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To assess the quality of an adult client's pain, what approach should the nurse use?C

A) Observe body language and movement.

B) Provide a numeric pain scale.

C) Ask the client to describe the pain.

D) Identify effective pain relief measures.

A client who has been diagnosed with terminal cancer tells the nurse, "The doctor told me I have cancer and do not have long to live." Which response is best for the nurse to provide?

A) "That's correct, you do not have long to live" D

B) "Would you like me to call your minister?"

C) "Don't give up, you still have chemotherapy to try."

D) "Yes, your condition is serious."

When performing blood pressure measurement to assess for orthostatic hypotension, which action should the nurse implement first? C

A) Apply the blood pressure cuff securely.

B) Record the client's pulse rate and rhythm. C) Position the client supine for a few minutes.

D) Assist the client to stand at bedside.

Female unlicensed assistive personnel (UAP) are assigned to take the vital signs of a client with pertussis for whom droplet precautions have been implemented. The UAP request a change in assignment, stating she has not yet been fitted for a

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D) The deltoid muscle.

A male Native American present to the clinic with complaints of frequent abdominal cramping and nausea. He states that he has chronic constipation and had not had a bowel movement in five days, despite trying several home remedies.Which intervention is most important for the nurse to implement?

A) Determine what home remedies were used.

B) Assess for the presence of an impaction.

C) Obtain list of prescribed home medications.

D) Evaluate stool sample for presence of blood.

What information is most important for the nurse to obtain in determining aclient's need for referral for obesity counseling?

A) Body weight 10% over ideal body weight.

B) Body mass index greater than 35.

C) Daily caloric intake of 3500 calories.

D) Client's expressed desire to lose 50 pounds.

The nurse is caring for a hospitalized client who was placed in restraints due toconfusion. The family removes the restraints while they are with client. When the family leaves, what action should the nurse take first?

A) Apply the restraints to maintain the client's safety.

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1. When turning an immobile bedridden client without assistance, whichaction by the nurse best ensures client safety?

A. Securely grasp the client's arm and leg.

B. Put bed rails up on the side of bed oppositefrom the nurse.

C. Correctly position and use a turn sheet.

D. Lower the head of the client's bed slowly.

Rationale:

Because the nurse can only stand on one side of the bed, bed rails should be up on the opposite side to ensure that the client does not fall out of bed. Option A can cause client injury to the skin or joint. Options C and D are useful techniques whileturning a client but have less priority in terms of safety than use of the bed rails.

2. The nurse identifies a potential for infection in a client with partial- thickness (second-degree) and full-thickness (third-degree) burns. Whatintervention has the highest priority in decreasing the client's risk of infection?

A. Administration of plasma expanders

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Rationale:

Comparing this reading with previous readings will provide information about what is normal for this client; this action should be taken first. Option A might unnecessarily alarm the client. Option B is premature. Further assessment is needed to determine if the reading is abnormal for this client. Option C could falsely decrease the reading and is not the correct procedure for obtaining a bloodpressure reading.

21. A nurse stops at a motor vehicle collision site to render aid until the emergency personnel arrive and applies pressure to a groin wound that is bleedingprofusely. Later the client has to have the leg amputated and sues the nurse for malpractice. Which is the most likely outcome of this lawsuit?

A. The Patient's Bill of Rights protects clients from malicious intents, so the nurse could losethe case.

B. The lawsuit may be settled out of court, but the

havenot been shown to be as effective as cranberry juice in preventing UTIs.

27.The nurse is counting a client's respiratory rate. During a 30-second interval, the nurse counts six respirations and the client coughs three times. In repeating thecount for a second 30-second interval, the nurse counts eight respirations. Which respiratory rate should the nurse document?

A. 14

B. 16

C. 17

D. 28

Rationale:

The most accurate respiratory rate is the second count obtained by the nurse, which

theclient leaves the bathroom.

C. Allow the client to cry alone and leave theclient in the bathroom.

D. Talk to the client and attempt to find out whythe client is crying.

Rationale:

The nurse's first concern should be for the client's safety, so an immediate assessment of the client's situation is needed. Option A is incorrect; the nurse should implement the intervention. The nurse may offer to stay nearby after firstassessing the situation more fully. Although option C may be correct, the nurse should determine if the client's safety is compromised and offer assistance, evenif it is refused

30. A client in a long-term care facility reports to the nurse that he has not had abowel movement in 2 days. Which intervention should the nurse implement first?

43. A nurse is assigned to care for a close friend in the hospital setting. Which action should the nurse take first when given the assignment?

A. Notify the friend that all medical information will be kept confidential.

B. Explain the relationship to the charge nurse and ask for reassignment.

C. Approach the client and ask if the assignment is uncomfortable.

D. Accept the assignment but protect the client's confidentiality.

Rationale:

Caring for a close friend can violate boundaries for nurses and should be avoided when possible (B). If the assignment is unavoidable (there are no other nurses to care for the client) then C, A, and D should be addressed.

44. The nurse-manager of a skilled nursing (chronic care) unit is instructing UAPs on ways to prevent complications of immobility. Which intervention should be included in this instruction?

A. Perform range-of-motion exercises to prevent contractures.

B. Decrease the client's fluid intake to prevent diarrhea.

D. Avocado salad, milk, and angel food cake

Rationale:

Clients with cholecystitis (inflammation of the gallbladder) should follow a low-fat diet, such as option B. Option A is a high-protein diet, and options C and D contain high-fat foods, which are contraindicated for this client.

47. When bathing an uncircumcised boy older than 3 years, which action should the nurse take?

A. Remind the child to clean his genital area.

B. Defer perineal care because of the child's age.

C. Retract the foreskin gently to cleanse the penis.

D. Ask the parents why the child is not circumcised.

every2 hours.

C. Dorsiflex and plantarflex the feet 10 timeseach hour.

D. Drink approximately 4 ounces of waterevery hour.

Rationale:

To reduce the risk of venous thrombosis, the nurse should instruct the client in measures that promote venous return, such as dorsiflexion and plantar flexion. Options A, B, and D are helpful to prevent other complications of immobility butare less effective in preventing venous thrombus formation than option C.

52. In assisting an older adult client prepare to take a tub bath, whichnursing action is most important?

A. Check the bath water temperature.

B. Shut the bathroom door.

C. Ensure that the client has voided.

D. Provide extra towels.

Rationale:

To prevent burns or excessive chilling, the nurse must check the bath water temperature. Options B, C, and D promote comfort and privacy and are importantinterventions but are of less priority than promoting safety.

53. In taking a client's history, the nurse asks about the stool characteristics. Which description should the nurse report to the health care provider as soon as possible?

A. Daily black, sticky stool

B. Daily dark brown stool

C. Firm brown stools every other day

D. Soft light brown stool twice a day

Rationale:

Black sticky stool (melena) is a sign of gastrointestinal bleeding and should be reported to the health care provider promptly. Option C indicates constipation, which is a lesser priority. Options B and D are variations of normal.

54. After the nurse tells an older client that an IV line needs to be

obtained.

63. A community hospital is opening a mental health services department. Which document should the nurse use to develop the unit's nursing guidelines?

A. Americans with Disabilities Act of 1990

B. ANA Code of Ethics with Interpretative Statements

C. ANA's Scope and Standards of Nursing Practice

D. Patient's Bill of Rights of 1990

Rationale:

The ANA Scope of Standards of Practice for Psychiatric–Mental Health Nursing serves to direct the philosophy and standards of psychiatric nursing practice.

Options A and D define the client's rights. Option B provides ethical guidelines for nursing.

64. While conducting an intake assessment of an adult male at a community mental health clinic, the nurse notes that his affect is flat, he responds to questions with short answers, and he reports problems with sleeping. He reports that his life partner recently died from pneumonia. Which action is most important for the nurse to implement?

A. Encourage the client to see the clinic's grief counselor.

B. Determine if the client has a family history of suicide attempts.

C. Inquire about whether the life partner was suffering from AIDS.

D. Consult with the health care provider about the client's need for antidepressant medications.

Rationale:

The client is exhibiting normal grieving behaviors, so referral to a grief counselor is the most important intervention for the nurse to implement. Option B is indicated but is not a high-priority intervention. Option C is irrelevant at this time but might be important when determining the client's risk for contracting the illness. An antidepressant may be indicated, depending on further assessment, but grief counseling is a better action at this time because grief is an expected reaction to the loss of a loved one.

65. An older adult who recently began self-administration of insulin calls the

70. The nurse is preparing to administer 10 mL of liquid potassium chloride through a feeding tube, followed by 10 mL of liquid acetaminophen. Which action should the nurse include in this procedure?

A. Dilute each of the medications with sterile water prior to administration.

B. Mix the medications in one syringe before opening the feeding tube.

C. Administer water between the doses of the two liquid medications.

D. Withdraw any fluid from the tube before instilling each medication.

Rationale:

Water should be instilled into the feeding tube between administering the two medications to maintain the patency of the feeding tube and ensure that the total dose of medication enters the stomach and does not remain in the tube. These liquid medications do not need to be diluted when administered via a feeding tube and should be administered separately, with water instilled between each medication.

71. The nurse transcribes the postoperative prescriptions for a client who returns to the unit following surgery and notes that an antihypertensive medication that was prescribed preoperatively is not listed. Which action should the nurse take?

aninterpreter translating.

C. Request the accompanying family memberto translate.

D. Instruct a bilingual employee to readthe instructions.

Rationale:

Wound care instructions should be given directly to the client by the nurse with aninterpreter who is trained to provide accurate and objective translation in the client's primary language, so that the client has the opportunity to ask questions during the teaching process. The interpreter usually does not have any health care experience, so the nurse must provide client teaching. Family members should notbe used to translate instructions because the client or family member may alter theinstructions during conversation or be uncomfortable with the topics discussed.

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Immediately stop the infusion. Lower the height of the enema bag.

Advance the enema tubing 2 to 3 inches.

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

Abdominal cramping during a soapsuds enema may be due to too rapid administration of the enemasolution. Lowering the height of the enema bag slows the flow and allows the bowel time to adapt tothe 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 restartingthe 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 reinforces the dressing on the pressure ulcer. Legally, were the nurse's actions adequate?

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

The nurse provided supportive nursing care for the well-being of the client.

Debridement of the pressure ulcer should have been done before the dressing was appliedTreatment should not have been instituted until the health care provider's prescriptions were received.

iniron

High

in

fluids

Low

in

residue

A common side effect of vincristine is a paralytic ileus that results in constipation. Preventative measures include high-fiber foods and fluids that exceed minimum requirements. These will keep thestool bulky and soft, thereby promoting evacuation. Low in fat, high in iron, and low in residue dietaryplans will not provide the roughage andfluids needed to minimize the constipation associated with vincristine.

A postoperative client says to the nurse, "My neighbor, I mean the person in the next room,sings all night and keeps me awake." The neighboring client has dementia and is awaiting transfer to a nursing home. How can the nurse best handle this situation?

Tell the neighboring client to

stopsinging. Close the doors to

both

er

Den

ial

Bar

g

ainin

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Acc

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ptan

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Communication and interventions during the acceptance stage are mainly nonverbal (e.g.,holding theclient's hand). The nurse should be quiet but available. During the anger stage the nurse should accept that the client is angry. The anger stage requires verbal communication. During the denial stage the nurse should accept the client's behavior but not reinforce the denial. The denial stage requires verbal communication. During the bargaining stage the nurse should listen intently but not provide false reassurance. The bargaining stage requires verbal communication.

When a client files a lawsuit against a nurse for malpractice, the client must prove that there isa link between the harm suffered and actions performed by the nurse that were negligent. Thisis known as:

Evidence

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Tort discovery

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Proximat

e cause

Commo

n cause

Proximate cause is the legal concept meaning that the client must prove that the nurse's actions contributed to or caused the client's injury. Evidence is data presented in proof of the facts, which may include witness testimony, records, documents, or objects. A tort is a wrongful act, not including a breach of contract of trust that results in injury to another person. Common cause means to unite one's interest with another's.

Following a surgery on the neck, the client asks the nurse why the head of the bed is up so high. The nurse should tell the client that the high-Fowler position is preferred for what reason?

To avoid strain on the incisionTo promote drainage of the woundTo provide stimulation for the client

To reduce edema at the operative site

This position prevents fluid accumulation in the tissue, thereby minimizing edema. This position will neither increase nor decrease strain on the suture line. Drainage

The nurse plans care for a client with a somatoform disorder based on the understanding that the disorder is:

A physiological response to stress A conscious defense against anxiety An intentional attempt to gain attention

An unconscious means of reducing stress

When emotional stress overwhelms an individual's ability to cope, the unconscious seeks to reduce stress. A conversion reaction removes the client from the stressful situation, and the conversion reaction's physical/sensory manifestation causes little or no anxiety in the individual. This lack of concern is called la belle indifference. No physiologic changes are involved with this unconscious resolution of a conflict. The conversion of anxiety to physical symptoms operates on an unconsciouslevel.

Implement nursing interventions.

First the nurse should gather data. Based on the data, the client's needs are assessed. After the needs have been determined, the goals for care are established. The next step isplanning care based on the knowledge gained from the previous steps. Implementation follows the development ofthe plan of care.

In what position should the nurse place a client recovering from general anesthesia?

Supine
Side-lying
High Fowler
Trendelenburg

Turning the client to the side promotes drainage of secretions and prevents aspiration, especially when the gag reflex is not intact. This position also brings the tongue forward,preventing it from occluding the airway when it is in the relaxed

state. The risk for aspiration is increased when the supine position is assumed by a semi-alert client. High Fowler position may cause the neck to flex in

Documentation of vital sign Assessment of intake and output Administration of antiemetic drugs Replacement of fluid and electrolytes

When skin turgor is assessed, the presence of tenting may be related to loss of subcutaneous tissueassociated with aging rather than to dehydration; skin over the sternum should be used instead of skin on the arm for checking turgor. Older adults aresusceptible to central nervous system side effects, such as confusion, associated with antiemetic drugs; dosages must be reduced, and responses must be evaluated closely.

Because many older adults have delicate fluid balance and may have cardiac and renal disease, replacement of fluid and electrolytes may result in adverse consequences, suchas hypervolemia, pulmonary edema, and electrolyte imbalance. Vital signs canbe obtained as with any other adult. Intake and output can be measured accurately in olderadults.

What should the nurse consider when obtaining an informed consent from a 17-year-oldadolescent?

If the client is allowed to give consent

The client cannot make informed decisions about health care.

If the client is permitted to give voluntary consent when parents are not available.

rash

Leg

cram

ps

Tach

ycar

dia

Muscle weakness

Leg cramps occur with hypokalemia because of potassium deficit. Muscle weakness occurs with hypokalemia because of the alteration in the sodium-potassium pump mechanism. Diplopia does notindicate an electrolyte deficit. A skin rash does not indicatean electrolyte deficit. Tachycardia is not associated with hypokalemia, bradycardia is.

A nurse in the surgical intensive care unit is caring for a client with a large surgical incision.The nurse reviews a list of vitamins and expects that which medication will be prescribed because of its major role in wound healing?

Assisting a client who has PCA to the bathroom does not require professional nursing judgment and is within thejob description of the UAP. Evaluating human responses to medications requires the expertise of a licensed professional nurse. Obtaining an apicalpulse rate requires a professional nursing judgmentto determine whether or not the medication should be administered. Evaluating human responses to health care interventions requires the expertise of a licensed professional nurse.

A client has an anaphylactic reaction after receiving intravenous penicillin. What does thenurse conclude is the cause of this reaction?

3

Respiratory

acidosis4

Respirator

yalkalosis

A low pH and low bicarbonate level are consistent with metabolic acidosis. The pH indicates acidosis.The CO2 concentration is within normal limits, which is inconsistentwith respiratory acidosis; it is elevated with respiratory acidosis.

1

A low pH and low bicarbonate level are consistent with metabolic acidosis. The pH indicates acidosis.The CO2 concentration is within normal limits, which is inconsistentwith respiratory acidosis; it is elevated with respiratory acidosis.

Ph-7.35-

7.45

PCO2

- 35-45

HCO3 - 22-30

Toxicity can result because the action of calcium ions is similar to that of digoxin. Calcium gluconatecannot be added to a solution containing carbonate or phosphate because a dangerous precipitationwill occur. Calcium gluconate can be added to the IVsolution the client is receiving. If calcium infiltrates, sloughing of tissue will result.

A nurse administers an intravenous solution of 0.45% sodium chloride. In what category of fluids does this solution belong?

Isotonic

Isometric

Hypotonic

Hypertonic

Hypotonic solutions are less concentrated (contain less than 0.85 g of sodium chloride in each 100 mL) than body fluids. Isotonic solutions are those that cause no change in the cellular volume or pressure, because their concentration is equivalent to that of body fluid. This relates to two compounds that possess the same molecular formula but that differ in their properties or in the position of atoms in the molecules (isomers).
Hypertonic solutions contain more than 0.85 g of solutein each 100 mL.

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Monitor the client's pain level for another hour.2 Determine the integrity ofthe intravenous delivery system.3 Reprogram the pump to deliver a bolusdose every eight minutes.4 Arrange for the client to be evaluated by the health care provider.

Initially, integrity of the intravenous system should be verified to ensure thatthe client is receiving medication. The intravenous tubing may be kinked or compressed, or the catheter may be dislodged.Continued monitoring will result in the client experiencing unnecessary pain. The nurse may not reprogram the pump to deliver larger or more frequent doses of medication without a health care provider's prescription. The health care provider should be notified if the system is intact and the client is not obtaining relieffrom pain. The prescription may have to be revised; the basal dose may be increased, the length of the delay may be reduced, or another medication or mode of delivery maybe prescribed.