

A nurse is caring for a client with a history of peptic ulcer disease. Which of the following should the nurse instruct the client to avoid?

- A. Eating small, frequent meals
- B. Drinking caffeinated beverages
- C. Using antacids between meals
- D. Taking antiplatelet medications as prescribed

Answer:

B. Drinking caffeinated beverages

Rationale: Caffeine can stimulate gastric acid secretion and irritate the stomach lining, exacerbating peptic ulcers.

10. Question:

A nurse is caring for a client who is receiving an opioid analgesic for pain management. Which of the following is the priority nursing action?

- A. Monitor the client for signs of nausea
- B. Assess the client's respiratory rate
- C. Provide a high-fiber diet
- D. Encourage the client to perform deep breathing exercises

Answer:

B. Assess the client's respiratory rate

Rationale: Opioids can cause respiratory depression, so monitoring the respiratory rate is a priority to ensure the client's safety.

11. Question:

A nurse is caring for a client with hyperthyroidism. Which of the following findings should the nurse expect to assess?

- A. Cold intolerance
- B. Weight gain
- C. Tachycardia
- D. Constipation

Answer:

C. Tachycardia

Rationale: Hyperthyroidism increases metabolism, leading to symptoms such as tachycardia, weight loss, and increased bowel movements.

12. Question:

A nurse is caring for a client who is 1 day post-op following a laparoscopic cholecystectomy. Which of the following findings is expected and should be reported?

- A. Abdominal distension
- B. Small amount of clear drainage at the incision site
- C. Pain at the incision site
- D. Elevated temperature of 100.4°F (38°C)

Answer:

A. Abdominal distension

Rationale: Abdominal distension post-op can indicate a complication such as retained gas or obstruction, which should be reported to the healthcare provider.

13. Question:

A nurse is teaching a client with heart failure about fluid restriction. Which of the following statements by the client indicates understanding?

- A. "I can drink a small glass of water with each meal."
- B. "I should avoid all fluids after 6:00 PM."
- C. "I will drink a liter of fluid per day."
- D. "I can drink unlimited amounts of fluid if I restrict salt."

Answer:

B. "I should avoid all fluids after 6:00 PM."

Rationale: Restricting fluid intake, especially in the evening, can help prevent fluid overload and nocturnal dyspnea in clients with heart failure.

14. Question:

A nurse is assessing a client with a history of asthma. Which of the following findings is a priority?

- A. Wheezing on expiration
- B. Decreased breath sounds bilaterally
- C. Productive cough with clear sputum
- D. Shortness of breath with minimal exertion

95. **Q:** What is the priority for a client undergoing a blood transfusion?
A: Monitor for signs of a transfusion reaction, such as fever or rash.
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Miscellaneous

96. **Q:** What is the most common side effect of opioids?
A: Constipation.
97. **Q:** What is the antidote for a benzodiazepine overdose?
A: Flumazenil.
98. **Q:** What type of precaution is needed for a client with tuberculosis?
A: Airborne precautions.
99. **Q:** What is the first step in treating anaphylaxis?
A: Administer epinephrine.
100. **Q:** What is a priority teaching point for a client on corticosteroids?
A: Do not stop abruptly; taper the dose as prescribed.

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