWER B) HCO₃ of 34 mEq/L

Rationale: Diuretics (non-potassium sparing) cause metabolic alkalosis. A) PO₂ of 78 mm Hg: This Po₂ demonstrates mild hypoxemia, consistent with respiratory disorders, not with diuretic use. C) PCO₂ of 56 mm Hg: CO₂ retention results from hypoventilation, which is not consistent with diuretic use. D) pH of 7.31: This pH is acidotic; diuretics promote metabolic alkalosis.

23. The nurse is preparing a teaching plan for a client who is newly diagnosed with Type 1 diabetes mellitus. Which signs and symptoms should the nurse describe when teaching the client about hypoglycemia?

- A) Sweating, trembling, tachycardia.
- B) Polyuria, polydipsia, polyphagia.
- C) Nausea, vomiting, anorexia.
- D) Fruity breath, tachypnea, chest pain. - CORRECT ANSWER A) Sweating, trembling, tachycardia.

Rationale: Sweating, dizziness, and trembling are signs of hypoglycemic reactions related to the release of epinephrine as a compensatory response to the low blood sugar (A). (B, C, and D) do not describe common symptoms of hypoglycemia.

Which reaction should the nurse identify in a client who is responding to stimulation of the sympathetic nervous system?

- A) Pupil constriction.
- B) Increased heart rate.
- C) Bronchial constriction.
- D) Decreased blood pressure. - CORRECT ANSWER B) Increased heart rate.

Rationale: Any stressor that is perceived as threatening to homeostasis acts to stimulate the sympathetic nervous system and manifests as a flight-or-fight response, which includes an increase in heart rate (B). (A, C, and D) are responses of the parasympathetic nervous system.

24. Which client should the nurse recognize as most likely to experience sleep apnea?

- A) Middle-aged female who takes a diuretic nightly.
 - B) Obese older male client with a short, thick neck.
 - C) Adolescent female with a history of tonsillectomy.
 - D) School-aged male with a history of hyperactivity disorder. - CORRECT ANSWER
- B) Obese older male client with a short, thick neck.

Rationale: Sleep apnea is characterized by lack of respirations for 10 seconds or more during sleep and is due to the loss of pharyngeal tone which allows the pharynx to collapse during inspiration and obstructs air flow through the nose and mouth. With obstructive sleep apnea, the client is often obese or has a short, thick neck as in (B). (A, C, and D) are not typically prone to sleep apnea.

25. To decrease the risk of acid-base imbalance, what does the client with diabetes mellitus strive for?

- A) Checking blood glucose levels once daily
 - B) Drinking 3 L of fluid per day
 - C) Eating regularly every 4 to 8 hours
 - D) Maintaining blood glucose levels within normal limits - CORRECT ANSWER D)
- Maintaining blood glucose level within normal limits

Rationale: Maintaining blood glucose levels within normal limits is the best way to decrease the risk of acid-base imbalance. A) Blood glucose levels must be checked several times a day. B) Drinking 3 L of fluid per day is not necessary to maintain acid-base balance. C) Eating regularly is a way to achieve acid-base balance but is not the goal itself.

26. After the fourth dose of gentamicin sulfate (Garamycin) IV, the nurse plans to draw blood samples to determine peak and trough levels. When are the best times to draw these samples?

- A) 15 minutes before and 15 minutes after the next dose.
- B) One hour before and one hour after the next dose.
- C) 5 minutes before and 30 minutes after the next dose.
- D) 30 minutes before and 30 minutes after the next dose. - CORRECT ANSWER C) 5 minutes before and 30 minutes after the next dose.

edema increases tissue pressure, blood flow to the distal extremity is compromised, which is manifested by slow capillary refill and absent distal pulses (C), so the healthcare provider should be notified about any compromised circulation that requires escharotomy. Although eschar formation occurs more readily over full thickness burns (A), the circumferential location of the burn is most likely to constrict underlying structures. Limited movement (B) is often due to pain. (D) may be related to the depth of the burn.

The nurse completes visual inspection of a client's abdomen. What technique should the nurse perform next in the abdominal examination?

- A) Percussion.
- B) Auscultation.
- C) Deep palpation.
- D) Light palpation. - CORRECT ANSWER B) Auscultation.

Rationale: Auscultation (B) of the client's abdomen is performed next because manual manipulation (A, C, and D) can stimulate the bowel and create false sounds heard during auscultation.

A client who has just tested positive for human immunodeficiency virus (HIV) does not appear to hear what the nurse is saying during post-test counseling. Which information should the nurse offer to facilitate the client's adjustment to HIV infection?

- A) Inform the client how to protect sexual and needle-sharing partners.
- B) Teach the client about the medications that are available for treatment.
- C) Identify the need to test other people who have had risky contact with the client.
- D) Discuss retesting to verify the results, which will ensure continuing contact. - CORRECT ANSWER D) Discuss retesting to verify the results, which will ensure continuing contact.

Rationale: Encouraging retesting (D) supports hope and gives the client time to cope with the diagnosis. Although post-test counseling should include education about (A, B, and C), retesting encourages the client to maintain medical follow-up and management.

The nurse hears short, high-pitched sounds just before the end of inspiration in the right and left lower lobes when auscultating a client's lungs. How should this finding be recorded?

- A) Inspiratory wheezes in both lungs.
- B) Crackles in the right and left lower lobes.
- C) Abnormal lung sounds in the bases of both lungs.
- D) Pleural friction rub in the right and left lower lobes. - CORRECT ANSWER B) Crackles in the right and left lower lobes.

Rationale: Fine crackles (B) are short, high-pitched sounds heard just before the end of inspiration that are the result of rapid equalization of pressure when collapsed alveoli or terminal bronchioles suddenly snap open. Wheezing (A) is a continuous high-pitched squeaking or musical sound caused by rapid vibration of bronchial walls that are first evident on expiration and may be audible. Although (C) describes an adventitious lung sound, this documentation is vague. (D) is a creaking or grating sound from roughened, inflamed surfaces of the pleura rubbing together heard during inspiration, expiration, and with no change during coughing.

A client asks the nurse about the purpose of beginning chemotherapy (CT) because the tumor is still very small. Which information supports the explanation that the nurse should provide?

- A) Side effects are less likely if therapy is started early.
- B) Collateral circulation increases as the tumor grows.
- C) Sensitivity of cancer cells to CT is based on cell cycle rate.
- D) The cell count of the tumor reduces by half with each dose. - CORRECT ANSWER
- D) The cell count of the tumor reduces by half with each dose.

Rationale: Initiating chemotherapy while the tumor is small provides a better chance of eradicating all cancer cells because 50% of cancer cells or tumor cells are killed with each dose. (A, B, and C) vary based on the type of cancer.

The nurse is caring for a client with non-Hodgkin's lymphoma who is receiving chemotherapy. Laboratory results reveal a platelet count of 10,000/ml. What action should the nurse implement?

- A) Encourage fluids to 3000 ml/day.
- B) Check stools for occult blood.
- C) Provide oral hygiene every 2 hours.
- D) Check for fever every 4 hours. - CORRECT ANSWER
- B) Check stools for occult blood.

Rationale: Platelet counts less than 100,000/mm³ are indicative of thrombocytopenia, a common side effect of chemotherapy. A client with thrombocytopenia should be assessed frequently for occult bleeding in the emesis, sputum, feces (B), urine, nasogastric secretions, or wounds. (A) does not minimize the risk for bleeding associated with thrombocytopenia. (C) may cause increased bleeding in a client with thrombocytopenia. (D) assesses for infection, not risk for bleeding.

The nurse is caring for a client with end stage liver disease who is being assessed for the presence of asterixis. To assess the client for asterixis, what position should the nurse ask the client to demonstrate?

- A) Extend the left arm laterally with the left palm upward.
- B) Extend the arm, dorsiflex the wrist, and extend the fingers.

* Low sperm count and loss of motility are seen in males with Hodgkin's disease before any therapy. Radiotherapy often results in permanent aspermia, or sterility (C). (A, B, and D) are inaccurate.

The nurse is preparing discharge instructions for a client who is going home with a surgical wound on the coccyx that is healing by second intention. What is the priority nursing diagnosis that should guide the discharge instruction plan?

- A) Acute pain.
- B) Risk for infection.
- C) Disturbed body image.
- D) Risk for deficient fluid volume. - CORRECT ANSWER B) Risk for infection.

* A wound healing by second intention is an open wound that is at risk for infection (B). Discomfort should be minimal 2 days after surgery, and acute pain (A) is not the priority. Risk for deficient fluid volume (D) requires a significant amount of wound draining, which is not evident. Although a wound may contribute to a disturbed body image (C), the client's distress may be minimal because the wound is not visible to others.

The nurse is preparing an adult client for an upper gastrointestinal (UGI) series. Which information should the nurse include in the teaching plan?

- A) The xray procedure may last for several hours.
- B) A nasogastric tube (NGT) is inserted to instill the barium.
- C) Enemas are given to empty the bowel after the procedure.
- D) Nothing by mouth is allowed for 6 to 8 hours before the study. - CORRECT ANSWER D) Nothing by mouth is allowed for 6 to 8 hours before the study.

* The client should be NPO for at least 6 hours before the UGI (D). (A) is not typical for this procedure. A NGT is not needed to instill the barium (B) unless the client is unable to swallow. A laxative, not enemas (C), is given after the procedure to help expel the barium.

A client is admitted to the hospital with a traumatic brain injury after his head violently struck a brick wall during a gang fight. Which finding is most important for the nurse to assess further?

- A) A scalp laceration oozing blood.
- B) Serosanguineous nasal drainage.
- C) Headache rated 10 on a 0-10 scale.
- D) Dizziness, nausea and transient confusion. - CORRECT ANSWER B) Serosanguineous nasal drainage.

* Any nasal discharge should be evaluated (B) to determine the presence of cerebral spinal fluid which indicates a tear in the dura making the client susceptible to meningitis. The scalp is highly vascular and results in blood oozing from wounds (A). Pain is

(F) are removed to prevent damage, loss or misplacement, or injury during surgery. (C and D) should remain with the client.

A client's prostate-specific antigen (PSA) exam result showed a PSA density of 0.13 ng/ml. Which conclusion regarding this lab data is accurate?

- A) Probable prostatitis.
- B) Low risk for prostate cancer.
- C) The presence of cancer cells.
- D) Biopsy of the prostate is indicated. - CORRECT ANSWER Correct Answer(s): B

* Clients with a PSA density less than 0.15 ng/ml are considered at low risk for prostate cancer (B). (A, C, and D) are incorrect interpretations of the test results.

The nurse is providing postoperative instructions for a female client after a mastectomy. Which information should the nurse include in the teaching plan? (Select all that apply.)

- A) Empty surgical drains once a week using procedure gloves.
- B) Report inflammation of the incision site or the affected arm.
- C) Wear clothing with snug sleeves over the arm on the operative side.
- D) Avoid lifting more than 4.5 kg (10 lb) or reaching above the head. - CORRECT ANSWER Correct Answer(s): B, D

* Part of the client's teaching plan should include reporting evidence of inflammation at the incision or of the affected arm (B), and avoiding lifting or reaching (D), which places the client at risk of injury to the extremity that may have compromised lymphatic drainage. The client should be instructed to empty surgical drains daily, not (A). Activity that decreases circulation (C) in the affected arm, such as carrying a handbag over the shoulder, wearing tight clothing, or tight jewelry, should be avoided.

Which sexually transmitted infection (STI) should the nurse include in a client's teaching plan about the risk for cervical cancer?

- A) Neisseria gonorrhoea.
- B) Chlamydia trachomatis.
- C) Herpes simplex virus.
- D) Human papillomavirus. - CORRECT ANSWER Correct Answer(s): D

* Human papillomavirus (D) is known to alter cervical epithelium cytology, which is consistent with early changes of cervical cancer. Although STIs (A, B, and C) place the client at risk for exposure to HPV, these are likely to place the client at risk for pelvic inflammatory disease, infertility sequela, and painful reoccurrence.

A client who returns to the unit after having a percutaneous transluminal coronary angioplasty (PTCA) complains of acute chest pain. What action should the nurse implement next?

- A) Inform the healthcare provider.
- B) Obtain a 12-lead electrocardiogram.
- C) Give a sublingual nitroglycerin tablet.
- D) Administer prescribed analgesic. - CORRECT ANSWER Correct Answer(s): C

* After a percutaneous transluminal coronary angioplasty (PTCA), a client who experiences acute chest pain may be experiencing cardiac ischemia related to restenosis, stent thrombosis, or acute coronary syndrome involving any coronary artery. The first action is to administer nitroglycerin (C) to dilate the coronary arteries and increase myocardial oxygenation. Then, (A, B, and D) are implemented.

A client is admitted to the Emergency Department with a tension pneumothorax. Which assessment should the nurse expect to identify?

- A) An absence of lung sounds on the affected side.
- B) An inability to auscultate tracheal breath sounds.
- C) A deviation of the trachea toward the side opposite the pneumothorax.
- D) A shift of the point of maximal impulse to the left, with bounding pulses. - CORRECT ANSWER Correct Answer(s): C

* Tension pneumothorax is caused by rapid accumulation of air in the pleural space, causing severely high intrapleural pressure. This results in collapse of the lung, and the mediastinum shifts toward the unaffected side, which is subsequently compressed (C). (A, B, and D) are not demonstrated with a tension pneumothorax.

A middle-aged male client asks the nurse what findings from his digital rectal examination (DRE) prompted the healthcare provider to prescribe a repeat serum prostatic surface antigen (PSA) level. What information should the nurse provide?

- A) A uniformly enlarged prostate is benign prostatic hypertrophy that occurs with aging.
- B) The spongy or elastic texture of the prostate is normal and requires no further testing.
- C) An infection is usually present when the prostate indents when a finger is pressed on it.
- D) Stony, irregular nodules palpated on the prostate should be further evaluated. - CORRECT ANSWER Correct Answer(s): D

* PSA levels are prescribed to screen for prostatic cancer which is often detected by DRE and manifested as small, hard, or stony, irregularly-shaped nodules on the surface of the prostate (D). Although PSA levels are prescribed for routine screening, the findings suggestive of BPH (A), normal texture (B) or infection (C) do not suggest cancer of the prostate, which requires further evaluation.

What is the primary nursing diagnosis for a client with asymptomatic primary syphilis?

* Further teaching is needed in response to the client's misunderstanding of sexuality after a hysterectomy that is reflected in statement (C). The client's knowledge about reproduction (A), a positive outlook with plans for the future (B), and her anticipated need for assistance and support during recovery (D) indicate she understands the present status of her recovery.

A client with a fractured right radius reports severe, diffuse pain that has not responded to the prescribed analgesics. The pain is greater with passive movement of the limb than with active movement by the client. The nurse recognizes that the client is most likely exhibiting symptoms of which condition?

- A) Acute compartment syndrome.
- B) Fat embolism syndrome.
- C) Venous thromboembolism.
- D) Aseptic ischemic necrosis. - CORRECT ANSWER Correct Answer(s): A

* These signs are specific indications of Acute Compartment Syndrome (A), and should be treated as an emergency situation. The signs do not indicate (B, C, or D).

A client who had abdominal surgery two days ago has prescriptions for intravenous morphine sulfate 4 mg every 2 hours and a clear liquid diet. The client complains of feeling distended and has sharp, cramping gas pains. What nursing intervention should be implemented?

- A) Obtain a prescription for a laxative.
- B) Withhold all oral fluid and food.
- C) Assist the client to ambulate in the hall.
- D) Administer the prescribed morphine sulfate. - CORRECT ANSWER Correct Answer(s): C

* Postoperative abdominal distention is caused by decreased peristalsis as a result of handling the intestine during surgery, limited dietary intake before and after surgery, and anesthetic and analgesic agents. Peristalsis is stimulated and distention minimized by implementing early and frequent ambulation (C). Based on the client's status, laxatives (A) or withholding dietary progression (B) are not indicated at this time. Although pain management should be implemented (D), another analgesic prescription may be needed because morphine reduces intestinal motility and contributes to the client's gas pains.

The nurse is caring for a male client who had an inguinal herniorrhaphy 3 hours ago. The nurse determines the client's lower abdomen is distended and assesses dullness to percussion. What is the priority nursing action?

- A) Assessment of the client's vital signs.
- B) Document the finding as the only action.
- C) Determine the time the client last voided.

* PET scans provide information regarding certain diseases of the heart (determination of tissue viability), brain (dementia, Parkinson's disease), and early detection of tumors and their aggressiveness. This diagnostic test scans the body to detect the spread of cancer (metastasis) (D). (A, B, and C) are not the purpose of PET.

A client with rheumatoid arthritis is prescribed piroxicam (Feldene), a nonsteroidal anti-inflammatory drug (NSAID). Which effect is characteristic of (NSAIDs) used for treating rheumatoid arthritis?

- A) Production of replacement cartilage is stimulated.
 - B) Further destruction of the articular cartilage is prevented.
 - C) Inflammation is reduced by inhibiting prostaglandin synthesis.
 - D) Bradykinin is inhibited, thereby reducing acute and chronic pain. - CORRECT
- ANSWER Correct Answer(s): C

* Nonsteroidal anti-inflammatory drugs (NSAIDs), used for treating rheumatoid arthritis, inhibit the synthesis of prostaglandins and relieve associated pain (C), but they do not generate new cartilage (A). NSAIDs are not an effective treatment to inhibit bradykinin (D). Joint destruction is not preventable with this disease process (B).

A deficiency of intrinsic factor should alert the nurse to assess a client's history for which condition?

- A) Emphysema.
- B) Hemophilia.
- C) Pernicious anemia.
- D) Oxalic acid toxicity. - CORRECT ANSWER Correct Answer(s): C

* Pernicious anemia (A) is a type of anemia due to failure of absorption of cobalamin (Vit B12). The most common cause is lack of intrinsic factor, a glucoprotein produced by the parietal cells of the gastric lining. (A, C, and D) are incorrect.

A client with a history of hypertension, myocardial infarction, and heart failure is admitted to the surgical intensive care unit after coronary artery bypass surgery graft (CABG). The nurse determines the client's serum potassium level is 4.5 mEq/L. What action should the nurse implement?

- A) Notify the healthcare provider.
- B) Decrease the IV solution flow rate.
- C) Document the finding as the only action.
- D) Administer potassium replacement as prescribed. - CORRECT ANSWER Correct Answer(s): C

* Coronary artery bypass surgery graft (CABG) places a client at risk for hypokalemia from hemodilution, nasogastric suction, or diuretic therapy, so the serum potassium