Braindumps NCLEX-PN. 725

Number: NCLEX-PN
Passing Score: 800
Time Limit: 120 min
File Version: 12.5

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NCLEX-PN

National Council Licensure Examination

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NCLEX-PN

QUESTION 1
A middle-aged woman tells the nurse that she has been experiencing irregular menses for the past six months. The nurse should assess the woman for other symptoms of:

A. climacteric.
B. menopause.
C. perimenopause.
D. postmenopause.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Perimenopause refers to a period of time in which hormonal changes occur gradually, ovarian function diminishes, and menses become irregular. Perimenopause lasts approximately five years. Climacteric is a term
applied to the period of life in which physiologic changes occur and result in cessation of a woman's reproductive
ability and lessened sexual activity in males. The term applies to both genders. Climacteric and menopause are
interchangeable terms when used for females. Menopause is the period when permanent cessation of menses has
occurred. Postmenopause refers to the period after the changes accompanying menopause are complete.Health
Promotion and Maintenance

QUESTION 2
When obtaining a health history on a menopausal woman, which information should a nurse recognize as a contraindication for hormone replacement therapy?

A. family history of stroke
B. ovaries removed before age 45
C. frequent hot flashes and/or night sweats
D. unexplained vaginal bleeding

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Unexplained vaginal bleeding is a contraindication for hormone replacement therapy. Family history of stroke is not a contraindication for hormone replacement therapy. If the woman herself had a history of stroke or
other blood-clotting events, hormone therapy could be contraindicated. Frequent hot flashes and/or night sweats
can be relieved by hormone replacement therapy.Health Promotion and Maintenance

QUESTION 3
Which of the following statements, if made by the parents of a newborn, does not indicate a need for further teaching about cord care?

A. "I should put alcohol on my baby's cord 34 times a day."
B. "I should put the baby's diaper on so that it covers the cord."
C. "I should call the physician if the cord becomes dark."

D. "I should wash my hands before and after I take care of the cord."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Parents should be taught to wash their hands before and after providing cord care. This prevents transferring
pathogens to and from the cord. Folding the diaper below the cord exposes the cord to air and allows for drying.
It also prevents wet or soiled diapers from coming into contact with the cord. Current recommendations include
cleaning the area around the cord 34 times a day with a cotton swab but do not include putting alcohol or other
antimicrobials on the cord. It is normal for the cord to turn dark as it dries.Health Promotion and Maintenance

QUESTION 4
The nurse is teaching parents of a newborn about feeding their infant. Which of the following instructions should the nurse include?

A. Use the defrost setting on microwave ovensto warm bottles.
B. When refrigerating formula, don't feed the baby partially used bottles after 24 hours.
C. When using formula concentrate, mix two parts water and one part concentrate.
D. If a portion of one bottle is left for the next feeding, go ahead and add new formula to fill it.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Parents must be careful when warming bottles in a microwave oven because the milk can become superheated.
When a microwave oven is used, the defrost setting should be chosen, and the temperature of the formula should
be checked before giving it to the baby. Refrigerated, partially used bottles should be discarded after 4 hours
because the baby might have introduced some pathogens into the formula. Returning the bottle to the refrigerator
does not destroy pathogens. Formula concentrate and water are usually mixed in a 1:1 ratio of one part concentrate
and one part water. Infants should be offered fresh formula at each feeding. Partially used bottles should not have
fresh formula added to them. Pathogens can grow in partially used bottles of formula and be transferred to the new
formula.Health Promotion and Maintenance

QUESTION 5
The nurse is assessing the dental status of an 18-month-old child. How many teeth should the nurse expect to examine?

A. 6
B. 8
C. 12
D. 16

Correct Answer: C

Section: (none)
Explanation

Explanation/Reference:
Explanation:

In general, children begin dentition around 6 months of age. During the first 2 years of life, a quick guide to the number of teeth a child should have is as follows: Subtract the number 6 from the number of months in the
age of the child. In this example, the child is 18 months old, so the formula is 18 6 = 12. An 18-month-old child
should have approximately 12 teeth.Health Promotion and Maintenance

QUESTION 6
Which of the following physical findings indicates that an 1112-month-old child is at risk for developmental dysplasia of the hip?

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A. refusal to walk
B. not pulling to a standing position
C. negative Trendelenburg sign
D. negative Ortolani sign

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse might be concerned about developmental dysplasia of the hip if an 1112-month-old child doesn't pull to a standing position. An infant who does not walk by 15 months of age should be evaluated. Children should start walking between 1115 months of age. Trendelenberg sign is related to weakness of the gluteus
medius muscle, not hip dysplasia. Ortolani sign is used to identify congenital subluxation or dislocation of the
hip in infants.Health Promotion and Maintenance

QUESTION 7
When administering intravenous electrolyte solution, the nurse should take which of the following precautions?

A. Infuse hypertonic solutions rapidly.
B. Mix no more than 80 mEq of potassium per liter of fluid.
C. Prevent infiltration of calcium, which causes tissue necrosis and sloughing.
D. As appropriate, reevaluate the client's digitalis dosage. He might need an increased dosage because IV calcium diminishes digitalis's action.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Preventing tissue infiltration is important to avoid tissue necrosis. Choice 1 is incorrect because hypertonic solutions should be infused cautiously and checked with the RN if there is a concern. Choice 2 is incorrect because
potassium, mixed in the pharmacy per physician order, is mixed at a concentration no higher than 60 mEq/L.
Physiological Adaptation

QUESTION 8
Teaching about the need to avoid foods high in potassium is most important for which client?

A. a client receiving diuretic therapy
B. a client with an ileostomy
C. a client with metabolic alkalosis
D. a client with renal disease

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clients with renal disease are predisposed to hyperkalemia and should avoid foods high in potassium. Choices 1, 2, and 3 are incorrect because clients receiving diuretics with ileostomy or with metabolic alkalosis
are at risk for hypokalemia and should be encouraged to eat foods high in potassium.Physiological Adaptation

QUESTION 9
What do the following ABG values indicate: pH 7.38, PO2 78 mmHg, PCO2 36mmHg, and HCO3 24 mEq/L?

A. metabolic alkalosis
B. homeostasis
C. respiratory acidosis
D. respiratory alkalosis

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

These ABG values are within normal limits. Choices 1, 3, and 4 are incorrect because the ABG values indicate none of these acid-base disturbances.Physiological Adaptation

QUESTION 10
The major electrolytes in the extracellular fluid are:

A. potassium and chloride.
B. potassium and phosphate.
C. sodium and chloride.
D. sodium and phosphate.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:

Explanation:

Sodium and chloride are the major electrolytes in the extracellular fluid.Physiological Adaptation

QUESTION 11
A client with Kawasaki disease has bilateral congestion of the conjunctivae, dry cracked lips, a strawberry tongue, and edema of the hands and feet followed by desquamation of fingers and toes. Which of the following nursing measures is most appropriate to meet the expected outcome of positive body image?

A. administering immune globulin intravenously
B. assessing the extremities for edema, redness and desquamation every 8 hours
C. explaining progression of the disease to the client and his or her family
D. assessing heart sounds and rhythm

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Teaching the client and family about progression of the disease includes explaining when symptoms can be expected to improve and resolve. Knowledge of the course of the disease can help them understand that no
permanent disruption in physical appearance will occur that could negatively affect body image.
Clients with
Kawasaki disease might receive immune globulin intravenously to reduce the incidence of coronary artery lesions
and aneurysms. Cardiac effects could be linked to body image, but Choice 3 is the most direct link to body image.
The nurse assesses symptoms to assist in evaluation of treatment and progression of the disease.Health Promotion and Maintenance

QUESTION 12
Which of the following is most likely to impact the body image of an infant newly diagnosed with Hemophilia?

A. immobility
B. altered growth and development
C. hemarthrosis
D. altered family processes

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Altered Family Processes is a potential nursing diagnosis for the family and client with a new diagnosis of Hemophilia. Infants are aware of how their caregivers respond to their needs. Stresses can have an immediate
impact on the infant's development of trust and how others relate to them because of their diagnosis. The longterm
effects of hemophilia can include problems related to immobility. Altered growth and development could not have developed in a newly diagnosed client. Hemarthrosis is acute bleeding into a joint space that is characteristic
of hemophilia. It does not have an immediate effect on the body image of a newly diagnosed hemophiliac.Health
Promotion and Maintenance

QUESTION 13

While undergoing fetal heart monitoring, a pregnant Native-American woman requests that a medicine woman be present in the examination room. Which of the following is an appropriate response by the nurse?

A. "I will assist you in arranging to have a medicine woman present."
B. "We do not allow medicine women in exam rooms."
C. "That does not make any difference in the outcome."
D. "It is old-fashioned to believe in that."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This statement reflects cultural awareness and acceptance that receiving support from a medicine woman is
important to the client. The other statements are culturally insensitive and unprofessional.Reduction of Risk Potential

QUESTION 14
All of the following should be performed when fetal heart monitoring indicates fetal distress except:

A. increase maternal fluids.
B. administer oxygen.
C. decrease maternal fluids.
D. turn the mother.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Decreasing maternal fluids is the only intervention that shouldnotbe performed when fetal distress is indicated.Reduction of Risk Potential

QUESTION 15
Which fetal heart monitor pattern can indicate cord compression?

A. variable decelerations
B. early decelerations
C. bradycardia
D. tachycardia

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Variable decelerations can be related to cord compression. The other patterns are not.Reduction of Risk Potential

QUESTION 16
Which of the following conditions is mammography used to detect?

A. pain

B. tumor
C. edema
D. epilepsy

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Mammography is used to detect tumors or cysts in the breasts, not the other conditions.Reduction of Risk Potential

QUESTION 17
Why might breast implants interfere with mammography?

A. They might cause additional discomfort.
B. They are contraindications to mammography.
C. They are likely to be dislodged.
D. They might prevent detection of masses.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Breast implants can prevent detection of masses. Choices 1, 2, and 3 are not ways in which breast implants
interfere with mammography.Reduction of Risk Potential

QUESTION 18
Which of the following instructions should the nurse give a client who will be undergoing mammography?

A. Be sure to use underarm deodorant.
B. Do not use underarm deodorant.
C. Do not eat or drink after midnight.
D. Have a friend drive you home.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Underarm deodorant should not be used because it might cause confusing shadows on the X-ray film. There
are no restrictions on food or fluid intake. No sedation is used, so the client can drive herself home.Reduction of
Risk Potential

QUESTION 19
Which of the following diseases or conditions is least likely to be associated with increased potential for bleeding?

A. metastatic liver cancer
B. gram-negative septicemia

C. pernicious anemia
D. iron-deficiency anemia

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pernicious anemia results from vitamin B12 deficiency due to lack of intrinsic factor. This can result from inadequate dietary intake, faulty absorption from the GI tract due to a lack of secretion of intrinsic factor normally produced by gastric mucosal cells and certain disorders of the small intestine that impair absorption.
The nurse should instruct the client in the need for lifelong replacement of vitamin B12, as well as the need for
folic acid, rest, diet, and support.Physiological Adaptation

QUESTION 20
A client has been diagnosed with Disseminated Intravascular Coagulation (DIC) and transferred to the medical intensive care unit (ICU) subsequent to an acute bleeding episode. In the ICU, continuous Heparin drip therapy is initiated. Which of the following assessment findings indicates a positive response to Heparin therapy?

A. increased platelet count
B. increased fibrinogen
C. decreased fibrin split products
D. decreased bleeding

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Effective Heparin therapy should stop the process of intravascular coagulation and result in increased availability of fibrinogen. Heparin administration interferes with thrombin-induced conversion of fibrinogen to fibrin. Bleeding should cease due to the increased availability of platelets and coagulation factors.Physiological
Adaptation

QUESTION 21
A client, age 28, was recently diagnosed with Hodgkin's disease. After staging, therapy is planned to include combination radiation therapy and systemic chemotherapy with MOPP-- nitrogen mustard, vincristine (Onconvin), prednisone, and procarbazine. In planning care for this client, the nurse should anticipate which of the following side effects to contribute to a sense of altered body image?

A. cushingoid appearance
B. alopecia
C. temporary or permanent sterility
D. pathologic fractures

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pathologic fractures are not common to the disease process. Its treatment through osteoporosis is a

potential
complication of steroid use. Hodgkin's disease most commonly affects young adults (males), is spread through
lymphatic channels to contiguous nodes, and also might spread via the hematogenous route to extradal sites (GI,
bone marrow, skin, and other organs). A working staging classification is performed for clinical use and care.
Physiological Adaptation

QUESTION 22
Which of the following is an inappropriate item to include in planning care for a severely neutropenic client?

A. Transfuse netrophils (granulocytes) to prevent infection.
B. Exclude raw vegetables from the diet.
C. Avoid administering rectal suppositories.
D. Prohibit vases of fresh flowers and plants in the client's room.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Granulocyte transfusion is not indicated to prevent infection. Produced in the bone marrow, granulocytes normally comprise 70% of all WBCs. They are subdivided into three types based on staining properties: neutrophils, eosinophils, and basophils. They can be beneficial in a selected population of infected, severely
granulocytopenic clients (less than 500/mm3) who do not respond to antibiotic therapy and who are expected
to experience prolonged suppression of granulocyte production.Physiological Adaptation

QUESTION 23
Which sign might the nurse see in a client with a high ammonia level?

A. coma
B. edema
C. hypoxia
D. polyuria

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Coma might be seen in a client with a high ammonia level.Reduction of Risk Potential

QUESTION 24
A client with which of the following conditions is at risk for developing a high ammonia level?

A. renal failure
B. psoriasis
C. lupus
D. cirrhosis

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client with cirrhosis is at risk for developing a high ammonia level.Reduction of Risk Potential

QUESTION 25
For which of the following conditions might blood be drawn for uric acid level?

A. asthma
B. gout
C. diverticulitis
D. meningitis

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Uric acid levels are indicated for clients with gout.Reduction of Risk Potential

QUESTION 26
Which of the following foods might a client with a hypercholesterolemia need to decrease his or her intake of?

A. broiled catfish
B. hamburgers
C. wheat bread
D. fresh apples

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Due to the high cholesterol content of red meats, such as hamburger, intake needs to be decreased. The other
options do not have high cholesterol content, so they do not need to be decreased.Reduction of Risk Potential

QUESTION 27
Which of the following lab values is associated with a decreased risk of cardiovascular disease?

A. high HDL cholesterol
B. low HDL cholesterol
C. low total cholesterol
D. low triglycerides

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
High HDL cholesterol and low LDL cholesterol are associated with a decreased risk of cardiovascular disease.Reduction of Risk Potential

QUESTION 28

Which of the following organs of the digestive system has a primary function of absorption?

A. stomach
B. pancreas
C. small intestine
D. gallbladder

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The small intestine has a primary function of absorption. The remaining digestive organs have other primary
functions.Physiological Adaptation

QUESTION 29
For a client with suspected appendicitis, the nurse should expect to find abdominal tenderness in which quadrant?

A. upper right
B. upper left
C. lower right
D. lower left

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse should expect to find abdominal tenderness in the lower-right quadrant in a client with appendicitis.
Physiological Adaptation

QUESTION 30
A 20-year-old obese female client is preparing to have gastric bypass surgery for weight loss. She says to the nurse, "I need this surgery because nothing else I have done has helped me to lose weight." Which response by the nurse is most appropriate?

A. "If you eat less, you can save some money."
B. "Exercise is a healthier way to lose weight."
C. "You should try the Atkins diet first."
D. "I respect your decision to choose surgery."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This statement is most appropriate, as it shows respect and empathy. The other statements are both insensitive
and unprofessional.Physiological Adaptation

QUESTION 31
A pregnant Asian client who is experiencing morning sickness wants to take ginger to relieve the nausea.

Which of the following responses by the nurse is appropriate?

A. "I will call your physician to see if we can start some ginger."
B. "We don't use home remedies in this clinic."
C. "Herbs are not as effective as regular medicines."
D. "Just eat some dry crackers instead."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This statement reveals cultural sensitivity. Ginger is sometimes used to relieve nausea. The other statements
are culturally insensitive and do not show an awareness of herbal pharmacology.Physiological Adaptation

QUESTION 32
Which of the following medications is a serotonin antagonist that might be used to relieve nausea and vomiting?

A. metoclopramide (Reglan)
B. onedansetron (Zofran)
C. hydroxyzine (Vistaril)
D. prochlorperazine (Compazine)

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Zofran is a serotonin antagonist that can be used to relieve nausea and vomiting. The other medications can
be used for nausea and vomiting, but they have different mechanisms of action.Physiological Adaptation

QUESTION 33
Which of the following is likely to increase the risk of sexually transmitted disease?

A. alcohol use
B. certain types of sexual practices
C. oral contraception use
D. all of the above

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

STDs affect certain groups in groups in greater numbers. Factors associated with risk include being younger
than 25 years of age, being a member of a minority group, residing in an urban setting, being impoverished, and
using crack cocaine.Physiological Adaptation

QUESTION 34
Teaching the client with gonorrhea how to prevent reinfection and further spread is an example

of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. primary health care prevention.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Secondary prevention targets the reduction of disease prevalence and disease morbidity through early diagnosis and treatment.Physiological Adaptation

QUESTION 35
The nurse teaching about preventable diseases should emphasize the importance of getting the following vaccines:

A. human papilloma virus, genital herpes, measles.
B. pneumonia, HIV, mumps.
C. syphilis, gonorrhea, pneumonia.
D. polio, pertussis, measles.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vaccines are one of the most effective methods of preventing and controlling certain communicable diseases.
The smallpox vaccine is not currently in use because the smallpox virus has been declared eradicated from the
world's population. Diseases such as polio, diphtheria, pertussis, and measles are mostly controlled by routine
childhood immunization. They have not, however, been eradicated, so children need to be immunized against
these diseases.Physiological Adaptation

QUESTION 36
Acyclovir is the drug of choice for:

A. HIV.
B. HSV 1 and 2 and VZV.
C. CMV.
D. influenza A viruses.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acyclovir (Zovirax) is specific for treatment of herpes virus infections. There is no cure for herpes. Acyclovir is excreted unchanged in the urine and therefore must be used cautiously in the presence of renal impairment.

Drugs that treat herpes inhibit viral DNA replication by competing with viral substrates to form shorter, ineffective DNA chains.Physiological Adaptation

QUESTION 37
A safety measure to implement when transferring a client with hemiparesis from a bed to a wheelchair is:

A. standing the client and walking him or her to the wheelchair.
B. moving the wheelchair close to client's bed and standing and pivoting the client on his unaffected extremity to the wheelchair.
C. moving the wheelchair close to client's bed and standing and pivoting the client on his affected extremity to the wheelchair.
D. having the client stand and push his body to the wheelchair.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Moving the wheelchair close to client's bed and having him stand and pivot on his unaffected extremity to the
wheelchair is safer because it provides support with the unaffected limb.Basic Care and Comfort

QUESTION 38
Assessment of a client with a cast should include:

A. capillary refill, warm toes, no discomfort.
B. posterior tibial pulses, warm toes.
C. moist skin essential, pain threshold.
D. discomfort of the metacarpals.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Assessment for adequate circulation is necessary. Signs of impaired circulation include slow capillary refill, cool fingers or toes, and pain.Basic Care and Comfort

QUESTION 39
In teaching clients with Buck's Traction, the major areas of importance should be:

A. nutrition, ROM exercises.
B. ROM exercises, transportation.
C. nutrition, elimination, comfort, safety.
D. elimination, safety, isotonic exercises.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nutrition, elimination, comfort, and safety are the major areas of importance. The diet should be high in protein with adequate fluids.Basic Care and Comfort

QUESTION 40
When a client informs the nurse that he is experiencing hypoglycemia, the nurse provides immediate

intervention by providing:

A. one commercially prepared glucose tablet.
B. two hard candies.
C. 46 ounces of fruit juice with 1 teaspoon of sugar added.
D. 23 teaspoons of honey.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The usual recommendation for treatment of hypoglycemia is 1015 grams of a fast-acting simple carbohydrate,
orally, if the client is conscious and able to swallow (for example, 34 commercially prepared glucose tablets or 46
oz of fruit juice). It is not necessary to add sugar to juice, even if it is labeled as unsweetened juice because the fruit
sugar in juice contains enough simple carbohydrate to raise the blood glucose level. Addition of sugar might result in a sharp rise in blood sugar that could last for several hours.Physiological Adaptation

QUESTION 41
A client comes to the clinic for assessment of his physical status and guidelines for starting a weight-reduction diet. The client's weight is 216 pounds and his height is 66 inches. The nurse identifies the BMI (body mass index) as:

A. within normal limits, so a weight-reduction diet is unnecessary.
B. lower than normal, so education about nutrient-dense foods is needed.
C. indicating obesity because the BMI is 35.
D. indicating overweight status because the BMI is 27.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Obesity is defined by a BMI of 30 or more with no co-morbid conditions. It is calculated by utilizing a chart or nomogram that plots height and weight. This client's BMI is 35, indicating obesity. Goals of diet therapy are
aimed at decreasing weight and increasing activity to healthy levels based on a client's BMI, activity status, and
energy requirements.Physiological Adaptation

QUESTION 42
Which of the following injuries, if demonstrated by a client entering the Emergency Department, is the highest priority?

A. open leg fracture
B. open head injury
C. stab wound to the chest
D. traumatic amputation of a thumb

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:

Explanation:
A stab wound to the chest might result in lung collapse and mediastinal shift that, if untreated, could lead to death. Treatment of an obstructed airway or a chest wound is a higher priority than hemorrhage.
The principle of
ABC (airway, breathing, and circulation) prioritizes care decisions.Physiological Adaptation

QUESTION 43
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

A. The clothing is the property of another and must be treated with care.
B. Such care facilitates repair and salvage of the clothing.
C. The clothing of a trauma victim is potential evidence with legal implications.
D. Such care decreases trauma to the family members receiving the clothing.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Trauma in any client, living or dead, has potential legal and/or forensic implications. Clothing, patterns of stains, and debris are sources of potential evidence and must be preserved. Nurses must be aware of state and
local regulations that require mandatory reporting of cases of suspected child and elder abuse, accidental death,
and suicide. Each Emergency Department has written policies and procedures to assist nurses and other health
care providers in making appropriate reports. Physical evidence is real, tangible, or latent matter that can be
visualized, measured, or analyzed. Emergency Department nurses can be called on to collect evidence. Health
care facilities have policies governing the collection of forensic evidence. The chain of evidence custody must
be followed to ensure the integrity and credibility of the evidence. The chain of evidence custody is the pathway
that evidence follows from the time it is collected until is has served its purpose in the legal investigation of an
incident.Physiological Adaptation

QUESTION 44
Which of the following terms refers to soft-tissue injury caused by blunt force?

A. contusion
B. strain
C. sprain
D. dislocation

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A contusion is a soft-tissue injury caused by blunt force. It is an injury that does not break the skin, is caused
by a blow and is characterized by swelling, discoloration, and pain. The immediate application of cold might limit the development of a contusion. A strain is a muscle pull from overuse, overstretching, or excessive stress.
A sprain is caused by a wrenching or twisting motion. A dislocation is a condition in which the articular

surfaces
of the bones forming a joint are no longer in anatomic contact.Physiological Adaptation

QUESTION 45
A client with dumping syndrome should _____ while a client with GERD should _____.

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A. sit up 1 hour after meals; lie flat 30 minutes after meals
B. lie down 1 hour after eating; sit up at least 30 minutes after eating
C. sit up after meals; sit up after meals
D. lie down after meals; lie down after meals

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clients with dumping syndrome should lie down after eating to decrease dumping syndrome.
GERD clients
should sit up to prevent backflow of acid into the esophagus.Basic Care and Comfort

QUESTION 46
A client with an ileus is placed on intestinal tube suction. Which of the following electrolytes is lost with intestinal suction?

A. calcium
B. magnesium
C. potassium
D. sodium chloride

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Duodenal intestinal fluid is rich in K+, NA+, and bicarbonate. Suctioning to remove excess fluids decreases the client's K+ and NA+ levels.Basic Care and Comfort

QUESTION 47
Following a classic cholecystectomy resection for multiple stones, the PACU nurse observes a serosanguious drainage on the dressing. The most appropriate intervention is to:

A. notify the physician of the drainage.
B. change the dressing.
C. reinforce the dressing.
D. apply an abdominal binder.

Correct Answer: C

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Serosanguious drainage is expected at this time. The dressing should be reinforced. Changing a new postop
dressing increases the risk of infection. An abdominal binder interferes with visualization of the dressing.Basic
Care and Comfort

QUESTION 48
A client who is immobilized secondary to traction is complaining of constipation. Which of the following medications should the nurse expect to be ordered?

A. Advil
B. Anasaid
C. Clinocil
D. Colace

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Colace is a stool softener that acts by pulling more water into the bowel lumen, making the stool soft and easier to evacuate.Basic Care and Comfort

QUESTION 49
A client is complaining of difficulty walking secondary to a mass in the foot. The nurse should document this finding as:

A. plantar fasciitis.
B. hallux valgus.
C. hammertoe.
D. Morton's neuroma.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Morton's neuroma is a small mass or tumor in a digital nerve of the foot. Hallux valgus is referred to in lay terms as abunion.Hammertoe is where one toe is cocked up over another toe. Plantar fasciitis is an inflammation
of, or pain in, the arch of the foot.Basic Care and Comfort

QUESTION 50
A client turns her ankle. She is diagnosed as having a Pulled Ligament. This should be documented as a:

A. sprain.
B. strain.
C. subluxation.
D. distoration.

Correct Answer: B

Section: (none)
Explanation

Explanation/Reference:
Explanation:

A strain is excessive stretching of a ligament. A sprain involves a twisting motion involving muscles.Basic Care and Comfort

QUESTION 51
To remove hard contact lenses from an unresponsive client, the nurse should:

A. gently irrigate the eye with an irrigating solution from the inner canthus outward.
B. grasp the lens with a gentle pinching motion.
C. don sterile gloves before attempting the procedure.
D. ensure that the lens is centered on the cornea before gently manipulating the lids to release the lens.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

To remove hard contact lenses, the upper and lower eyelids are gently maneuvered to help loosen the lens and
slide it out of the eye. The lens must be situated on the cornea, not the sclera, before removal. An attempt to grasp
a hard lens might result in a scratch on the cornea. Clean gloves are an option if drainage is present.Basic Care
and Comfort

QUESTION 52
To remove a client's gown when she has an intravenous line, the nurse should:

A. temporarily disconnect the intravenous tubing at a point close to the client and thread it through the gown.
B. cut the gown with scissors.
C. thread the bag and tubing through the gown sleeve, keeping the line intact.
D. temporarily disconnect the tubing from the intravenous container and thread it through the gown.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Threading the bag and tubing through the gown sleeve keeps the system intact. Opening an intravenous line
causes a break in a sterile system and introduces the potential for infection. Cutting a gown off is not an alternative
except in an emergency. IV gowns, which open along sleeves, are widely available.Basic Care and Comfort

QUESTION 53
When making an occupied bed, it is important for the nurse to:

A. keep the bed in the low position.
B. use a bath blanket or top sheet for warmth and privacy.
C. constantly keep side rails raised on both sides.
D. move back and forth from one side to the other when adjusting the linens.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Using a bath blanket or top sheet keeps the client warm and provides privacy. Keeping the bed in the low position and working above raised side rails might strain the nurse's back. Continually moving back and forth to
tuck and arrange linen is time-consuming and disorganized.Basic Care and Comfort

QUESTION 54
Diagnostic genetic counseling, for procedures such as amniocentesis and chorionic villus sampling, allows clients to make all of the following choices except:

A. terminating the pregnancy.
B. preparing for the birth of a child with special needs.
C. accessing support services before the birth.
D. completing the grieving process before the birth.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
If findings are ominous, the grieving process will not be completed before birth. If the couple elects to terminate a pregnancy based on diagnostic tests, there will be grief and concerns for future pregnancies. Couples
might choose to access support services and prepare for the birth of an infant with special needs. Some fetal
conditions can be treated in utero.Health Promotion and Maintenance

QUESTION 55
A client who is experiencing infertility says to the nurse, "I feel I will be incomplete as a man/woman if I cannot have a child." Which of the following nursing diagnoses is likely to be appropriate for this client?

A. Risk for Self Harm
B. Body Image Disturbance
C. Ineffective Role Performance
D. Powerlessness

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Of the nursing diagnoses listed, the client's statement most represents Body Image Disturbance because it directly refers to loss of the function of having a child. Nothing in the statement indicates that the client is at risk for harming herself. Ineffective Role Performance could be correct but is not the best choice because the
statement does not reflect a disruption of the parent's role. Powerlessness could be an appropriate nursing diagnosis if the client described feeling powerless about the infertility.Health Promotion and Maintenance

QUESTION 56
Which of the following foods is a complete protein?

A. corn
B. eggs
C. peanutsDsunflower seeds

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Eggs are a complete protein. The remaining options are incomplete proteins.Health Promotion and Maintenance

QUESTION 57
Which condition is associated with inadequate intake of vitamin C?

A. rickets
B. marasmus
C. kwashiorkor
D. scurvy

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Scurvy is associated with inadequate intake of vitamin C. The remaining choices refer to other nutritional deficiencies.Health Promotion and Maintenance

QUESTION 58
What is the primary nutritional deficiency of concern for a strict vegetarian?

A. vitamin C
B. vitamin B12
C. vitamin E
D. magnesium

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vitamin B12 is the primary nutritional deficiency of concern for a strict vegetarian.Health Promotion and Maintenance

QUESTION 59
How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?

A. every 24 hours
B. every 36 hours
C. every 48 hours
D. every 72 hours

Correct Answer: A
Section: (none)

Explanation

Explanation/Reference:
Explanation:

The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to
the high risk of bacterial growth.Health Promotion and Maintenance

QUESTION 60
Which of the following values should the nurse monitor closely while a client is on total parenteral nutrition?

A. calcium
B. magnesium
C. glucose
D. cholesterol

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Glucose is monitored closely when a client is on total parenteral nutrition, due to high glucose concentration in the solutions. The other values are not monitored as closely.Health Promotion and Maintenance

QUESTION 61
A teenage client is admitted to the hospital because of acetaminophen (Tylenol) overdose. Overdoses of acetaminophen can precipitate life-threatening abnormalities in which of the following organs?

A. lungs
B. liver
C. kidneys
D. adrenal glands

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acetaminophen is extensively metabolized in the liver. Choices 1, 3, and 4 are incorrect because prolonged use of acetaminophen might result in an increased risk of renal dysfunction, but a single overdose does not precipitate life-threatening problems in the respiratory system, renal system, or adrenal glands.Pharmacological
Therapies

QUESTION 62
Light therapy can be effective for:

A. overcoming weight problems.
B. helping with allergies.
C. use in alternative medical treatments.
D. working with sleep patterns.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Light therapy can be effective in treating problems associated with sleep patterns, stress, moods, jaundice in
newborns, and seasonal affective disorders.Nonpharmacological Therapies

QUESTION 63
Broccoli, oranges, dark greens, and dark yellow vegetables can be eaten to:

A. supplement vitamin pills.
B. balance body molecules.
C. cure many diseases.
D. help improve body defenses.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Controversy over what types of food to eat and not eat is still under investigation. Certain foods can help improve body defenses to possibly prevent certain diseases.Nonpharmacological Therapies

QUESTION 64
A diet high in fiber content can help an individual to:

A. lose body weight fast.
B. reduce diabetic ketoacidosis.
C. lower cholesterol.
D. reduce the need for folate.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Fiber-rich foods (such as grains, apples, potatoes, and beans) can help lower cholesterol.Nonpharmacological
Therapies

QUESTION 65
Which of the following is an appropriate nursing goal for a client at risk for nutritional problems?

A. provide oxygen
B. promote healthy nutritional practices
C. treat complications of malnutrition
D. increase weight

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Promoting healthy nutritional practices is an appropriate nursing goal for a client at risk for nutritional problems. Choice 1 is incorrect because it is a nursing intervention, not a goal statement. Choice 3 is

incorrect
because it is a therapeutic treatment. Choice 4 is incorrect because weight gain is an appropriate goal only if the
client is underweight.Basic Care and Comfort

QUESTION 66
The nurse explains to a client who underwent gastric resection that which of the following meals is most likely to cause rapid emptying of the stomach?

A. a high-protein meal
B. a high-fat meal
C. a large meal regardless of nutrient content
D. a high-carbohydrate meal

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Meals that are high in carbohydrates promote rapid gastric emptying. The other options are associated with decreased emptying time.Basic Care and Comfort

QUESTION 67
Which of the following foods should be avoided by clients who are prone to develop heartburn as a result of gastroesophgeal reflux disease (GERD)?

A. lettuce
B. eggs
C. chocolate
D. butterscotch

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Ingestion of chocolate can reduce lower esophageal sphincter (LES) pressure leading to reflux and clinical symptoms of GERD. The other foods do not affect LES pressure.Basic Care and Comfort

QUESTION 68
Nurses caring for clients who have cancer and are taking opioids need to assess for all of the following except:

A. tolerance.
B. constipation.
C. sedation.
D. addiction.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Addiction is not of primary concern when treating the pain of terminally ill clients. Clients with cancer who are taking opioid analgesics can develop tolerance, constipation, and sedation.Basic Care and Comfort

QUESTION 69
The goals of palliative care include all of the following except:

A. giving clients with life-threatening illnesses the best quality of life possible.
B. taking care of the whole person--body, mind, spirit, heart, and soul.
C. no interventions are needed because the client is near death.
D. support of needs of the family and client.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The goals of palliative care include choices 1, 2, and 4. Choice 3 is not part of palliative care. All aspects of medical, emotional, social, and spiritual needs of the dying client should be focused on until the end of life.Basic
Care and Comfort

QUESTION 70
Major competencies for the nurse giving end-oflife care include:

A. demonstrating respect and compassion, and applying knowledge and skills in care of the family and the client.
B. assessing and intervening to support total management of the family and client.
C. setting goals, expectations, and dynamic changes to care for the client.
D. keeping all sad news away from the family and client.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

There are many competencies that the nurse must have to care for families and clients at the end of life. Demonstration of respect and compassion as well as using knowledge and skills in the care of the client and
family are major competencies.Basic Care and Comfort

QUESTION 71
Assessment of the client with an arteriovenous fistula for hemodialysis should include:

A. inspection for visible pulsation.
B. palpation of thrill.
C. percussion for dullness.
D. auscultation of blood pressure.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Thrill should be present. The client should be taught to check this daily at home. Pulsation is not typically visible. Percussion gives no information about the patency of a fistula. Blood pressure is not auscultated in a limb
with an AVF. Auscultation of the AVF, for a bruit, is part of an assessment for patency.Physiological

Adaptation

QUESTION 72
A client with stress incontinence should be advised:

A. to purchase absorbent undergarments.
B. that Kegel exercises might help.
C. that effective surgical treatments are nonexistent.
D. that behavioral therapy is ineffective.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Kegel exercises, tightening and releasing the pelvic floor muscles, might improve stress incontinence. Choice 1
is not an appropriate treatment for stress incontinence. Several effective surgical treatments exist. Lifestyle and
dietary modifications can also be helpful.Physiological Adaptation

QUESTION 73
An appropriate intervention for the client with suspected genitourinary trauma and visible blood at the urethral meatus is:

A. insertion of a Foley catheter.
B. in and out catheter specimen for urinalysis.
C. a voided urine specimen for urinalysis.
D. a urologist consult.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A urologist consult is appropriate for a client with visible blood at the urethral meatus and suspected trauma.
Choices 1 and 2 are contraindicated. A urinalysis might be ordered by the physician, but the question does not
provide enough information to make Choice 3 the correct answer.Physiological Adaptation

QUESTION 74
Erythropoietin used to treat anemia in clients with renal failure should be given in conjunction with:

A. iron, folic acid, and B12.
B. an increase of protein in the diet.
C. vitamins A and C.
D. an increase of calcium in the diet.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The kidneys of a client in renal failure produce no erythropoietin, a hormone necessary for RBC production.

Erythropoietin can be given as replacement, but the client needs adequate iron, folate, and B12 to increase the
effectiveness of EPO. Choice 2 is not necessary for RBC production and can increase uremia. Choices 3 and 4
are not necessary for RBC production.Physiological Adaptation

QUESTION 75
The kind of man who beats a woman is:

A. from a minority culture in a low-income group.
B. from a majority culture in a middle-income group.
C. one who was never allowed to compete as a child.
D. from any walk of life, race, income group, or profession.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Batterers cannot be predicted by demographic features related to age, ethnicity, race, religious denomination,
education, socioeconomic status, or class. Ninety-five percent of domestic abuse cases involve male perpetrators
and female victims.Psychosocial Integrity

QUESTION 76
A batterer is usually someone who:

A. grew up in a loving, secure home.
B. was an only child.
C. was physically or psychologically abused.
D. admits he has a problem with anger.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Many batterers report having been abused as children.Psychosocial Integrity

QUESTION 77
When helping a client gain insight into anxiety, the nurse should:

A. help relate anxiety to specific behaviors.
B. ask the client to describe events that precede increased anxiety.
C. instruct the client to practice relaxation techniques.
D. confront the client's resistive behavior.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

To gain insight, the client needs to recognize causal events. The other activities focus on recognition of anxiety.Psychosocial Integrity

QUESTION 78
A client has been taking alprazolam (Xanax) for four years to manage anxiety. The client reports taking 0.5 mg four times a day. Which statement indicates that the client understands the nurse's teaching about discontinuing the medication?

A. "I can drink alcohol now that I am decreasing my Xanax."
B. "I should not take another Xanax pill. Here is what is left of my last prescription."
C. "I should take three pills per day next week, then two pills for one week, then one pill for one week."
D. "I can expect to be sleepy for several days after stopping the medicine."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Xanax, like other benzodiazepines, can cause withdrawal symptoms that include agitation, insomnia, hypertension, seizures, and abdominal pain. The drug must be slowly decreased to prevent withdrawal symptoms.
Psychosocial Integrity

QUESTION 79
A 10-month-old child is brought to the Emergency Department because he is difficult to awaken. The nurse notes bruises on both upper arms. These findings are most consistent with:

A. wearing clothing that is too small for the child.
B. the child being shaken.
C. falling while learning to walk.
D. parents trying to awaken the child.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Children who are shaken are frequently grasped by both upper arms. Symptoms of brain injury associated with shaking include decreased level of consciousness.Psychosocial Integrity

QUESTION 80
A health care worker is concerned about a new mother being overwhelmed by caring for her infant. The health care worker should:

A. immediately contact child protective services.
B. provide the mother with literature about child care.
C. consult a therapist to help the mother work out her fears.
D. refer the mother to parenting classes.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Prevention of child abuse is centered on teaching the parents how to care for their child and cope with the demands of infant care. Parenting classes can help build self-confidence, self-esteem, and coping skills.
Parents

benefit by understanding the developmental needs of their children, while learning how to manage their home
environment more effectively. The classes also increase the parents' social contacts and teach about community
resources.Psychosocial Integrity

QUESTION 81
Which of the following methods of contraception is able to reduce the transmission of HIV and other STDs?

A. intrauterine device (IUD)
B. Norplant
C. oral contraceptives
D. vaginal sponge

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The vaginal sponge is a barrier method of contraception that, when used with foam or jelly contraception, reduces the transmission of HIV and other STDs as well as reducing the risk of pregnancy. IUDs, Norplant, and oral contraceptives can prevent pregnancy but not the transmission HIV and STDs. Clients using the contraceptive methods in Choices 1, 2, and 3 should be counseled to use a chemical or barrier contraceptive
to decrease transmission of HIV or STDs.Health Promotion and Maintenance

QUESTION 82
Which of the following is the primary force in sex education in a child's life?

A. school nurse
B. peers
C. parents
D. media

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Parents are the primary force in sex education in a child's life. The school nurse is involved with formal sex education and counseling. Peers become more important in sex education during adolescence but might lack
correct information. The media play a powerful role in what children learn about sex through movies, TV, and
video games.Health Promotion and Maintenance

QUESTION 83
Which of the following nursing actions is most effective when evaluating a kinetic family drawing?

A. telling the child to draw their family doing something
B. offering specific suggestions of what to include in the drawing
C. discouraging the child from talking about the drawing
D. noting the omission of any family members

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

There are several guidelines for evaluating kinetic family drawings, including Choice 4.
Effective nursing
actions include asking the child to explain what each family member is doing, encouraging him or her to tell as
much as possible about the drawing, noting physical intimacy or distance, noting placement of family members in
the drawing, noting facial expressions of family members and noting if they are facing each other or turned away.
Choice 1 is initial instruction, not evaluation. Only general encouragement should be given to avoid suggesting
themes to the child.Health Promotion and Maintenance

QUESTION 84
All of the following factors, when identified in the history of a family, are correlated with poverty except:

A. high infant mortality rate.
B. frequent use of Emergency Departments.
C. consultation with folk healers.
D. low incidence of dental problems.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Dental problems are prevalent because of the lack of preventive care and access to care. High infant mortality
is one of the most significant problems correlated with poverty. Pregnant women who do not have access to
care might come to the Emergency Department when in labor. Those in poverty are likely to use Emergency
Departments because they may not be turned away. Those in poverty might also turn to folk healers or other
persons in their community for care who might be easier to access and might not demand payment.Health Promotion and Maintenance

QUESTION 85
A client is having a seizure; his blood oxygen saturation drops from 92% to 82%. What should the nurse do first?

A. Open the airway.
B. Administer oxygen.
C. Suction the client.
D. Check for breathing.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse needs to open the airway first when the oxygen saturation drops. The other actions might be appropriate, but the airway must be patent.Reduction of Risk Potential

QUESTION 86
Which of the following might be an appropriate nursing diagnosis for an epileptic client?

A. Dysreflexia
B. Risk for Injury
C. Urinary Retention
D. Unbalanced Nutrition

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The epileptic client is at risk for injury due to the complications of seizure activity, such as possible head trauma associated with a fall. The other choices are not related to the question.Reduction of Risk Potential

QUESTION 87
A young boy is recently diagnosed with a seizure disorder. Which of the following statements by the boy's mother indicates a need for further teaching by the nurse?

A. "I should make sure he gets plenty of rest."
B. "I should get him a medic alert bracelet."
C. "I should lay him on his back during a seizure."
D. "I should loosen his clothing during a seizure."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client having a seizure should be turned to the side to prevent aspiration of secretions. The other statements
are correct and indicate adequate understanding of teaching.Reduction of Risk Potential

QUESTION 88
Which of the following nursing diagnoses might be appropriate as Parkinson's disease progresses and complications develop?

A. Impaired Physical Mobility
B. Dysreflexia
C. Hypothermia
D. Impaired Dentition

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client with Parkinson's disease can develop a shuffling gait and rigidity, causing impaired physical mobility. The other diagnoses do not necessarily relate to a client with Parkinson's disease.Reduction of Risk
Potential

QUESTION 89
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

A. epilepsy
B. Parkinson's
C. muscular sclerosis
D. Huntington's chorea

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Huntington's chorea is characterized by writhing, twisting movements of the face and limbs. The remaining options are neurological disorders that do not have such movements as part of their disease process.Reduction of
Risk Potential

QUESTION 90
Ashley and her boyfriend Chris, both 19 years old, are transported to the Emergency Department after being involved in a motorcycle accident. Chris is badly hurt, but Ashley has no apparent injuries, though she appears confused and has trouble focusing on what is going on around her. She complains of dizziness and nausea. Her pulse is rapid, and she is hyperventilating. The nurse should assess Ashley's level of anxiety as:

A. mild.
B. moderate.
C. severe.
D. panic.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The person whose anxiety is assessed as severe is unable to solve problems and has a poor grasp of what's
happening in his or her environment. Somatic symptoms such as those described by Ashley are usually present.
Vital sign changes are observed. The individual with mild anxiety might report being mildly uncomfortable and
might even find performance enhanced. The individual with moderate anxiety grasps less information about the
situation, has some difficulty problem-solving, and might have mild changes in vital signs. The individual in panic demonstrates markedly disturbed behavior and might lose touch with reality.Psychosocial Integrity

QUESTION 91
What interpersonal relief behavior is Ashley using?

A. acting out
B. somatizing
C. withdrawal
D. problem-solving

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Somatizing means one experiences an emotional conflict as a physical symptom. Ashley manifests several physical symptoms associated with severe anxiety. Acting out refers to behaviors such as anger, crying, laughter,
and physical or verbal abuse. Withdrawal is a reaction in which psychic energy is withdrawn from the environment
and focused on the self in response to anxiety. Problem-solving takes place when anxiety is identified and the
unmet need is met.Psychosocial Integrity

QUESTION 92
A primary belief of psychiatric mental health nursing is:

A. most people have the potential to change and grow.
B. every person is worthy of dignity and respect.
C. human needs are individual to each person.
D. some behaviors have no meaning and cannot be understood.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Every person is worthy of dignity and respect. Every person has the potential to change and grow. All people
have basic human needs in common with others. All behavior has meaning and can be understood from the
client's perspective.Psychosocial Integrity

QUESTION 93
James returns home from school angry and upset because his teacher gave him a low grade on an assignment. After returning home from school, he kicks the dog. This coping mechanism is known as:

A. denial.
B. suppression.
C. displacement.
D. fantasy.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Displacement is the transference of anger to another. Anger is displaced on the dog as a convenient object.
Psychosocial Integrity

QUESTION 94
A woman asks, "How much alcohol can I safely drink while pregnant?" The nurse's best response is:

A. "The amount of alcohol that is safe during pregnancy is unknown."
B. "Consuming one or two beers or glasses of wine a day is considered safe for a healthy pregnant woman."
C. "Drinking three or more drinks on any given occasion is the only harmful type of drinking during pregnancy."
D. "You can have a drink to help you relax and get to sleep at night."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The amount of alcohol that is safe during pregnancy is unknown. Fetal alcohol syndrome is a combination of mental and physical abnormalities present in infants born to mothers who have consumed alcohol during pregnancy.Psychosocial Integrity

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QUESTION 95
A client is taking hydrocodone (Vicodin) for chronic back pain. The client has required an increase in the dose and asks whether this means he is addicted to Vicodin. The nurse should base her reply on the knowledge that:

A. the client's body has developed tolerance, requiring more drug to produce the same effect.
B. the client is preoccupied with getting the drug and is experiencing loss of control, indicating drug dependence.
C. addiction is the term used to describe physical dependence with withdrawal symptoms and tolerance.
D. the client has a dual diagnosis of substance abuse and chronic back pain.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Drug tolerance is characterized by the ability to ingest a larger dose without adverse effect and decreased sensitivity to the substance. Substance dependence is a severe condition indicating physical problems and disruption of the person's social, family, and work life. The psychological behaviors related to substance use are
termed addiction. Dual diagnosis is the coexistence of substance abuse and psychiatric disorders.Psychosocial
Integrity

QUESTION 96
Which is the proper hand position for performing chest percussion?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The hands are cupped for performing percussion, producing a vibration that helps loosen respiratory secretions.
The other hand positions do not accomplish this task.Reduction of Risk Potential

QUESTION 97
Which is the proper hand position for performing chest vibration?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The hands are flattened over the area of the body where chest percussion is used to conduct vibration through
to the chest and loosen secretions. The other hand positions do not accomplish this task.Reduction of Risk Potential

QUESTION 98
Which of the following indicates a hazard for a client on oxygen therapy?

A. A No Smoking sign is on the door.
B. The client is wearing a synthetic gown.
C. Electrical equipment is grounded.
D. Matches are removed.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A synthetic gown might generate sparks of static electricity, which can be a fire hazard, particularly in the presence of oxygen. The client on oxygen therapy should wear a cotton gown. The remaining options are appropriate safety measures.Reduction of Risk Potential

QUESTION 99
When a client needs oxygen therapy, what is the highest flow rate that oxygen can be delivered via nasal cannula?

A. 2 liters/minute
B. 4 liters/minute
C. 6 liters/minute
D. 8 liters/minute

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The highest flow rate that oxygen can be delivered via nasal cannula is 6 liters/minute. Higher flow rates must be delivered by mask.Reduction of Risk Potential

QUESTION 100
When the nurse is determining the appropriate size of an oropharyngeal airway to insert, what part of a client's body should she measure?

A. corner of the mouth to the tragus of the ear
B. corner of the eye to the top of the ear
C. tip of the chin to the sternum
D. tip of the nose to the earlobe

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An oropharyngeal airway is measured from the corner of the client's mouth, to the tragus of the ear. Reduction of Risk Potential

Topic 2, Questions Set B

QUESTION 101
A nurse observes a client sitting alone and talking. When asked, the client reports that he is "talking to the voices." The nurse's next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nurses might observe behavioral cues that can indicate the presence of hallucinations. Talking about the hallucinations is reassuring and validating to the client who has them. Focusing on the symptoms and asking
about the hallucinations helps the client gain control.Psychosocial Integrity

QUESTION 102
A nurse observes a client sitting alone and talking. When asked, the client reports that he is "talking to the voices." The nurse's next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Nurses need to inform clients that there is a difference in perceptions and pay attention to the content of hallucinations. The other options are not therapeutic.Psychosocial Integrity

QUESTION 103
A 12-year-old male is brought to his primary care provider to determine whether sexual abuse has occurred. The mother states, "Because there is no permanent physical damage, he does not need any more treatment." The nurse's response should be based on which of the following pieces of information?

A. Male victims of sexual abuse seldom have long-term psychological problems.
B. Survivors of male sexual abuse might become confused about their sexual identity.
C. Unless treated, all male sex abuse survivors grow up to abuse other children.
D. All children who have been sexually abused have the same needs, regardless of gender.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Male children are sexually abused nearly as often as female children. Perpetrators are usually men but can be women. Needs of male children who have been sexually abused might be different from the needs of female
survivors. Male survivors might respond in anger, question their sexuality, use alcohol and other drugs, and might
try to prove their masculinity by performing daring acts.Psychosocial Integrity

QUESTION 104
A nurse is planning a brief treatment program for a client who was raped. A realistic, short-term goal is to:

A. identify all psychosocial problems.
B. eliminate the client's enticing behaviors.
C. resolve feelings of trauma and fear.
D. verbalize feeling about the event.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
A realistic short-term goal is for the client to verbalize feelings about the event. A brief treatment program is not designed to identify or resolve problems. The focus is on managing acute symptoms. If in- depth psychological
problems are identified, the nurse might make referrals for treatment.Psychosocial Integrity

QUESTION 105
The intent of the Patient Self Determination Act (PSDA) of 1990 is to:

A. enhance personal control over legal care decisions.
B. encourage medical treatment decision making prior to need.
C. give one federal standard for living wills and durable powers of attorney.
D. emphasize client education.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The purpose of the PSDA is to promote decision-making prior to need. Choices 1, 3 and 4 are incorrect. The
focus of the PSDA is individual health care decision-making. A federal standard for advance directives

does not
exist. Each state has jurisdiction regarding these policies and protocols.Coordinated Care

QUESTION 106
Client self-determination is the primary focus of:

A. malpractice insurance.
B. nursing's advocacy for clients.
C. confidentiality.
D. health care.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Advocacy for clients by nurses is the primary focus of the client's right to autonomy and self- determination. Confidentiality involves the maintenance of the privacy of the client and information regarding him or her. Malpractice insurance is a type of insurance for professionals.Coordinated Care

QUESTION 107
The focus of a nurse case manager is:

A. nursing care needs at discharge.
B. the comprehensive care needs of the client for continuity of care.
C. client education needs upon discharge.
D. financial resources for needed care.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

By definition, case management is a process of providing for the comprehensive care needs of a client for continuity of care throughout the health care experience.Coordinated Care

QUESTION 108
Mr. H. is upset regarding being in the hospital for another day because he states it costs too much. The rights he is likely to demand include all of the following except:

A. the right to examine and question the bill.
B. the right to reasonable response to requests.
C. the right to refuse treatment.
D. the right to confidentiality.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Confidentiality is the maintenance of privacy of information. The question does not suggest that confidentiality
has been breached. The client is likely to demand the other rights and may exercise them in choosing to leave the
hospital early.Coordinated Care

QUESTION 109
On first meeting, a new nurse manager makes eye contact, smiles, initiates conversation about the previous work experience of nurses, and encourages active participation by nurses in the dialogue. Her behavior is an example of:

A. aggressiveness.
B. passive aggressiveness.
C. passiveness.
D. assertiveness.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This nurse manager is demonstrating assertive behavior. Aggressive behavior dominates or embarrasses. Passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness.
Coordinated Care

QUESTION 110
Legal protection of confidentiality:

A. extends only to written documentation.
B. extends to the electronic dissemination of information not identifiable to a specific client.
C. is important only within the court system.
D. extends to both written and verbal information.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Legal protection of confidentiality extends to both written and verbal information identifiable as individual private health information.Coordinated Care

QUESTION 111
A 65-year-old female client is experiencing postmenopausal bleeding. Which type of physician should this client be encouraged to see?

A. a radiologist
B. a gynecologist
C. a physiatrist
D. an oncologist

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A gynecologist is the physician who treats and manages disease of the female reproductive organs. A radiologist
evaluates X-rays. A physiatrist is the physician manager of a rehabilitation team. An oncologist treats clients with

cancer.Coordinated Care

QUESTION 112
People who live in poverty are most likely to obtain health care from:

A. their primary care physician (family doctor).
B. a neighborhood clinic.
C. specialists.
D. Emergency Departments or urgent care centers.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Statistical patterns of health care utilization indicate that Emergency Departments and urgent care centers provide a large portion of health care to those who live in poverty.Coordinated Care

QUESTION 113
Quality is defined as a combination of all of the following except:

A. conforming to standards.
B. performing at the minimally acceptable level.
C. meeting or exceeding customer requirements.
D. exceeding customer expectations.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Compliance or performance at the minimally acceptable level is not considered quality care.Coordinated Care

QUESTION 114
All of the following are common reasons that nurses are reluctant to delegate except:

A. lack of self-confidence.
B. desire to maintain authority.
C. confidence in subordinates.
D. getting trapped in the "I can do it better myself" mindset.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If a delegator has confidence in his subordinates and feels that a task will be performed correctly, he is more
likely to delegate. Reasons that delegators are reluctant to delegate include their own lack of confidence, fear of
losing authority or personal satisfaction, and feeling that the task can only be performed correctly if they do it
themselves.Coordinated Care

QUESTION 115
Following the change of shift report, the nurse should analyze the information and set priorities accordingly. When the plan has been formulated, at what point during the shift can or should the nurse's plan be altered or modified?

A. halfway through the shift
B. at the end of the shift before the nurse reports off
C. when needs change
D. after the top-priority tasks have been completed

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse changes the plan to respond to changes in needs.Coordinated Care

QUESTION 116
A client states, "I eat a well-balanced diet. I do not smoke. I exercise regularly, and I have a yearly checkup with my physician. What else can I do to help prevent cancer?" The nurse should respond with which of the following statements?

A. Sleep at least 68 hours a night.
B. Practice monthly self-breast examination.
C. Reduce stress.
D. All of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of the choices are methods of preventing cancer. Sleep is important in maintaining homeostasis, which helps the body respond to disease. Monthly breast examination can indicate cancer or fibrocystic disease. The
body has a physiological response to stress that can decrease the immune response and increase the risk of
disease.Health Promotion and Management

QUESTION 117
A 35-year-old Latin-American client wishes to lose weight to reduce her chances of developing heart disease and diabetes. The client states, "I do not know how to make my diet work with the kind of foods that my family eats." What should the nurse do first to help the client determine a suitable diet for disease prevention?

A. Provide her with copies of the approved dietary guidelines for the American Diabetic Association and the American Heart Association.
B. Ask the client to provide a list of the types of foods she eats to determine how to best meet her needs.
C. Provide a high-protein diet plan for the client.
D. Provide the client with information related to risk factors for heart disease and diabetes.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Assessment is the first step. Assessing what the client eats helps the nurse determine a plan for dietary recommendations based on the ADA and AHA guidelines. Providing the client with a copy of the guidelines is
important but is not the first priority. Based on the client's wish to reduce her chances of heart disease and diabetes, a high-protein diet plan might not be appropriate. Providing information to the client related to risk factors for heart disease and diabetes is important but is not the first step.Health Promotion and Management

QUESTION 118
According to the ANA Code of Ethics for Nurses, professional nurses have an ethical obligation to:

A. clients (patients).
B. the profession of nursing.
C. provide high-quality care.
D. all of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All the choices are elements of the ANA Code of Ethics for Nurses.Coordinated Care

QUESTION 119
The role of the incident report in risk management is:

A. liability protection.
B. to provide data for analysis by a risk manager to determine how future problems can be avoided.
C. to discipline staff for errors.
D. all of the above.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Incident reports are a tool for determining how future problems can be avoided. Incident reports do not provide liability protection. Incident reports are not meant to be used for disciplining staff.Safety and Infection
Control

QUESTION 120
Which of the following individuals may legally give informed consent?

A. an 86-year-old male with advanced Alzheimer's disease
B. a 14-year-old girl needing an appendectomy who isnotan emancipated minor
C. a 72-year-old female scheduled for a heart transplant
D. a 6-month-old baby needing bowel surgery

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The 72-year-old client scheduled for heart transplant surgery may give informed consent for the surgery.

There are no age limitations with the exception of minors. Choices 1, 2, and 4 are incorrect. An individual with
advanced Alzheimer's disease is incompetent to make decisions. Only an emancipated minor may give consent
(a 14-year-old child who lives alone, away from family, and is totally independent). Infants are unable to give
consent.Coordinated Care

QUESTION 121
A wrong committed by one person against another (or against the property of another) that might result in a civil trial is:

A. a tort.
B. a crime.
C. a misdemeanor.
D. a felony.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Torts are wrongs committed by one person against another person (or against the property of another), which
might result in civil trials. A crime is also defined as a wrong against a person or their property but is considered to
be against the public as well. Misdemeanors are crimes that are commonly punishable with fines or imprisonment
for less than one year, with both or with parole. A felony is a serious crime punishable by imprisonment in a State
or Federal penitentiary for more than one year.Coordinated Care

QUESTION 122
The family carries out its health care functions in which of the following ways?

A. Family provides very little preventive health care to its members at home.
B. Family provides sick care to its members.
C. Family pays for most health services.
D. Family decides when and where to hospitalize its members.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The family provides sick care to its members. The other options are incorrect.Prevention and Early Detection of Disease

QUESTION 123
What is the primary theory that explains a family's concept of health and illness?

A. Health Belief Model
B. Education-School-Completing Factor
C. Family Health Expert Factor
D. Disconnected Family Factor

Correct Answer: A
Section: (none)

Explanation

Explanation/Reference:
Explanation:
The Health Belief Model describes readiness factors; the perceived feelings of susceptibility and seriousness
of the health problem (the threat); and positive motivation to maintain, regain, or attain wellness.Health Promotion and Maintenance

QUESTION 124
Health promotion activities are designed to help clients:

A. reduce the risk of illness.
B. maintain maximal function.
C. promote healthy habits related to health care.
D. all of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Health promotion activities are designed to help clients reduce the risk of illness, maintain maximum function, and promote health habits related to health care.Health Promotion and Maintenance

QUESTION 125
Rehabilitation services begin:

A. when the client enters the health care system.
B. after the client requests rehabilitation services.
C. after the client's physical condition stabilizes.
D. when the client is discharged from the hospital.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Rehabilitation services should begin when the client enters the health care system.Health Promotion and Maintenance

QUESTION 126
In conducting a health screening for 12-month-old children, the nurse expects them to have been immunized against which of the following diseases?

A. measles, polio, pertussis, hepatitis B
B. diptheria, pertussis, polio, tetanus
C. rubella, polio, pertussis, hepatitis A
D. measles, mumps, rubella, polio

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

By 12 months of age, the child should have had DtaP and polio. MMR is not administered until a child is 12 months of age.Health Promotion and Maintenance

QUESTION 127
As part of a routine health screening, the nurse notes the play of a 2-year-old child. Which of the following is an example of age-appropriate play at this age?

A. builds towers with several blocks
B. tries to color within the lines
C. says "Mine!" when playing with toys
D. tries to jump rope

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Toddlers are possessive and struggle for independence. The other play activities are too advanced for a 2-year-old child.Health Promotion and Maintenance

QUESTION 128
Vaccines provide what type of immunity?

A. active
B. passive
C. transplacental
D. active and passive

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vaccines provide active immunity. Passive immunity comes from antibodies produced in another human or host. Transplacental immunity comes from passive immunity transferred from mother to infant.Health Promotion
and Maintenance

QUESTION 129
A 2-year-old child diagnosed with HIV comes to a clinic for immunizations. Which of the following vaccines should the nurse expect to administer in addition to the scheduled vaccines?

A. pneumococcal vaccine
B. hepatitis A vaccine
C. Lyme disease vaccine
D. typhoid vaccine

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pneumococcal vaccine should be administered as a supplemental vaccine. Hepatitis A vaccine is for travelers
and individuals with chronic liver disease. The Lyme disease vaccine is for people between the ages of 15

and
70 who are at risk for Lyme disease (transmitted by ticks primarily). The typhoid vaccine is for workers in microbiology laboratories who frequently work with Salmonella typhi.Health Promotion and Maintenance

QUESTION 130
Ms. Petty is having difficulty falling asleep. Which of the following measures promote sleep?

A. exercising vigorously for 20 minutes each night beginning at 9:30 p.m.
B. taking a cool shower and drinking a hot cup of tea
C. watching TV nightly until midnight
D. getting a back rub and drinking a glass of warm milk

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

These are appropriate measure to promote sleep. Choices 1, 2, and 3 are all stimulation actions that increase
arousal and wakefulness.Basic Care and Comfort

QUESTION 131
A 4-year-old client is unable to go to sleep at night in the hospital. Which nursing intervention best promotes sleep for the child?

A. turning out the room light and closing the door
B. tiring the child during the evening with play exercises
C. identifying the child's home bedtime rituals and following them
D. encouraging visitation by friends during the evening

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Preschool-age children require bedtime rituals that should be followed in the hospital if possible. Choice 1
increases a child's fear. Choices 2 and 4 do not promote sleep.Basic Care and Comfort

QUESTION 132
The 24-hour day-night cycle is known as:

A. circadian rhythm.
B. infradium rhythm.
C. ultradian rhythm.
D. non-REM rhythm.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Circadian rhythm is rhythmic repetition of patterns each 24 hours. The other options are incorrect.Basic Care and Comfort

QUESTION 133

Which of the following solutions is routinely used to flush an IV device before and after the administration of blood to a client?

A. 0.9% sodium chloride
B. 5% dextrose in water solution
C. sterile water
D. Heparin sodium

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Normal saline is 0.9% sodium chloride. This solution has the same osmolarity as blood. Its use does not cause lysis of cells. Choices 2 and 3 are hypotonic solutions that can cause cell lysis. Choice 4 is an anticoagulant.
Pharmacological Therapies

QUESTION 134
Central venous access devices (CVADs) are frequently utilized to administer chemotherapy. What is an advantage of using CVADs for chemotherapeutic agent administration?

A. CVADs are less expensive than a peripheral IV.
B. Weekly administration is possible.
C. Chemotherapeutic agents can be caustic to smaller veins.
D. The client or family can administer the drug at home.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Many chemotherapeutic drugs are vesicants (highly active corrosive materials that can produce tissue damage
even in low concentrations). Administration into a large vein is optimal. Choice 1 is incorrect because CVADs
are more expensive than a peripheral IV. Choice 2 is incorrect because dosing depends on the drug. Choice 4 is
incorrect because IV chemotherapeutic agents are not routinely administered at home; they are usually given in
a hospital or in an outpatient or clinic setting.Pharmacological Therapies

QUESTION 135
The chemotherapeutic DNA alkylating agents such as nitrogen mustards are effective because they:

A. cross-link DNA strands with covalent bonds between alkyl groups on the drug and guanine bases on DNA.
B. have few, if any, side effects.
C. are used to treat multiple types of cancer.
D. are cell-cycle-specific agents.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Alkylating agents are highly reactive chemicals that introduce alkyl radicals into biologically active molecules
and thereby prevent their proper functioning, replication, and transcription. Choice 2 is incorrect because alkylating
agents have numerous side effects including alopecia, nausea, vomiting, and myelosuppression. Choice 3 is incorrect because nitrogen mustards have a broad spectrum of activity against chronic lymphocytic leukemia, non-Hodgkin's lymphoma, and breast and ovarian cancer, but they are effective chemotherapeutic agents because of DNA crosslinkage. Choice 4 is incorrect because alkylating agents are non-cell-cycle-specific agents.PharmacologicalTherapies

QUESTION 136
Medication bound to protein can have which of the following effects?

A. enhancement of drug availability
B. rapid distribution of the drug to receptor sites
C. less availability to produce desired medicinal effects
D. increased metabolism of the drug by the liver

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Only an unbound drug can be distributed to active receptor sites. Therefore, the more of a drug that is bound
to protein, the less it is available for the desired drug effect. Choice 1 is incorrect because less drug is available if
it is bound to protein. Choice 2 is incorrect because distribution to receptor sites is irrelevant if the drug, which is
bound to protein, cannot bind with a receptor site. Choice 4 is incorrect because metabolism is not increased. The
liver first has to remove the drug from the protein molecule before metabolism can occur. The protein is then free
to return to circulation and be used again.Pharmacological Therapies

QUESTION 137
The physician orders the antibiotics ampicillin (Omnipen) and gentamicin (Garamycin) for a newly admitted client with an infection. The nurse should:

A. administer both medications simultaneously.
B. give the medications sequentially, and flush well between them.
C. ask the physician or pharmacy which medication to give first and how long to wait before giving the other drug.
D. start one medication now and begin the other medication in 24 hours.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client with an infection needs both antibiotics as soon a possible. However, the pH of ampicillin is 810, and the pH of gentamicin is 35.5 (making them incompatible when given together). Flushing well between drugs is necessary. Choice 3 is incorrect because the PN determines the correct steps and consults with the
pharmacist and the physician as necessary. Choice 4 is incorrect because delaying the second medication by
several hours slows the treatment of the client's infection.Pharmacological Therapies

QUESTION 138
Fat emulsions are frequently administered as a part of total parenteral nutrition. Which statement is true regarding fat emulsions?

A. They have a high energy-to-fluid-volume ratio.
B. Even though hypertonic, they are well tolerated.
C. They are a basic solution secondary to the addition of sodium hydroxide (NaOH).
D. The pH is alkaline, making them compatible with most medications.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

They have a high energy-to-fluid-volume ratio. Fat emulsions are formulated in 10%, 20%, and 30% solutions and supply 1.1, 2, and 3 kilocalories respectively for each milliliter. A milliliter of 5% dextrose only supplies 0.17 kilocalories. Choices 2, 3, and 4 are incorrect because fat emulsions are essentially pH neutral and
isotonic.Pharmacological Therapies

QUESTION 139
The nurse wishes to decrease a client's use of denial and increase the client's expression of feelings. To do this the nurse should:

A. tell the client to stop using the defense mechanism of denial.
B. positively reinforce each expression of feelings.
C. instruct the client to express feelings.
D. challenge the client each time denial is used.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse should positively reinforce each expression of feelings.Psychosocial Integrity

QUESTION 140
A 57-year-old woman is recently widowed. She states, "I will never be able to learn how to manage the finances. My husband did all of that." Select the nurse's response that could help raise the client's self-esteem.

A. "You feel inadequate because you have never learned to balance a checkbook."
B. "You should have insisted your husband teach you about the finances."
C. "You are strong and will learn how to manage your finances after awhile."
D. "Why don't you take a class in basic finance from the local college?"

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse can raise the client's self-esteem by communicating confidence the client can participate in actively finding solutions to the problem. The nurse also conveys the client is a worthwhile person by listening

and accepting the client's feelings and praising the client for seeking assistance.Psychosocial Integrity

QUESTION 141
An elderly client denies that abuse is occurring. Which of the following factors could be a barrier for the client to admit being a victim?

A. knowledge that elder abuse is rare
B. personal belief that abuse is deserved
C. lack of developmentally appropriate screening tools
D. fear of reprisal or further violence if the incident is reported

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Barriers to reporting elder abuse include victim shame, fear of reprisals, fear of loss of caregiver, and lack of
knowledge of agencies that provide services. Many elders fear that reporting abuse results in their placement in
long-term care because the current caregiver is the abuser. Choices 1 and 3 are incorrect. Choice 2 might be true
but is not the best choice.Psychosocial Integrity

QUESTION 142
The nurse observes bilateral bruises on the arms of an elderly client in a long-term care facility. Which of the following questions should the nurse ask this client?

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A. "How did you get those bruises?"
B. "Did someone grab you by your arms?"
C. "Do you fall often?"
D. "What did you bump against?"

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Using a direct approach is best when asking about suspected abuse. Clients are reluctant to report abuse because of shame and fear of reprisal.Psychosocial Integrity

QUESTION 143
Distribution of a drug to various tissues is dependent on the amount of cardiac output to each type of tissue. Which tissue would receive the highest amount of cardiac output and thus the highest amount of a drug?

A. skin
B. adipose tissue
C. skeletal muscle

D. myocardium

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Highly perfused tissue includes all vital organs: the brain, heart, kidneys, adrenal glands, and liver. Choices 1,
2, and 3 are incorrect because the skin and adipose tissue are poorly perfused, while the skeletal muscle is better
perfused.Pharmacological Therapies

QUESTION 144
A syringe pump is a type of electronic infusion pump used to infuse fluids or medications directly from a syringe. This device is commonly used for:

A. solutions administered in obstetrics.
B. dilute antibiotics.
C. large volumes of IV solution.
D. the neonatal and pediatric populations.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Small volumes of medication or fluids are delivered and sometimes at slow rates to neonates and pediatric clients. The syringe pump allows precise infusion of small volumes. Choice 1 is incorrect because a syringe pump can be used in almost any setting, but is not generally for adult clients. Choices 2 and 3 are incorrect because large volumes of fluids are not administered with a syringe pump.Pharmacological Therapies

QUESTION 145
A client with massive chest and head injuries is admitted to the ICU from the Emergency Department. All of the following are true except:

A. B.the physician in charge of the case is the only person allowed to decide whether organ donation can occur.
B. C.the client's legally responsible party may make the decision for organ donation for the donor if the client is unable to do so.
C. D.the organ procurement organization makes the decision regarding which organs to harvest.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client's legally responsible party may make the decision for organ donation if the client is unable to do so.
The donor (or legally responsible party for the donor), the physician, and the organ-procurement organization are
all involved in the process regarding whether organ donation is appropriate for a specific donor.Coordinated Care

QUESTION 146
A 45-year-old client with type I diabetes is in need of support services upon discharge from a skilled rehabilitation unit. Which of the following services is an example of a skilled support service?

A. shopping for groceries
B. house cleaning
C. transportation to physician's visits
D. medication instruction

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The only skilled service listed is medication instruction. Grocery shopping, house-cleaning services, and transportation services are all examples of unskilled services offered by volunteer and fee-for- service agencies.
Coordinated Care

QUESTION 147
Narrow therapeutic index medications:

A. are drug formulations with limited pharmacokinetic variability.
B. have limited value and require no monitoring of blood levels.
C. have less than a twofold difference in minimum toxic levels and minimum effective concentration in the blood.
D. have limited potency and side effects.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The therapeutic index is the ratio between the median lethal dose and median effective dose of a drug. It provides a general indication of the margin of safety of a drug. Choice 1 is incorrect because pharmacokinetics
is the process of adsorption, distribution, metabolism, and elimination. Choice 2 is incorrect because narrow
therapeutic index drugs require close monitoring since there is often little difference between the desired drug
effect and toxicity. Choice 4 is incorrect because narrow therapeutic index drugs have the potential for severe
toxic effects with only slight increases in the dose or slight decreases in elimination.Pharmacological Therapies

QUESTION 148
A client can receive the mumps, measles, rubella (MMR) vaccine if he or she:

A. is pregnant.
B. is immunocompromised.
C. is allergic to neomycin.
D. has a cold.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A simple cold without fever does not preclude vaccination. Choices 1 and 2 are incorrect because pregnant women and immunocompromised individuals cannot have the MMR vaccine because the rubella component is a
live virus and might cause birth defects and/or disease. Choice 3 is incorrect because the American Academy of
Pediatrics states, "Persons who have experienced anaphylactic reactions to topically or systemically administered
neomycin should not receive measles vaccine."Pharmacological Therapies

QUESTION 149
A chemical reaction between drugs prior to their administration or absorption is known as:

A. a drug incompatibility.
B. a side effect.
C. an adverse event.
D. an allergic response.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This occurs most often when drug solutions are combined before they are given intravenously but can occur
with orally administered drugs as well. Choices 2, 3, and 4 are incorrect because drugs can cause these events
after administration and absorption.Pharmacological Therapies

QUESTION 150
A client is given an opiate drug for pain relief following general anesthesia. The client becomes extremely somnolent with respiratory depression. The physician is likely to order the administration of:

A. naloxone (Narcan).
B. labetalol (Normodyne).
C. neostigmine (Prostigmin).
D. thiothixene (Navane).

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Naloxone is an opiate antagonist. It attaches to opiate receptors and blocks or reverses the action of narcotic
analgesics. Choice 2 is incorrect because Labetalol is a beta blocker. Choice 3 is incorrect because Neostigmine is
an anticholinesterase agent. Choice 4 is incorrect because Thiothixene is an antipsychotic agent.Pharmacological
Therapies

QUESTION 151
A client is given an opiate drug for pain relief following general anesthesia. The client becomes extremely somnolent with respiratory depression. The physician is likely to order the administration of:

A. naloxone (Narcan).
B. labetalol (Normodyne).
C. neostigmine (Prostigmin).

D. thiothixene (Navane).

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Tolerance is the capacity to ingest an increasing amount of a substance without effect and the experience of
decreased sensitivity to the substance. Tolerance can develop with long-term use of many drugs. Choice 1 is the
dose required to produce a defined magnitude of drug effect. Choice 3 binds to a receptor and causes an action.
Choice 4 is the maximal response produced by a drug.Pharmacological Therapies

QUESTION 152
The greatest time savers when planning client care include all of the following except:

A. reacting to the crisis of the moment.
B. setting goals.
C. planning.
D. specifying priorities.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The greatest time-savers when planning client care are activities that facilitate focus and completion of priority items. Time-savers include setting goals, establishing priorities, planning tasks, delegating where appropriate, re-assessment, and ongoing evaluation of needs.Coordinated Care

QUESTION 153
Common problems for supervisors include all of the following except:

A. the supervisor facilitates development of staff members.
B. the supervisor micromanages staff members.
C. the supervisor wants to control the style in which a staff member correctly performs a task.
D. the supervisor does not delegate.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Facilitating the development of staff members is an important goal for a supervisor. Micromanagement,
intolerance for individual differences in style, and inability to delegate all interfere with team building and overall
effectiveness.Coordinated Care

QUESTION 154
What significant event occurs in the orientation phase of a nurse-client relationship?

A. establishment of roles

B. identification of transference phenomenon
C. placement of the client within the client's family structure
D. client agreement that the nurse has the authority in the relationship

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Transference phenomena are intensified in relationships with authority, such as physicians and nurses. Common positive transferences include desire for affection and gratification of dependency needs. Common
negative transferences include hostility and competitiveness. These transferences must be recognized and resolved before growth and positive change can be undertaken in the working stage.Psychosocial Integrity

QUESTION 155
At what point in the nurse-client relationship should termination first be addressed?

A. in the working phase
B. in the termination phase
C. in the orientation phase
D. when the client initially brings up the topic

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client has a right to know the parameters of the nurse-client relationship. If the relationship is to be time
limited, the client should be informed of the number of sessions. If it is open-ended, the termination date is not
known at the outset, and the client should know that this is an issue that is negotiated at a later date.Coordinated
Care

QUESTION 156
A hospitalized client has just been informed that he has terminal cancer. He says to the nurse, "There must be some mistake in the diagnosis." The nurse determines that the client is demonstrating which of the following?

A. denial
B. anger
C. bargaining
D. acceptance

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Denial (Kübler-Ross's Stages of Grieving) is the refusal to believe that loss is happening.Psychosocial Integrity

QUESTION 157

The nurse is caring for a client who is dying. While assessing the client for signs of impending death, the nurse observes the client for:

A. elevated blood pressure.
B. Cheyne-Stokes respiration.
C. elevated pulse rate.
D. decreased temperature.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cheyne-Stokes respirations are rhythmic waxing and waning of respirations from very deep breathing to very
shallow breathing with periods of temporary apnea, often associated with cardiac failure. This can be a sign of
impending death.Psychosocial Integrity

QUESTION 158
A couple from the Philippines living in the United States is expecting their first child. In providing culturally competent care, the nurse must first:

A. review their own cultural beliefs and biases.
B. respectfully request that the couple utilize only medically approved health care providers.
C. realize that the clients have to learn their new country's accepted medical practices.
D. study family dynamics to understand the male and female gender roles in the clients' culture.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse needs to recognize her own beliefs and biases and learn about the client's cultural beliefs.
Psychosocial Integrity

QUESTION 159
Nursing considerations when caring for African- American clients include that:

A. families are generally distant and unsupportive.
B. special hair, skin, and nail care might be required.
C. fad diets are a cultural norm.
D. clients are generally future-oriented.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Special hair, skin, and nail care might be required for African-American clients.Psychosocial Integrity

QUESTION 160
Which of the following ethnic groups is at highest risk in the United States for pesticide-related injuries?

A. Native American
B. Asian-Pacific
C. Norwegian
D. Hispanic

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Because Hispanic people represent a large percentage of migrant workers in the United States, many work in
agricultural settings and might be exposed to pesticides, putting them at higher risk than the other groups.Safety
and Infection Control

QUESTION 161
The nurse should teach parents of small children that the most common type of first-degree burn is:

A. scalding from hot bath water or spills.
B. contact with hot surfaces such as stoves and fireplaces.
C. contact with flammable liquids or gases resulting in flash burns.
D. sunburn from lack of protection and overexposure.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The most common type of first-degree burn is sunburn, underscoring the need for education regarding the use
of sunscreens and avoiding exposure.Safety and Infection Control

QUESTION 162
The most common cause of injury from a house fire is:

A. explosion.
B. falls from second-story windows.
C. thermal damage to skin and body surfaces.
D. inhalation injury.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Inhalation is the most common cause of injury from a house fire.Accident Prevention

QUESTION 163
The client's lab culture report is negative for a suspected infection. A test that can correctly identify those who do not have a given disease is:

A. specific.

B. sensitive.
C. negative culture.
D. marginal finding.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Testing that identifies clients without a disease is said to be specific, while testing that identifies clients with a
disease is said to be sensitive. Safety and Infection Control

QUESTION 164
A client is told that his test is positive, but in fact, the client does not have the disease tested for.
Which type of false report is this an example of?

A. positive
B. false positive
C. negative
D. false negative

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A false-positive result occurs when a test result is labeled positive in error, when the actual result is negative.
Safety and Infection Control

QUESTION 165
The vast majority of deaths resulting from unintentional poisoning occur in:

A. infants.
B. toddlers.
C. teens.
D. adults.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The vast majority of deaths resulting from unintentional poisoning occur in toddlers.Safety and Infection Control

QUESTION 166
The nurse is teaching a teenage female about preventing the transmission of genital herpes. Which of the following statements should the nurse include?

A. "Do not sit on toilet seats without protection."
B. "Oral sex does not transmit the virus."
C. "This infection can be transmitted via intercourse even when you do not feel ill."
D. "Try to drink lots of fluids after sex to flush the reproductive tract."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Genital herpes can be transmitted by oral, genital, and anal sex. The other statements are myths.Safety and
Infection Control

QUESTION 167
A client is diagnosed with HIV. Which of the following are antiviral drug classes used in the treatment of HIV/AIDS?

A. nucleoside reverse transcriptase inhibitors
B. protease inhibitors
C. HIV fusion inhibitors
D. all of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of the choices are anti-HIV drugs.Safety and Infection Control

QUESTION 168
Someone who has received a recent tattoo should be screened for:

A. tuberculosis.
B. herpes.
C. hepatitis.
D. syphilis.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Tattooing puts a client at risk for blood-borne hepatitis B or C if strict sterile procedures are not followed. Tuberculosis is an airborne pathogen, while herpes and syphilis are spread directly (such as through sexual
contact).Safety and Infection Control

QUESTION 169
Several passengers aboard an airliner suddenly become weak and suffer breathing difficulty. The diagnosis is likely to be:

A. outbreak of Asian flu.
B. Chemical exposure.
C. bacterial pneumonia.
D. allergic reaction.

Correct Answer: B
Section: (none)

Explanation

Explanation/Reference:
Explanation:

The most likely cause of groups of individuals suddenly experiencing similar signs of illness all at once is a chemical exposure.Safety and Infection Control

QUESTION 170
A child comes to the clinic with a skin rash. The maculopapular lesions are distributed around the mouth and have honey-colored drainage. The caregiver states that the rash is getting worse and seems to spread with the child's scratching. Which of the following advisory comments should be given?

A. The history and presentation might indicate chickenpox, a highly contagious disease.
B. The lesions might indicate a noncontagious infection that does not require isolation.
C. The history and presentation might indicate an infectious illness called impetigo.
D. The lesions are not contagious unless others have open wounds or lesions themselves.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The scenario describes classic impetigo for which the physician is likely to order antibiotic therapy. Chickenpox is highly contagious but presents with a history of high fever followed by a vesicular rash.Safety and
Infection Control

QUESTION 171
The nurse is teaching a client about the use of Rifampin for prophylaxis after an exposure to meningitis. What change in bodily functions should the nurse advise the client about?

A. The client's urine might turn blue.
B. The client remains infectious to others for 48 hours.
C. The client's contact lenses might be stained orange.
D. The client's skin might take on a crimson glow.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Rifampin has the unusual effect of turning body fluids an orange color. Soft contact lenses might become permanently stained. Clients should be taught about these side effects to avoid unnecessary concern.Safety and
Infection Control

QUESTION 172
A concern regarding maternal and infant mortality and morbidity is that:

A. a segment of the population is not receiving prenatal care.
B. families appear unconcerned about quality health care.
C. the personnel shortage in the maternity field will increase.
D. maternal-child health workers are not adequately prepared.

Correct Answer: A
Section: (none)

Explanation

Explanation/Reference:
Explanation:

There is a concern that a segment of the population is not accessing prenatal care, affecting infant and maternal mortality and morbidity.Health Promotion and Maintenance

QUESTION 173
The nurse teaching an obese client about nutritional needs and weight loss should include all of the following except:

A. knowledge of food and food products.
B. development of a positive mental attitude.
C. adequate exercise.
D. starting a fast weight-loss diet.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Start a fast weight-loss diet.Health Promotion and Maintenance

QUESTION 174
An assessment of the skull of a normal 10-monthold baby should identify which of the following?

A. closure of the posterior fontanel.
B. closure of the anterior fontanel.
C. overlap of cranial bones.
D. ossification of the sutures.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The posterior fontanel should close by the age of 2 months.Health Promotion and Maintenance

QUESTION 175
Which is the best way to position a client's neck for palpation of the thyroid?

A. flexed toward the side being examined
B. hyperextended directly backward
C. flexed away from the side being examined
D. flexed directly forward

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Flexed toward the side being examined.Health Promotion and Maintenance

QUESTION 176
Signs of impaired breathing in infants and children include all of the following except:

A. nasal flaring.
B. grunting.
C. seesaw breathing.
D. quivering lips.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Lip quivering is a distracter. Signs of impaired breathing in infants and children include all the other options.
Physiological Adaptation

QUESTION 177
Which of the following observations is most important when assessing a client's breathing?

A. presence of breathing and pulse rate
B. breathing pattern and adequacy of breathing
C. presence of breathing and adequacy of breathing
D. patient position and adequacy of breathing

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
It is not enough to simply make sure the client is breathing. The client must be breathingadequately.
Physiological Adaptation

QUESTION 178
A client has chronic respiratory acidosis caused by end-stage chronic obstructive pulmonary disease (COPD). Oxygen is delivered at 1 L/min per nasal cannula. The nurse teaches the family that the reason for this is to avoid respiratory depression, based on which of the following explanations?

A. COPD clients are stimulated to breathe by hypoxia.
B. COPD clients depend on a low carbon dioxide level.
C. COPD clients tend to retain hydrogen ions if they are given high doses of oxygen.
D. COPD clients thrive on a high oxygen level.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

COPD clients are compensating for low oxygen and high carbon dioxide levels. Hypoxia is the main stimulus
to breathe in persons with chronic hypercapnia. Increasing the level of oxygen decreases the stimulus to breathe.
Physiological Adaptation

QUESTION 179
A client goes to the Emergency Department with acute respiratory distress and the following arterial blood gases (ABGs): pH 7.35, PCO2 40 mmHg, PO2 63mmHg, HCO3 23, and oxygenation saturation (SaO2)

93%. Which of the following represents the best analysis of the etiology of these ABGs?

A. tuberculosis (TB)
B. pneumonia
C. pleural effusion
D. hypoxia

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
A combined low PO2 and lowSaO2 indicates hypoxia. The pH, PCO2, and HCO3 are normal.
ABGs are not
necessarily altered in TB or pleural effusion. Depending on the degree of the pneumonia, the PO2 and
PCO2
might be low because hypoxia stimulates hyperventilation.Physiological Adaptation

QUESTION 180
The nurse is teaching a client about erythema infectiosum. Which of the following factors are not correct?

A. There is no rash.
B. The disorder is uncommon in adults.
C. There is no fever.
D. There is sometimes a "slapped face" appearance.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Fifth's disease, erythema infectiosum, is uncommon in adults. All the other statements are correct.Safety
and
Infection Control

QUESTION 181
Which isolation procedure will be followed for secretions and blood?

A. Respiratory
B. Standard Precautions
C. Contact Isolation
D. Droplet

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Standard precautions are taken in all situations for all clients and involve all body secretions except sweat
and
are designed to reduce the rate of transmission of microbes from one host to another or one source
(environment
such as the client's bedside table) to another.Safety and Infection Control

QUESTION 182
A 17-year-old female was raped by a young man in her neighborhood. She is in the Emergency

Department for evaluation and tests. After the procedure is completed, a rape crisis counselor (nurse specialist) talks to the client in a conference room regarding the rape. Implementing counseling by the nurse specialist for the raped victim represents:

A. assessment.
B. crisis intervention.
C. empathetic concern.
D. unwarranted intrusion.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Choice 2 is part of the Crisis Intervention Model. Counseling by a nurse specialist at the time of a stressful event (rape) can strengthen the client's coping. A nurse specialist in rape crisis intervention is educationally prepared in counseling and crisis intervention specific to rape victims.Coordinated Care

QUESTION 183
The death of a beloved spouse places the surviving partner in which type of crisis?

A. maturational
B. reactive
C. nonreactive
D. situational

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A situational crisis is an unexpected, unplanned event, such as the death of a spouse. Option 1 is a normal maturational crisis; Choices 2 and 3 are not recognized crisis states.Coordinated Care

QUESTION 184
A client with asthma develops respiratory acidosis. Based on this diagnosis, what should the nurse expect the client's serum potassium level to be?

A. normal
B. elevated
C. low
D. unrelated to the pH

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hyperkalemia occurs in a state of acidosis because potassium moves from injured cells into the bloodstream.
Physiological Adaptation

QUESTION 185
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

A. Test all excreta for occult blood.
B. Use a soft toothbrush or foam cleaner for oral hygiene.
C. Implement reverse isolation.
D. Avoid IM injections.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Reverse isolation does not affect the risk of hemorrhage.Physiological Adaptation

QUESTION 186
High uric acid levels can develop in clients who are receiving chemotherapy. This can be caused by:

A. the inability of the kidneys to excrete the drug metabolites.
B. rapid cell catabolism.
C. toxic effects of the prophylactic antibiotics that are given concurrently.
D. the altered blood pH from the acid medium of the drugs.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Chemotherapy causes damage to cells, and uric acid is a cell metabolite.Physiological Adaptation

QUESTION 187
The drug of choice to decrease uric acid levels is:

A. prednisone (Colisone).
B. allopurinol (Zyloprim).
C. indomethacin (Indocin).
D. hydrochlorothiazide (HydroDiuril).

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Allopurinol is a drug used to treat gout, and it decreases uric acid formation. Prednisone is a corticosteroid used to decrease inflammation. Indomethacin is an analgesic, anti-inflammatory, and antipyretic agent. Hydrochlorothiazide is a thiazide diuretic used to treat hypertension and edema.Physiological Adaptation

QUESTION 188
A client recently lost a child due to poisoning. The client tells the nurse, "I don't want to make any new friends right now." This is an example of which of the following indicators of stress?

A. emotional behavioral indicator
B. spiritual indicator
C. sociocultural indicator
D. intellectual indicator

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Stress can alter a person's relationships with others.Psychosocial Integrity

QUESTION 189
A corporate executive works 6080 hours a week. The client is experiencing some physical signs of stress. The nurse teaches the client biofeedback techniques. This is an example of which of the following health-promotion interventions?

A. structure
B. relaxation technique
C. time management
D. regular exercise

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Biofeedback techniques can be used to quiet the mind, release tension, and counteract responses of general
adaptation syndrome or stress syndrome. Nurses teaching relaxation techniques should encourage use of these
techniques in stressful situations.Psychosocial Integrity

QUESTION 190
In an emergency situation, the nurse determines whether a client has an airway obstruction.
Which of the following does the nurse assess?

A. ability to speak
B. ability to hear
C. oxygen saturation
D. adventitious breath sounds

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Ability to speak is a major way to identify an airway obstruction.Safety and Infection Control

QUESTION 191
In a disaster situation, the nurse assessing a diabetic client on insulin assesses for all of the following except:

A. diabetic signs and symptoms.
B. nutritional status.
C. bleeding problems.
D. availability of insulin.

Correct Answer: C

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Bleeding problems are not characteristic of diabetes. All the other options are appropriate areas of assessment.
Safety and Infection Control

QUESTION 192
In an obstetrical emergency, which of the following actions should the nurse perform first after the baby delivers?

A. Place extra padding under the mother to absorb blood from the delivery.
B. Cut the umbilical cord using sterile scissors.
C. Suction the baby's mouth and nose.
D. Wrap the baby in a clean blanket to preserve warmth.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

After the baby delivers, the nurse should clear the mouth and nose of the infant first. Choice 4 is the next step. Choices 1 and 2 might be performed depending on the situation.Safety and Infection Control

QUESTION 193
Ethical and moral issues concerning restraints include all of the following except:

A. emotional impact on the client and family.
B. dignity of the client.
C. client's quality of life.
D. policies and procedures.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Policies and procedures, though important, are not in the category of ethical and moral issues. The other
options are ethical and moral issues.Safety and Infection Control

QUESTION 194
Attaching a restraint to a side rail or other movable part of the bed can:

A. do nothing to the client.
B. injure the client if the rail or bed is moved.
C. help the client stay in the bed without falling out.
D. help the client with better posture.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Attaching a restraint to a movable part of the bed can cause client injury if that part of the bed is moved before releasing restraints.Safety and Infection Control

QUESTION 195
How often must physical restraints be released?

A. every 2 hours
B. between 1 and 3 hours
C. every 30 minutes
D. at least every 4 hours

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Restraints must be released every 2 hours, and the client must be assessed every 30 minutes while restrained.
Safety and Infection Control

QUESTION 196
Social support systems include of the following except:

A. call-in help lines.
B. emotional assistance provided by others.
C. community support groups.
D. use of coping skills and verbalization for anger management.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Use of coping skills and verbalization for anger management are personal strategies, not examples of social
support systems. Choices 1, 2, and 3 are all social support systems.Psychosocial Integrity

QUESTION 197
Support-system enhancement includes all of the following except:

A. determining the barriers to using support systems.
B. discussing ways to help with others who are concerned.
C. exploring life problems of the support-team members.
D. involving spouse, family, and friends in the care and planning.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The exploration of life problems of support-team members is not necessary to enhance the support system.

Choices 1, 2, and 4 are all enhancements for a support system.Psychosocial Integrity

QUESTION 198
Using clichés in therapeutic communication leads the client toward:

A. viewing the nurse as human.
B. accepting himself as human.
C. self-disclosing.
D. feeling discounted.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The use of clichés in therapeutic communication is commonly construed by the client as the nurse's lack of understanding, involvement, and caring, so the client might feel demeaned and discounted.Psychosocial Integrity

QUESTION 199
In performing a psychosocial assessment, the nurse begins by asking questions that encourage the client to describe problematic behaviors and situations. The next step is to elicit the client's:

A. feelings about what has been described.
B. thoughts about what has been described.
C. possible solutions to the problem.
D. intent in sharing the description.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Questions should be asked in a precise order (specifically, from the most-simple description to the moredifficult
disclosure of feelings). When the problems have been described, eliciting the client's thoughts about the dilemmas provides further assessment data as well as the client's interpretation of what has happened. Feelings,
solutions and articulating intent are more complex processes.Psychosocial Integrity

QUESTION 200
The most effective nursing strategy to assist a client in recognizing and using personal strength includes:

A. encouraging the client's self-identification of strengths.
B. promoting the client's active external thinking.
C. listening to the client and providing advice as needed.
D. assisting the client in maintaining an external locus of control.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Encouraging the client to identify his own strengths is the most effective strategy.Psychosocial Integrity

Topic 3, Questions Set C

QUESTION 201
Appropriate nursing strategies to assist a client in maintaining a sense of self include:

A. using the client's first name when addressing the client.
B. treating the client with dignity.
C. explaining procedures only if the client is attentive.
D. discouraging the use of personal items.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All clients must be treated with dignity. Rather than a strategy, treating clients with dignity is a basic core value universal to nursing.Psychosocial Integrity

QUESTION 202
A client with Parkinson's disease has difficulty performing voluntary movements. This is known as:

A. akinesia.
B. dyskinesia.
C. chorea.
D. dystonia.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Dyskinesia is an impairment of the ability to execute voluntary muscles.Physiological Adaptation

QUESTION 203
A client who is newly diagnosed with Parkinson's disease and beginning medication therapy asks the nurse, "How soon will I see improvement ?" The nurse's best response is:

A. "That varies from client to client."
B. "You should discuss that with your physician."
C. "You should notice a difference in a few days."
D. "It might take several weeks before you notice improvement."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It might take several weeks of therapy for the client with Parkinson's disease to see improvement in symptoms.
Choice 1 is also true but is not the best response to the question. Choice 2 might be indicated but is not the best
response to the question. Choice 3 is incorrect.Physiological Adaptation

QUESTION 204

A client newly diagnosed with Diabetes Mellitus needs education. Which of the following statements should the nurse include in this education?

A. "You can eat anything you want, but no foods with sugar."
B. "You need to lose weight, so your diet must be a restricted one."
C. "You need a diet and exercise program."
D. "You must eliminate all salt, fat, and sugar from your diet."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client newly diagnosed with Diabetes Mellitus needs teaching about diet and exercise.Physiological Adaptation

QUESTION 205
A client, age 28, is 8 1/2 months pregnant. She is most likely to display which normal skin-color variation?

A. vitiligo
B. erythema
C. cyanosis
D. chloasma

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Chloasma, also known as the mask of pregnancy, is described as tan-to-brown patches on the face. This hyperpigmentation results from hormonal changes.Health Promotion and Maintenance

QUESTION 206
Which instruction should be given in a health education class regarding testicular cancer?

A. All males should perform a testicular exam after the age of 30.
B. Testicular exams should be performed on a daily basis.
C. Reddening or darkening of the scrotum is a normal finding.
D. Testicular exams should be performed after a warm bath or shower.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Testicular exams should be performed after a warm shower or bath to relax the scrotum.
Testicular exams
should be performed on a monthly basis by all men beginning at about age 15. Reddening or darkening of the
scrotum is not normal finding and should be reported to a physician.Physiological Adaptation

QUESTION 207
Regardless of their practice area, nurses should be concerned with:

A. all drug-resistant bacteria.
B. microorganisms that are critical.
C. transmission of microorganisms.
D. overprescription of bacteriostatic drugs.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All nurses should be concerned with preventing the transmission of microorganisms to themselves as well as to others. One way to accomplish this goal is by asepsis. Nursing practice focuses on providing a safe and
therapeutic environment to protect clients, family members, and health care providers from acquiring infections.
Safety and Infection Control

QUESTION 208
An Rh-negative woman with previous sensitization has delivered an Rh-positive fetus. Which of the following nursing actions should be included in the client's care plan?

A. emotional support to help the family deal with feelings of guilt about the infant's condition
B. administration of MICRhoGam to the woman within 72 hours of delivery
C. administration of Rh-immune globulin to the newborn within 1 hour of delivery
D. lab analysis of maternal Direct Coombs' test

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If a woman is sensitized to the Rh factor, it poses a threat to any Rh-positive fetus she delivers. The nurse
needs to provide emotional support to help the family deal with the infant's condition, which might involve a host of conditions that could lead to death or marked neurological damage. RhoGam is never given to a woman
already sensitized. If not previously sensitized, MICRhoGam (a smaller dose of Rh immune globulin) is given
after an abortion or ectopic pregnancy to prevent sensitization. If not sensitized, RhoGam is given to the woman
within 72 hours of delivery. Rh-immune globulin is never given to the newborn. To determine if sensitization has
occurred, an Indirect Coombs' is drawn on the mother to measure the number of Rh-positive antibodies.Health
Promotion and Maintenance

QUESTION 209
The nurse is caring for a postpartum woman who has relinquished her baby for adoption. The care plan for the client should include which of the following priority strategies?

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A. Make a referral for grief counseling.
B. Allow the woman to see her baby initially, and then discourage further visits.
C. Provide opportunities for the woman to express her feelings.
D. Inform the woman she has the right to change her mind about relinquishment.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Most women who relinquish their infants at birth have come to that decision with a great deal of love and pain. They have made plans in advance. The nurse needs to first provide them with opportunities to express their
feelings that might include grief, loneliness, and guilt. A referral for grief counseling might be appropriate if no
other support system exists or the mother indicates that she wants assistance working through her grief. If the
nurse assesses that the grief process is abnormal, a referral is also appropriate. The mother has probably already
made a decision about whether or not she wants to see her baby. The nurse should ask her and make arrangements
for that to happen if the mother requests it. Seeing the baby might aid in the grief process. Until relinquishment
occurs, this is the mother's baby and she should be allowed to see it as often as she wants. The mother does have
the right to change her mind until final legal arrangements are made. But suggesting this option might lead her to
think that the nurse believes she shouldn't relinquish her baby.Health Promotion and Maintenance

QUESTION 210
Clients who take iron preparations should be warned of the possible side effects, which might include:

A. dizziness and orthostatic hypotension.
B. nausea, vomiting, diarrhea or constipation, and stomach cramps.
C. drowsiness, lethargy, and fatigue.
D. neuropathy and tingling in the extremities.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Oral iron preparations are often used to treat clients who have iron deficiency anemia to regain a positive iron
balance. These preparations need to be supplemented with adequate dietary intake of iron. It can take 23 weeks
to see improvement and up to 610 months to return to a stable iron level after a deficiency exists. The most common adverse effects associated with oral iron intake are related to direct GI upset, anorexia, nausea, vomiting,
diarrhea, dark stools, and constipation. Nursing comfort measures include taking the preparations with meals,
teaching about black stools, encouragement, and proper nutrition.Physiological Adaptation

QUESTION 211
What happens if folic acid is given to treat anemia without determining its underlying cause?

A. Erythropoiesis is inhibited.

B. Excessive levels of folic acid might accumulate, causing toxicity.
C. The symptoms of pernicious anemia might be masked, delaying treatment.
D. Intrinsic factor is destroyed.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Folic acid should not be used if pernicious anemia is suspected because it does not protect the client from CNS changes common to this type of anemia. Folic acid is usually given with Vitamin B12. Both are part of the
Vitamin B complex and are essential for cell growth and division. Folic acid is sometimes used as a rescue drug
for cells exposed to some toxic chemotherapeutic agents. The nature of the anemia must be confirmed to ensure
that the proper drug regimen is being used.Physiological Adaptation

QUESTION 212
Which of the following should not be included in the teaching for clients who take oral iron preparations?

A. Mix the liquid iron preparation with antacids to reduce GI distress.
B. Take the iron with meals if GI distress occurs.
C. Liquid forms should be taken with a straw to avoid discoloration of tooth enamel.
D. Oral forms should be taken with juice, not milk.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Iron should not be mixed with antacids.Physiological Adaptation

QUESTION 213
The test used to differentiate sickle cell trait from sickle cell disease is:

A. sickle cell preparation.
B. peripheral smear.
C. sickledex.
D. hemoglobin electrophoresis.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hemoglobin electrophoresis is used to differentiate between sickle cell trait and sickle cell disease. Physiological Adaptation

QUESTION 214
While performing a physical assessment on a 6-month-old infant, the nurse observes head lag. Which of the following nursing actions should the nurse perform first?

A. Ask the parents to allow the infant to lay on her stomach to promote muscle development.

B. Notify the physician because a developmental or neurological evaluation is indicated.
C. Document the findings as normal in the nurse's notes.
D. Explain to the parents that their child is likely to be mentally retarded.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Head lag should be completely resolved by 4 months of age. Continuing head lag at 6 months of age indicates the need for further developmental or neurological evaluation. Laying the infant on her stomach promotes muscle development of the neck and shoulder muscles, but because of the age of this child, a referral
should be the first action. These findings are not normal for a 6-month-old infant. Significant head lag can be seen
in infants with Down syndrome and hypoxia, as well as neurologic and other metabolic disorders. Some of those
disorders might have mental retardation as a component. However, this child needs to have the referral to determine the cause of the head lag first.Health Promotion and Maintenance

QUESTION 215
A preschooler has successfully completed the test item "counts 5 blocks" on the Denver II test. This pass is evidence of which of the following developmental concepts?

A. centration
B. causality
C. C.nonreversibility
D. D.conservation

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The ability to move five blocks to a piece of paper and state there are five blocks on the paper is evidence that the preschooler has the ability of conservation. This concept refers to the fact that the quantity of something
doesn't change just because the shape, contour, and so on has changed. Five blocks are still five blocks, whether
they are lying beside the paper, stacked on the paper or moved to the paper.Centrationis the ability to concentrate
on one feature of a situation while neglecting all other aspects.Causalityis based on the sequence of events, one
event ordinarily following another.Nonreversibilityrefers to the inability of preschoolers to reverse their operations. They are only able to think forward, not retrace or reverse their thought processes.Health Promotion
and Maintenance

QUESTION 216
Tuberculosis (mycobacterium) usually effects which system?

A. stomach (GI)
B. heart (cardiac)
C. lungs (respiratory)
D. skin (integumentary)

Correct Answer: C

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Mycobacterium tuberculosis is an aerobic bacillus that requires a great deal of oxygen to grow and flourish. It
needs highly oxygenated body sites, such as lungs, growing ends of bones, and the brain. The bacillus is airborne.
Physiological Adaptation

QUESTION 217
Which of the following statements is true about syphilis?

A. The cause and mode of transmission is unclear.
B. There is no known cure for the disease.
C. When the primary lesion heals, the disease is cured.
D. Syphilis can be cured with a course of antibiotic therapy.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Syphilis is an acute and chronic treponemal disease characterized clinically by a primary lesion, a secondary
eruption involving skin and mucous membranes, long periods of latency, and late lesions of skin, bone viscera, the
CNS, and the cardiovascular system. The primary lesion (chancre) appears about three weeks after exposure as an
indurated, painless ulcer with serous exudate at the site of initial invasion. Invasion of the bloodstream precedes
development of the initial lesion, and a firm, nonfluctuant, painless lymph node (bubo) commonly follows.
Infection might occur without a clinically evident chancre; that is, it might be in the rectum or on the cervix. After
foursix weeks, even without specific treatment, the chancre begins to involute, and, in approximately one-third of
untreated cases, a generalized secondary eruption appears, often accompanied by mild constitutional symptoms.
This symmetrical maculopapular rash involving the palms and soles, with associated lymphadenopathy is classic.
Secondary manifestations resolve spontaneously within weeks to 12 months. Again, about one- third of untreated
cases of secondary syphilis become clinically latent for weeks to years. In the early years of latency, infectious
lesions of the skin and mucous membranes might recur. Specific treatment includes long-acting penicillin G
(benzathine penicillin), 2.4 million units given in a single IM dose on the day that primary, secondary or early
latent syphilis is diagnosed. This ensures effective therapy, even if the client fails to return. Serologic testing is
important to ensure adequate therapy. Tests are repeated three and six months after treatment and later as needed.
In HIV-infected clients, testing should be repeated one, two, and three months after treatment, and at three-month
intervals thereafter. Any fourfold titer rise indicates the need for retreatment.Physiological Adaptation

QUESTION 218
The sexually transmitted disease, sometimes referred to as the silent STD, that is more common than gonorrhea and a leading cause of PID is:

A. genital herpes.
B. trichomoniasis.
C. syphilis.
D. chlamydia.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Chlamydia is a sexually transmitted genital infection and is manifested in males primarily as urethritis and in
females as mucopurulent cervicitis. Clinical manifestations of urethritis are often difficult to distinguish from gonorrhea and include mucopurulent discharges of scant or moderate quantity, urethral itching, and burning on
urination. Possible complications or sequelae of male urethral infections include epididymitis, infertility, and Reiter
syndrome. In homosexual men, receptive anorectal intercourse might result in chlamydial proctitis. In women, the
clinical manifestations might be similar to those of gonorrhea and frequently present as a mucopurulent endocervical
discharge, with edema, erythema, and easily induced endocervical bleeding caused by inflammation of the endocervical columnar epithelium. However, up to 70% of sexually active women with chlamydial infections are
asymptomatic. Complications and sequelae include salpingitis with subsequent risk of infertility, ectopic pregnancy,
or chronic pelvic pain. Asymptomatic chronic infections of the endometrium and fallopian tubes might lead to the
same outcome.Physiological Adaptation

QUESTION 219
Which of the following is true concerning human immunodeficiency virus (HIV)?

A. HIV infection involves CD4 receptor protein on the surface of helper T-cells.
B. The presence of circulating antibodies that neutralize HIV is evidence that the individual has immunity-HIV.
C. HIV replication occurs extracellularly.
D. DNA replication

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The virus makes a DNA copy of its own RNA using the reverse transcriptase enzyme, and the DNA copy is inserted into the genetic material of the infected cell.Physiological Adaptation

QUESTION 220
After breast reconstruction secondary to breast cancer, the nurse should recognize which of the following expected client outcomes as evidence of a favorable response to nursing interventions related to disturbed body image?

A. maintaining adequate tissue perfusion
B. demonstrating behaviors that reduce fears
C. restored body integrity
D. remaining free of infection

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A sense of restored body integrity is an expected outcome for interventions related to disturbed body image.
Adequate tissue perfusion is an outcome for risk of injury and risk of infection, not disturbed body image. Demonstrating behaviors that might reduce fears is an outcome for anxiety. Remaining free of infection is an
outcome for risk of infection.Health Promotion and Maintenance

QUESTION 221
When a client with a major burn experiences body image disturbance, which of the following is an appropriate nursing intervention classification?

A. grief work facilitation
B. vital signs monitoring
C. medication administration: skin
D. anxiety reduction

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Grief work facilitation is a nursing intervention classification for disturbed body image in burn clients. The expected outcome is grief resolution. Vital signs monitoring is a nursing intervention classification for deficient
fluid volume in clients with major burns. Medication administration: skin is a nursing intervention classification
for impaired skin integrity for clients with major burns. Anxiety reduction is a nursing intervention classification
for anxiety experienced by clients with major burns.Health Promotion and Maintenance

QUESTION 222
The nurse should teach a client in the Emergency Department, who has suffered an ankle sprain, to:

A. use cold applications to the sprain during the first 2448 hours.
B. expect disability to decrease within the first 24 hours of injury.
C. expect pain to decrease within 3 hours after injury.
D. begin progressive passive and active range of motion exercises immediately.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cold applications are believed to produce vasoconstriction and reduce development of edema. Disability and
pain are anticipated to increase during the first 23 hours after injury. Progressive passive and active exercises
may begin in 25 days, according to the physician's recommendation. A sprain is a traumatic injury to the tendons, muscles, or ligaments around a joint, characterized by pain, swelling, and discoloration of the skin

over
the joint. The duration and severity of the symptoms vary with the extent of damage to the supporting tissues.
Treatment requires support, rest, and alternating cold and heat. X-ray pictures are often indicated to be certain
that no fracture has occurred.Physiological Adaptation

QUESTION 223
Jane Love, a 35-year old gravida III para II at 23 weeks gestation, is seen in the Emergency Department with painless, bright red vaginal bleeding. Jane reports that she has been feeling tired and has noticed ankle swelling in the evening. Laboratory tests reveal a hemoglobin level of 11.5 g/dL. After evaluating the situation, the nurse determines that Jane is at risk for placenta previa, based on which of the following data?

A. anemia
B. edema
C. painless vaginal bleeding
D. fatigue

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Placenta previa is a disorder where the placenta implants in the lower uterine segment, causing painless bleeding in the third trimester of pregnancy. The bleeding results from tearing of the placental villi from the uterine wall as the lower uterine segment contracts and dilates. It can be slight or profuse and can include bright
red, painless bleeding. The abdomen might be soft, nontender, and relax between contractions.Physiological
Adaptation

QUESTION 224
When caring for a client with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?

A. perineal shave
B. enema
C. urine specimen collection
D. blood specimen collection

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An enema could dislodge the placenta and increase bleeding.Physiological Adaptation

QUESTION 225
Melissa Smith came to the Emergency Department in the last week before her estimated date of confinement complaining of headaches, blurred vision, and vomiting. Suspecting PIH, the nurse should best respond to Melissa's complaints with which of the following statements?

A. "The physician will probably want to admit you for observation."
B. "The physician will probably order bed rest at home."
C. "These are really dangerous signs."
D. "The physician will probably prescribe some medicine for you."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pregnancy-induced hypertension (PIH) is a hypertensive disorder of pregnancy, developing after 20 weeks gestation. It is characterized by edema, hypertension, and proteinuria (preclampsia and eclampsia). The cause is
unknown. The client with advanced PIH needs rest, and home is the best place to get it. Hospitalization is not
necessary in this situation. Medication is not indicated.Physiological Adaptation

QUESTION 226
Which physiologic mechanism best describes the function of the sodium-potassium pump?

A. active transport
B. diffusion
C. filtration
D. osmosis

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Active transport is a process requiring energy to transport ions against a concentration gradient, as is needed
in the sodium-potassium pump. Choices 2, 3, and 4 are other regulatory mechanisms involved in fluid and electrolyte balance.Physiological Adaptation

QUESTION 227
Laboratory tests reveal the following electrolyte values for Mr. Smith: Na 135 mEq/L, Ca 8.5 mg/dL, Cl 102 mEq/L, and K 2.0 mEq/L. Which of the following values should the nurse report to the physician because of its potential risk to the client?

A. Ca
B. K
C. Na
D. Cl

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Normal serum potassium level ranges between 3.5 and 5.5 mEq/L. The levels in choices 1, 3, and 4 are within normal ranges.Physiological Adaptation

QUESTION 228
A client receiving drug therapy with furosemide and digitalis requires careful observation and care. In planning care for this client, the nurse should recognize that which of the following electrolyte imbalances is most likely to occur?

A. hyperkalemia

B. hypernatremia
C. hypokalemia
D. hypomagnesemia

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Diuretics such as furosemide might deplete serum potassium. Additionally, the action of digitalis might be potentiated by hypokalemia. These drugs are not associated with hyperkalemia. Diuretic therapy could cause
hyponatremia, not hypernatremia. Choice 4 is generally associated with poor nutrition, alcoholism, and excessive
GI or renal losses.Physiological Adaptation

QUESTION 229
Which statement best describes electrolytes in intracellular and extracellular fluid?

A. There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
B. There is an equal concentration of sodium and potassium in extracellular fluid.
C. There is a greater concentration of potassium in extracellular fluid and sodium in intracellular fluid.
D. There is an equal concentration of sodium and potassium between intracellular and extracellular fluid.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
Physiological Adaptation

QUESTION 230
Which of the following instructions should a nurse give a client who is about to undergo pelvic ultrasonography?

A. "Urinate prior to the test."
B. "Have someone drive you home."
C. "Do not drink after midnight."
D. "Drink plenty of water."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A full bladder is required to serve as a landmark to define pelvic organs. No sedation is given, so the client may drive herself home after the test.Reduction of Risk Potential

QUESTION 231
Which of the following is not a reason for pelvic ultrasonography?

A. to measure uterine size
B. to detect multiple pregnancies

C. to measure renal size
D. to detect foreign bodies

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The remainder of the responses are indications for pelvic ultrasonography.Reduction of Risk Potential

QUESTION 232
Which of the following allergies might be a contraindication for a client to receive contrast enhancement for intracranial computed tomography?

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A. penicillin
B. iodine
C. erythromycin
D. aspirin

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Iodine allergy might be a contraindication for contrast media, not the other allergies.Reduction of Risk Potential

QUESTION 233
Which medication might the physician order if the client expresses discomfort with being in the enclosed space of a CT scanner?

A. Valium (diazepam)
B. Clozaril (clozapine)
C. Catapress (clonidine)
D. Lasix (furosemide)

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Valium is a sedative that might be given prior to receiving a CT scan. The other medications are not sedatives.
Reduction of Risk Potential

QUESTION 234
A Roman Catholic client is preparing to have magnetic resonance imaging. He wants to wear his metal

crucifix pendant while he is receiving the test. Which of the following is an appropriate response by the nurse?

A. "Because it gives you comfort, you may wear it."
B. "It is a violation of religious rights to forbid it."
C. "I am sorry, but it is not safe for you to wear the crucifix during this test."
D. "You may wear it because it is important to you."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

No metal objects may be worn while receiving magnetic resonance imaging, due to safety risks involved with the strong magnet. Other options for spiritual support should be explored with the client.Reduction of Risk
Potential

QUESTION 235
Which of the following statements by a client indicates adequate understanding of preparation for a lipoprotein fractionation test?

A. "I cannot eat or drink after midnight."
B. "I cannot eat for 12 hours before the test."
C. "I need to limit my fluid intake."
D. "I need to ingest a lipid solution."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

For lipid fractionation, the client cannot eat for 12 hours prior to the test, but he or she can drink an unrestricted
amount of water. No lipid solution is given. Thus, the other choices are incorrect.Reduction of Risk Potential

QUESTION 236
Which of the following tests is commonly performed on newborns with jaundice?

A. blood urea nitrogen
B. magnesium
C. bilirubin
D. prolactin

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A high bilirubin level is found with hepatic immaturity in newborns, from which jaundice results. The other choices are not.Reduction of Risk Potential

QUESTION 237
An elevation in which of the following enzymes is indicative of pancreatitis?

A. alkaline phosphatase
B. acid phosphatase
C. creatine phosphokinase
D. amylase

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Amylase is elevated in conditions of pancreatic inflammation, such as pancreatitis. The other enzymes are associated with other types of tissue damage.Reduction of Risk Potential

QUESTION 238
Which of the following isoenzymes is elevated in a client who has had a myocardial infarction?

A. CPK-BB
B. CPK-MM
C. CPK-MB
D. CPK-MI

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

CPK-MB is elevated in clients who have had a myocardial infarction. CPK-BB is elevated in clients who have brain damage, and CPK-MM is elevated in clients who have skeletal muscle damage. CPK- MI does not
exist.Reduction of Risk Potential

QUESTION 239
Which of the following lab values is elevated first after a client has a myocardial infarction?

A. LDH
B. troponin
C. CPK
D. SGOT

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The troponin level is the first to rise in a client who has had a myocardial infarction, followed by CPK, SGOT,
and LDH.Reduction of Risk Potential

QUESTION 240
Which is the most common microorganism associated with gastritis?

A. syphilis
B. cytomegalovirus

C. H. pylori
D. mycobacterium

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

H. pylori is the most common microorganism associated with gastritis. The other microorganisms listed might be associated with gastritis but to a lesser degree.Physiological Adaptation

QUESTION 241
Which of the following procedures describes an opening between the colon and abdominal wall?

A. ileostomy
B. jejunostomy
C. colostomy
D. cecostomy

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A colostomy is an opening between the colon and abdominal wall. The remaining terms describe other types
of ostomies.Physiological Adaptation

QUESTION 242
A client had a colostomy done one day ago. Which of the following is an abnormal finding when assessing the stoma?

A. mild edema
B. minimal bleeding
C. rose color
D. dark red color

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A dark red color is an abnormal finding when assessing the stoma. It indicates inadequate blood supply. The
other findings are normal one day postoperatively.Physiological Adaptation

QUESTION 243
A client with jaundice has which skin color?

A. pale
B. ruddy
C. yellow
D. pink

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Jaundice turns the skin yellow. The other skin colors are not symptoms of jaundice.Physiological Adaptation

QUESTION 244
Which type of hepatitis is transmitted via the fecal-oral route?

A. A
B. B
C. C
D. D

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Type A hepatitis is transmitted via the fecal-oral route. The remaining types have other modes of transmission.
Physiological Adaptation

QUESTION 245
To ensure proper immobilization and increase client comfort when using a rigid splint:

A. place the client on a stretcher before splinting.
B. place the client on a long spine board before splinting.
C. pad the spaces between the body part and the splint.
D. ensure that the splint conforms to the body curves.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

To ensure proper immobilization and increase client comfort when using a rigid splint, pad the spaces between the body part and the splint.Basic Care and Comfort

QUESTION 246
The method of splinting is always dictated by:

A. location of the injury and whether it is open or closed.
B. the severity of the client's condition and the priority decision.
C. the number of available rescuers and the type of splints.
D. all of the above.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:

Explanation:

The method of splinting is always dictated by the severity of the client's condition and the priority decision. Basic Care and Comfort

QUESTION 247
Hazards of improper splinting include:

A. aggravation of a bone or joint injury.
B. reduced distal circulation.
C. delay in transport of a client with a lifethreatening injury.
D. all of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hazards of improper splinting include aggravation of a bone or joint injury, reduced distal circulation, and delay in transport of a client with a life-threatening injury.Basic Care and Comfort

QUESTION 248
In evaluating the lab work of a client in a hepatic coma, which of the following lab tests is most important?

A. blood urea nitrogen
B. serum calcium
C. serum ammonia
D. serum creatinine

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When a client is in a hepatic coma, he is in live liver failure. The liver can no longer metabolize amino acids completely, thus ammonia levels increase causing brain-tissue irritation.Basic Care and Comfort

QUESTION 249
A client with major head trauma is receiving bolus enteral feeding. The most important nursing order for this client is:

A. measure intake and output.
B. check albumin level.
C. monitor glucose levels.
D. increase enteral feeding.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
It is important to measure intake (I) and output (O), which should be approximately equal.
Enteral feedings
are hyperosmotic agents pulling fluid from cells into the vascular bed. Water given before feeding presents a
hyperosmotic diuresis. I and O measures assess fluid balance.Basic Care and Comfort

QUESTION 250
A client has a nasogastric (NG) tube in place following abdominal surgery. The purpose of this tube immediately following surgery is to:

A. simplify medication administration.
B. measure accurate input and output.
C. prevent accumulation of fluids and gas.
D. facilitate collection of specimens.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Immediately postop abdominal surgery, the NG tube keeps the stomach decompressed to prevent surgical-site
disruption and fluid loss through vomiting.Basic Care and Comfort

QUESTION 251
A client is having problems with her ankles. To assess her ankles' ROM, which ROM exercises should the nurse have her perform?

A. flexion, extension, hyperextension
B. flexion, extension, abduction, adduction
C. external rotation, internal rotation
D. extension, flexion, inversion, eversion

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Moving a joint through the full range of motion identifies limitation of movement.Basic Care and Comfort

QUESTION 252
Pulling is easier than pushing. So pulling a client rather than pushing him or her has which of the following advantages?

A. reduces workload
B. decreases opposition from gravity
C. maintains stability
D. prevents muscle strain

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pulling an object works with gravitational force not opposing it, lowering risk of muscle strain.Basic Care and Comfort

QUESTION 253
The nurse is transferring a client from a wheelchair to the bed. Which is the correct procedure?

A. Pull the client toward you, and pivot him on the unaffected limb.
B. Pull the client toward you, and pivot him on the affected limb.
C. Push the client toward the bed, and pivot him on the affected limb.
D. Stand the client on both legs, and push him toward the bed.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pulling the client toward the nurse lowers the workload force. Pivoting on the unaffected limb offers strength
to support the affected limb while pivoting to the bed.Basic Care and Comfort

QUESTION 254
Pressure ulcers usually occur:

A. when clients are left in one position in bed for extended periods of time.
B. when clients are underweight.
C. when clients are overweight.
D. only in underweight and overweight clients.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pressure ulcers usually occur over bony prominences and are caused by decreased circulation. The client who
is left in one position in bed for extended periods of time is more prone to decreased circulation to an area of the
body and to acquiring a pressure ulcer.Basic Care and Comfort

QUESTION 255
Accurate documentation of assessment findings regarding pressure ulcers is very important because:

A. the law requires the nurse to document lesions.
B. the hospital requires the nurse to document lesions.
C. the physician requires the nurse to document lesions.
D. the nursing assessment of ulcers is a standard of nursing practice.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Documentation of assessments by the nurse promotes continuity of care and helps prevent further progression
of the ulcer.Basic Care and Comfort

QUESTION 256
Perineal care to a female client by the nurse can be performed:

A. without gloves, pouring water from a sterile bottle.

B. without gloves, having the client perform all care.
C. with gloves, washing the perineal area from front to back.
D. with gloves, washing the perineal area from back to front.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Gloves should always be worn, and the perineal area should be washed with a washcloth from front to back.
This method prevents E. coli and other bacteria from being swept into the urethra. The procedure should be
performed and explained in a private area with all equipment gathered first.Basic Care and Comfort

QUESTION 257
When a client who is having trouble conceiving says to the nurse, "I have started taking ginseng," the best response by the nurse is:

A. "No studies show that ginseng is effective for infertility."
B. "Some studies show that ginseng enhances in vitro sperm motility."
C. "Why don't you try acupuncture instead. Many studies have shown it to be effective for infertility."
D. "It's probably not going to hurt you, but it's also probably not going to help. Let's look at some other alternatives."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Some studies have shown that ginseng and astragalus have enhanced in vitro sperm motility. Ginseng has long been used in traditional Chinese medicine to enhance male fertility. So, Choice 2 is correct and directly addresses the client's comments. Many times couples struggling with infertility turn to alternative therapies in desperation. They can be very expensive, and some are harmful. Ginseng should not interfere with any of the traditional fertility treatments and might help the couple feel empowered that they are also doing something on their own. Choice 1 is not true. Choice 3 introduces another alternative therapy. It is true that acupuncture is a traditional Chinese medical therapy and has been shown in several clinical studies to be effective in treating infertility in both women and men. The best response by the nurse should address the therapy the client states she is using. Choice 4 dismisses the client's attempts to work through her issues and contribute to the solution. One concern is always that more traditional therapies might be ignored, and time might be lost to alternative therapies. But this response causes the client to perceive the nurse as unsupportive and inhibits further discussion and disclosure.Health Promotion and Maintenance

QUESTION 258
A client describes her cervical mucus as clear, thin, and elastic. Upon examination, the nurse demonstrates that the cervical mucus can be stretched 810 cm. The nurse correctly documents the finding as:

A. ferning capacity.
B. lack of ferning.
C. spinnbarkheit.
D. inhospitable.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:

Explanation:

Spinnbarkheit is the correct terminology to identify the cervical mucus described. This type of mucus occurs at ovulation and its assessment is used to help couples determine the time they are most likely to conceive. Ferning capacity or crystallization also increases as ovulation approaches. The only way that ferning can be identified is to place the cervical mucus on a microscope slide, let it air dry, and then examine it for a fern-type appearance. Lack of ferning cannot be determined without microscopic examination. Inhospitable cervical mucus refers to mazelike patterns of mucoid strands in cervical mucus that prohibit sperm motility. Other characteristics that make the mucus inhospitable relate to hormone levels, infection, and so on.These conditions cannot be determined by the description supplied in the question.Health Promotion and Maintenance

QUESTION 259
A client with a nasogastric (NG) tube begins vomiting. What action should the nurse take?

A. Retape the NG tube.
B. Clamp the NG tube.
C. Remove the NG tube.
D. Check the NG tube placement.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

For the client with an NG tube who begins vomiting, the nurse should check the tube placement because it might be displaced, thereby leading to vomiting. The other responses are not appropriate.Reduction of Risk
Potential

QUESTION 260
Which of the following is the most appropriate diet for a client who is unable to swallow?

A. nothing by mouth
B. nasogastric feedings
C. clear liquids
D. total parenteral nutrition

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nasogastric feedings are most appropriate for a client who is unable to swallow. Nothing by mouth leads to nutritional deficiencies. The client might aspirate a clear liquid diet. TPN is not necessary as long as the gut is
still functioning.Reduction of Risk Potential

QUESTION 261
Which of the following is a predisposing factor for cancer of the tongue?

A. tobacco use
B. obesity
C. sun exposure
D. eating sweets

Correct Answer: A

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Tobacco use is a predisposing factor for cancer of the tongue; the other choices are not.Reduction of Risk Potential

QUESTION 262
Which of the following statements by a client with gastroesophageal reflux disease (GERD) indicates adequate understanding?

A. "I should eat right before bedtime."
B. "I should eat large meals."
C. "I should sit up after eating."
D. "I should lie flat after eating."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client with GERD needs to sit up after eating or have the head of the bed elevated to avoid reflux. Thus, choices 1 and 4 are incorrect. Choice 2 is incorrect because the client needs to eat small, frequent meals.
Reduction of Risk Potential

QUESTION 263
Which of the following medications might cause upper-gastrointestinal (UGI) bleeding?

A. Cardizem (diltiazem)
B. Naprosyn (naproxen)
C. Elavil (amitryptiline)
D. Corgard (nadolol)

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Naprosyn might cause upper-gastrointestinal (UGI) bleeding.Reduction of Risk Potential

QUESTION 264
A contraindication for topical corticosteroid use in a client with atopic dermatitis (eczema) is:

A. parasite infection.
B. viral infection.
C. fungal infection.
D. spirochete infection.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:

Explanation:
Topical agents produce a localized, rather than systemic, effect. When treating atopic dermatitis with a steroidal preparation, the site is vulnerable to invasion by organisms. Viruses, such as herpes simplex or varicella zoster, present a risk of disseminated infection. Educate the client using topical corticosteroids to avoid crowds or people known to have infections and to report even minor signs of an infection. Topical corticosteroid use results in little danger of concurrent infection with the agents in choices 1, 3, and 4.Pharmacological Therapies

QUESTION 265
A client's postoperative pain seems to be getting worse instead of better. When the nurse asks the client, "Why do you think it's getting worse?" the client replies, "My wife died last month. It's all I can think about." The nurse must now consider:

A. calling the physician for an increased dosage of pain medication.
B. calling the physician for a sedative.
C. referring the client for a psychiatric consult.
D. developing interventions for grief and loss.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client's pain is affective as well as sensory. Grieving his wife's death is a normal response that does not necessarily require psychiatric consult. Choices 1 and 2 address the sensory, not the affective component of his pain.Basic Care and Comfort

QUESTION 266
Client education by the nurse entails:

A. telling the client everything about his disease, what is going to happen in the course of the disease, and the outcome.
B. giving information to the client that is accurate and understandable.
C. telling the client that the pain he experiences might not be real.
D. giving the client medication when pain is experienced.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Client education entails giving the client accurate and understandable information.Basic Care and Comfort

QUESTION 267
Distraction therapy is:

A. focusing one's attention on stimuli other than pain.
B. cognitive reappraisal.
C. the replacement of positive images of pain with other images.
D. the use of medication and meditation.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The focus of distraction therapy is on positive stimuli rather than negative input.Basic Care and Comfort

QUESTION 268
Which of the following foods present a problem for a client diagnosed with Celiac Disease?

A. butter
B. oats or barley cereal
C. fresh vegetables
D. coffee or tea

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Celiac disease, orceliac sprue,is a malabsorption disorder affecting the small intestine in which there is a problem with the ingestion of gluten, a protein normally found in grain products such as wheat, rye, oats, or barley. The other choices reflect substances that do not contain gluten and should not pose problems for a client
with this disorder.Basic Care and Comfort

QUESTION 269
The nurse has completed client teaching about introducing solid foods to an infant. To evaluate teaching, the nurse asks the mother to identify an appropriate first solid food. Which of the following is an appropriate response?

A. pureed canned squash
B. pureed apples
C. yogurt
D. infant rice cereal

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Single-grain infant cereals are recommended first because they are easily digestible and have added iron content. Choice 3 is incorrect because yogurt is a milk product and introduction should be delayed until the child is 12 months of age because of the risk of milk allergy. Choices 1 and 2 are incorrect because fruits and vegetables are usually given following the introduction of cereals.Basic Care and Comfort

QUESTION 270
A pregnant client has congenital heart disease. The nurse should expect to see which alterations in this client's diet during pregnancy?

A. reduced calories and reduced fat
B. caffeine and sodium restrictions
C. decreased protein and increased complex carbohydrates
D. fluid restriction and reduced calories

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Caffeine might increase heart rate that is already stressed due to pregnancy. Sodium can cause fluid retention. Both might need to be restricted. The other choices are incorrect because calories, fat, and protein are not usually decreased due to the risk of nutrient deficiencies.Basic Care and Comfort

QUESTION 271
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

A. Advil
B. Aleve
C. Toradol
D. Bextra

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM, IV, or PO.Basic Care and Comfort

QUESTION 272
A hospital discharge planning nurse is making arrangements for a client who has an epidural catheter for continuous infusion of opioids to be placed in a long-term care facility. The family prefers a facility in its neighborhood to facilitate visiting. The neighborhood facility has never cared for a client with this type of need. What is the most appropriate action by the discharge planning nurse?

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A. B.Arrange for immediate in-services for the long-term care facility staff on pain management using epidural catheters.
B. C.Explain the situation to the client and family and seek another long-term care facility for discharge from the hospital.
C. D.Encourage the family to hire private duty nurses skilled in epidural catheter pain management to allow the client to be transferred to the neighborhood facility.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Safety demands that a client be transferred to a facility that can deliver care equal to the hospital.Basic Care
and Comfort

QUESTION 273
In managing nausea related to Morphine epidural analgesia, the nurse should administer:

A. Indocin
B. Codeine
C. Motrin
D. Compazine

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Compazine is the drug that should be administered.Basic Care and Comfort

QUESTION 274
A client with sickle cell disease is worried about passing the disease on to children. Which of the following statements by the PN is most appropriate for this client?

A. "You should discuss this with your physician."
B. "Sickle cell disease is genetically based and might be passed on to children."
C. "Sickle cell disease is genetically based and is not passed on to children."
D. "Sickle cell disease is caused by an infection and cannot be passed on to children."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client with sickle cell disease passes on the least sickle cell trait and possibly sickle cell disease, depending
on the sickle status of the other parent. Choice 1 is not helpful to the client. Choices 3 and 4 are not true. Physiological Adaptation

QUESTION 275
When teaching a client about anti-retroviral therapy for human immunodeficiency virus (HIV), the PN should emphasize:

A. when started, therapy must not be interrupted to prevent viral resistance.
B. when started, therapy must not be interrupted to prevent opportunistic infection.
C. therapy should be interrupted for one day each month to prevent toxicity.
D. therapy should be interrupted for one week every three months to prevent toxicity.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
HIV mutates very rapidly, and any interruption of therapy can allow viral resistance to emerge-- even taking a dose late. Choice 2 is incorrect because, when the virus is kept in check with anti-retrovirals, the client's own
immune system is able to keep opportunistic infections at bay. Choices 3 and 4 are incorrect because therapy
should not be interrupted for any reason. If the client develops toxicity, another anti-retroviral drug might be prescribed.Physiological Adaptation

QUESTION 276
The best lab test to diagnose disseminated intravascular coagulation (DIC) is:

A. platelet count.
B. protime (PT).
C. partial thromboplastin time (PTT).
D. D-dimer.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In DIC, many small clots form throughout the body and are immediately broken down. D-dimer measures a specific fibrin split (or degradation) product and is the most specific test for DIC. Choice 1 is incorrect because
platelets are consumed in DIC, but this is not specific. Choices 3 and 4 are both elevated (because clotting factors
have been used up) but, again, are not specific.Physiological Adaptation

QUESTION 277
In teaching bleeding precautions to a client with leukemia, the PN should include which of the following instructions?

A. Use a soft toothbrush.
B. Use dental floss daily.
C. Hold pressure on any scrapes for 12 minutes.
D. Use a triple-edged razor.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A soft toothbrush is less likely to cause the gums to bleed than a stiff one. So many white cells are produced in
clients with leukemias that other cell types (like platelets) are crowded out, putting the client at risk for bleeding.
Choice 2 is incorrect because dental floss is contraindicated; it can make the gums bleed. Choice 3 is incorrect
because when clotting is impaired, pressure should be held for 510 minutes or longer, until the bleeding stops.
Choice 4 is incorrect because an electric razor should be used to prevent small cuts.Physiological Adaptation

QUESTION 278
Which of the following describes the stages of domestic violence in an intimate relationship?

A. happiness, crisis, angry outburst, intervention
B. honeymoon period, escalation of stress, outburst, reconciliation
C. acting out and making up
D. peace and calm, angry outburst, peace and calm, denial

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A pattern of behavior known as the cycle of abuse has been described in the literature. It involves a honeymoon stage, followed by a buildup of stress, an angry outburst that might involve beating, reconciliation, and another honeymoon phase. Clients who do not receive help are at increased risk of harm, which might include homicide.
Psychosocial Integrity

QUESTION 279
Which of the following statements is correct regarding rape?

A. Most rapes are reported.
B. Legally, a woman can be raped by her spouse.
C. Prosecution and conviction for rape is easy.
D. The most common location of rape is the victim's own home.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The definition ofrapeis sexual intercourse against someone's will. It is a degrading, brutal crime of violence and can occur between any two persons regardless of their marital status.Psychosocial Integrity

QUESTION 280
An effective intervention for a client diagnosed with Obsessive-Compulsive Disorder is:

A. discussing the repetitive action.
B. insisting the client not perform the repetitive act.
C. informing the client that the act is not necessary.
D. encouraging daily exercise.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Obsessive-Compulsive Disorder is an anxiety disorder. Exercise releases emotional energy, limits time for the maladaptive behavior, and directs the client's attention outward. Initially, nurses should not interfere with performance of the repetitive act, try reasoning the client out of the behavior, or ridicule the behavior.Psychosocial Integrity

QUESTION 281
A man reports his wife is constantly cleaning. The activity has interfered with the family life. Friends have stopped visiting because she makes them uncomfortable. He states he has awakened in the middle of the night and found her cleaning. The nurse should consult with the couple and recommend the husband help with therapy by:

A. telling his wife to stop cleaning whenever he notices her actions.
B. making a baseline record of the time the wife spends cleaning.
C. decreasing the stimuli in the home.
D. helping his wife with the cleaning.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
His wife is exhibiting obsessive-compulsive behavior. Because this is an anxiety disorder, it is desirable to maintain an environment that is calm and as stress free as possible. Attempting to stop or focusing on the behavior can increase the wife's anxiety and therefore the repetitive behavior.Psychosocial Integrity

QUESTION 282

An 8-year-old Asian child is being examined during a school screening. The nurse notices small bruises on the anterior and posterior ribs. The nurse should ask the child:

A. if the family practices coining.
B. who hit him.
C. if the child has fallen.
D. how long the abuse has been occurring.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse must be aware of cultural practices that resemble child abuse. These practices include coining, cupping, and fallen fontanella. Coining and cupping are thought to draw infections from the body. Coining involves rubbing a heated coin on the chest and torso and might cause bruising. Cupping uses heated glasses that can produce erythematous and ecchymotic rounded lesions or linear streaks on the body from the suction. Fallen fontanella involves turning a child upside down to correct a depressed fontanelle; it can cause vomiting, diarrhea, and dehydration in infants. Retinal hemorrhages can also occur, and sometimes Shaken-Baby Syndrome is erroneously diagnosed.Psychosocial Integrity

QUESTION 283
Incidences of child abuse apperar to be higher in the African-American community and might be explained by:

A. the increased number of African Americans viewing violence on television.
B. more single-parent households in African- American communities.
C. stricter child-rearing practices in African- American households.
D. a higher occurrence of rage in African Americans.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Child abuse is higher in households with lower socioeconomic status and single parents. The increased incidence might be due to increased stress and fewer support systems.Psychosocial Integrity

QUESTION 284
When teaching parents how their children learn sex role identification, the nurse should include which of the following statements?

A. Sex role identification begins in infancy.
B. Sex role identification begins in the preschool years.
C. Sex role identification begins during the school-age years.
D. Sex role identification begins during early adolescence.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Sex role identification begins during infancy. Infants can identify body parts by the end of the first year. Preschoolers frequently engage in masturbation and sex play with peers. School-age children continue to gain awareness of their sexual identity. During this time they might continue to masturbate and engage in sex play. They might add behaviors such as hugging and kissing members of the opposite sex. Adolescent

sex role identification is largely influenced by sexual maturation and trying out or assuming a sex role.Health Promotion and Maintenance

QUESTION 285
When working with multicultural populations, the nurse should consider all of the following when planning care for a client with an altered sexuality pattern except:

A. some members of the Hispanic and Native- American cultures are very open when discussing sexuality.
B. some cultures view the postpartum period as a state of impurity.
C. some women in the African-American culture view childbearing as a validation of their femaleness.
D. some Native-American women believe monthly menstruation maintains physical well-being and harmony.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Many cultures (including the Hispanic and Native-American cultures) are sometimes hesitant to discuss sexuality. Some Navajos, Hispanics, and Orthodox Jews view the postpartum period as a state of impurity and might seclude women as long as they are bleeding. The seclusion is usually ended with a ritual bath. Many white teenage girls approve of the prevention of pregnancy, and many African-American teenage girls value pregnancy. Many Native-American women believe in the importance of monthly menstruation to maintain physical wellbeing and harmony.Health Promotion and Maintenance

QUESTION 286
Which of the following client groups should the nurse recognize as the fastest-growing segment of the homeless population?

A. single, adult men
B. single mothers with 2 or 3 children
C. runaway adolescents
D. single, adult women

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Single mothers with two or three children are the fastest-growing segment of the homeless population. The majority of the children are under the age of five, and the total number of children who are homeless account for more than one-third of the homeless population in the United States. In the past, single adults were the largest group in the homeless population, with more men than women being homeless. Runaway adolescents account for another group of homeless children. Many are victims of abuse or long-term family or school problems.HealthPromotion and Maintenance

QUESTION 287
Which of the following strategies should the nurse include when planning care for children of migrant workers?

A. Delay immunization because of acute illness.
B. Provide parents with copies of medical records.
C. Schedule preventive services at acute illness visits.
D. Stress the importance of using one primary care provider.

Correct Answer: B
Section: (none)

Explanation

Explanation/Reference:
Explanation:

Migrant workers should be provided with the medical records and immunization records for their children, including growth charts. The parents should also be encouraged to take those records with them to every health care visit, including Emergency Department visits. It is important to provide immunizations even when the child is there for an acute illness because preventive care is often not obtained. Preventive services should also be provided, not scheduled, when a child presents for an acute illness. Using a single primary care provider is not an option for most migrant families. The nurse should ask the parents about where they are going next and give them the name, address, and phone numbers of providers there.Health Promotion and Maintenance

QUESTION 288
When assessing a client with amytrophic lateral sclerosis (ALS), the nurse should expect which of the following findings?

A. mental confusion
B. muscular weakness
C. sensory loss
D. emotional liability

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clients with ALS have progressive muscular weakness and wasting. However, the mind remains clear and sharp, and there is no sensory loss. There might be periods of grieving, but usually not emotional liability.Reduction of Risk Potential

QUESTION 289
A Hispanic client brings her father to the clinic because he is becoming more forgetful. He is diagnosed with Alzheimer's disease. The woman tells the nurse that she wants to try ginkgo biloba for her father, before using prescription medications. Which of the following is an appropriate response by the nurse?

A. "It is wiser to start a prescription."
B. "That herb won't do your father any good."
C. "You can't expect an herb to treat Alzheimer's."
D. "I will let the physician know of your wishes."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The culturally sensitive response is to notify the physician of the family member's wishes and to determine whether it is feasible. Ginkgo biloba has been shown to be of some benefit in treating dementia. The other statements are not culturally sensitive.Reduction of Risk Potential

QUESTION 290
Which of the following statements by an adult child of a client with late-stage Alzheimer's disease indicates a need for further teaching by the nurse?

A. "I should provide a regular schedule for toileting."
B. "I should talk to my father less because he can't communicate."

C. "I should give my father oral care after every meal and bedtime."
D. "I should assist my father with eating and drinking."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Even though an Alzheimer's client might not be able to talk or communicate his needs, the family should still
communicate through talking and touching. The other statements are correct and indicate adequate understanding.
Reduction of Risk Potential

QUESTION 291
An Asian family has an elderly member with latestage Alzheimer's disease. The physician has recommended placement in a long-term care facility, but the family refuses. Which of the following is an appropriate response to the family by the nurse?

A. "You really need to listen to what the physician says."
B. "You will get too tired to take care of him at home."
C. "What can I do to assist you to care for him at home?"
D. "You are too busy to be taking care of an elderly person."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This is the only culturally sensitive statement. Many Asian cultures have a high respect for elders, and members of these cultures might not consider placement in a long-term care facility. This is because they feel it is more respectful for them to care for the family member at home. The nurse might be able to assist the family by determining what community resources are available to assist them.Reduction of Risk Potential

QUESTION 292
Which of the following conditions has a severe complication of respiratory failure?

A. Bell's palsy
B. Guillain-Barré syndrome
C. trigeminal neuralgia
D. tetanus

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Guillain-Barré syndrome has a severe complication of respiratory failure. The remaining choices are peripheral nerve conditions, like Guillain-Barré. However, they do not lead to such a severe complication.Reduction of Risk Potential

QUESTION 293
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. When the nurse who was not promoted first read the memo and learned that the

other nurse had received the promotion, she left the room in tears. This behavior is an example of:

A. conversion.
B. regression.
C. introjection.
D. rationalization.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Crying is a regressive behavior. The ego returned to an earlier, comforting, and less-mature way of behaving in the face of disappointment. Conversion involves the transformation of anxiety into a physical symptom. Introjection involves intense unconscious identification with another person. Rationalization involves the unconscious process of developing acceptable explanations to justify unacceptable ideas, actions, or feelings.Psychosocial Integrity

QUESTION 294
The nurse who was not promoted then went to the utility room and slammed several cupboard doors while looking for Kleenex. This behavior exemplifies:

A. displacement.
B. sublimation.
C. conversion.
D. reaction formation.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Displacement unconsciously transfers emotions associated with a person, object, or situation to another lessthreatening person, object, or situation. The nurse slammed doors instead of striking the promoted nurse or the administrator who made the promotion decision. Sublimation is the unconscious process of substituting constructive activity for unacceptable impulses. This choice cannot be considered correct because the slamming of the cupboard doors cannot be considered a constructive activity. Conversion involves unconsciously transforming anxiety into a physical symptom. Reaction formation keeps unacceptable feelings or behaviors out of awareness by using the opposite feeling or behavior.Psychosocial Integrity

QUESTION 295
Which of the following coping mechanisms protects an individual from anxiety?

A. denial and fantasy
B. rationalization and suppression
C. regression and displacement
D. reaction formation and projection

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety. Psychosocial Integrity

QUESTION 296
Milieu therapy is best employed to perform which activity?

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A. investigating the client's view of the world
B. promoting socialization skills
C. focusing on inappropriate behavior
D. providing repetitive ordinary experiences on a daily basis

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.Psychosocial
Integrity

QUESTION 297
When discussing the patterns of use of alcohol and other drugs, the nurse should include which piece of information?

A. Lifetime prevalence and intensity of alcohol use is greater in women than men.
B. Hispanics and African Americans have higher levels of alcohol use than Caucasians.
C. Overuse of alcohol and other drugs increases into the mid-20s, then levels off and decreases with age.
D. Heavy use is more common in higher socioeconomic groups because they can afford to buy the drugs.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Recent research reveals that 83% of all persons in the United States, age 12 or older, report using alcohol sometime in their lives. Use of alcohol and illicit drugs appears to increase into the mid- 20s, and then levels off and decreases with age. Both lifetime prevalence and intensity of alcohol use are greater in males. Caucasians report higher levels of alcohol use than African Americans or Hispanics. Those with more education are more likely to use alcohol, but heavy use is more common among the less educated and the unemployed.Psychosocial Integrity

QUESTION 298
A client is admitted with a diagnosis of Multiple Drug Use. The nurse should plan care based on knowledge that:

A. multiple drug use is very uncommon.
B. people might use more than one drug to enhance the effect or relieve withdrawal symptoms.
C. alcohol and barbiturates used together are not dangerous because one is a stimulant and the other is a depressant.
D. assessment and intervention are easier with multiple drug use because of the synergistic effect.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Simultaneous or sequential use of more than one substance is very common. Multiple drug use can enhance, lessen, or change the nature of the intoxication, or relive withdrawal symptoms. Heroin users often also use alcohol, marijuana, or benzodiazepines. Multiple drug use is especially dangerous if synergistic drugs are combined. Multiple drug use complicates assessment and intervention because the client might be demonstrating the effects or withdrawal from several drugs.Psychosocial Integrity

QUESTION 299
When the nurse is determining the appropriate size of a nasopharyngeal airway to insert, which body part should be measured on the client?

A. corner of the mouth to tragus of the ear
B. corner of the eye to top of the ear
C. tip of the chin to the sternum
D. tip of the nose to the earlobe

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A nasopharyngeal airway is measured from the tip of the nose to the earlobe.Reduction of Risk Potential

QUESTION 300
When suctioning a client, what is the usual amount of time the nurse should spend for each suction pass?

A. 2 seconds
B. 10 seconds
C. 20 seconds
D. 30 seconds

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Ten seconds is the usual amount of time the nurse should spend for each suction pass. Two seconds is not
enough time to remove secretions. The remaining choices are too long and could lead to hypoxia and tissue
trauma.Reduction of Risk Potential

Topic 4, Questions Set D

QUESTION 301
When a client has a chest drainage system in place, where should the system be placed?

A. above the client's head
B. at the client's shoulders
C. at the level of the chest

D. below the level of the chest

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
A chest drainage system should be placed below the level of the client's chest so that the drainage flows out of the chest into the system. The remaining choices are too high and do not allow fluid to drain out of the chest.Reduction of Risk Potential

QUESTION 302
A client with a pleural drainage system to suction has gentle bubbling of the water seal. What should the nurse do?

A. Notify the physician.
B. Clamp the chest tube.
C. Replace the system.
D. Document the finding.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Gentle bubbling is a normal finding for the client who has a pleural drainage system to suction, so it simply needs to be documented. If the bubbling becomes vigorous, it could indicate a leak, which the nurse needs to investigate. The remaining choices are not necessary.Reduction of Risk Potential

QUESTION 303
A visitor accidentally knocks over a plastic pleural drainage system connected to a client, and it cracks. What should the nurse do first?

A. Observe the client's response.
B. Notify the physician.
C. Change the drainage system.
D. Observe for leaks.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If a crack is seen in a pleural drainage system, it should be changed immediately. The remaining choices can be performed later.Reduction of Risk Potential

QUESTION 304
A client with a diagnosis of Schizophrenia has been released from an acute care setting. The client had a prolonged recovery from relapse. One of the parents says to the discharge nurse, "I do not understand what is going on. The hospital said she was better, but all she does is sit around all day and smoke. We cannot get her to go to the vocational training you arranged." The nurse recognizes that more teaching is needed about:

A. the pathophysiology and acting out behaviors of schizophrenia.
B. support groups that can help the parents release their feelings of frustration.
C. the prolonged recovery time and depressive effects of medicines to prevent relapse.

D. motivational techniques that are effective in clients with schizophrenia.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse conducting discharge teaching must stress the lengthy recuperation process with emphasis on the sedative qualities of the medication used to prevent relapse. Support groups are useful for caregivers. The emphasis during recuperation is on maintaining nutrition and hygiene.Psychosocial Integrity

QUESTION 305
A nurse is teaching a group of clients with a diagnosis of Schizophrenia who are nearing discharge from a residential care facility. An essential topic to include is:

A. pathophysiology of the disease and expected symptoms.
B. how to recognize and manage symptoms of relapse.
C. the need to take extra medication when feeling stressed.
D. the importance of contact with follow-up care daily.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed, and might become withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone who is trusted, avoid negative people, and decrease stimuli and stress.Psychosocial Integrity

QUESTION 306
An adolescent female reports being raped at a party where alcohol was served. The client admits to drinking alcohol before being raped by an acquaintance. The nurse should:

A. inform the client that because she is underage, she is at fault for attending a party where alcohol was served.
B. ask the client if anyone witnessed the event because the client was intoxicated and might not remember correctly.
C. inform the client that it was not her fault, and support the client through the physical examination.
D. question whether the woman had consensual sex and now just feels guilty.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acquaintance rape remains a controversial topic because of lack of agreement on the definition of consent. Most acquaintance rapes take place in either the victim's or the assailant's home or apartment. Most victims of acquaintance rape inform someone close to them, but less than 30% report the incidence to the authorities. Survivors of acquaintance rape report similar levels of depression, anxiety, complications in subsequent relationships, and difficulty attaining prerape levels of sexual satisfaction to what survivors of stranger rape report. Coping is more difficult for victims of acquaintance rape if others fail to recognize that the emotional impact is just as serious.Psychosocial Integrity

QUESTION 307
A client goes to the mental health center for difficulty concentrating, insomnia, and nightmares. The client reports being raped as a child. The nurse should assess the client for further signs of:

A. general anxiety disorder.
B. schizophrenia.
C. post-traumatic stress disorder.
D. bipolar disorder.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Childhood sexual abuse is associated with adult-onset depression and with an increased risk for lifetime and current post-traumatic stress disorder (PTSD). About one-third of all victims of sexual abuse meet the diagnostic criteria for PTSD. A person with PTSD has three main types of symptoms: (1) Re-experiencing the traumatic event with flashbacks, nightmares, and exaggerated reactions to triggers that remind the person of the event. (2) Emotional numbing is evidenced by avoidance of activities, places, thoughts, feelings, or conversations related to the trauma; feelings of detachment from others; and restricted or blunted emotions. (3) Increased activity is seen in bursts of anger, difficulty sleeping, hypervigilence, difficulty concentrating, and an exaggerated startle response. Other problems associated with PTSD are panic attacks, suicidal thoughts and feelings, substance abuse, eating disorders, feelings of alienation and isolation, and feelings of mistrust and betrayal.Psychosocial Integrity

QUESTION 308
The advanced directive in a client's chart is dated August 12, 1998.The client's daughter produces a Power of Attorney for Health Care, dated 2003, which contains different care direction(s). The nurse is supposed to:

A. follow the 1998 version because it's part of the legal chart.
B. follow the 1998 version because the physician's code order is based on it.
C. follow the 2003 version, place it in the chart, and communicate the update appropriately.
D. follow neither until clarified by the unitmanager.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The document dated 2003 supersedes the previous version and should be used as a basis for care direction.
Choices 1 and 2 are incorrect because the 1998 version is now outdated. Choice 4 is incorrect because the nurse can be held negligent for not responding to the 2003 document as directed.Coordinated Care

QUESTION 309
The nurse acts as an advocate for the nursing profession by performing all of the following activities except:

A. encouraging political involvement by nurses with their legislators.
B. acting as a first-aid provider for a children's athletic team.
C. precepting newly licensed nurses in the work situation.
D. encouraging as many persons to become nurses as possible.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse acts as an advocate for the nursing profession by encouraging appropriate persons to become nurses, by being a positive role model and mentor, and by communicating the needs of nurses in the most professional manner possible, to those making the laws.Coordinated Care

QUESTION 310
The physician's role in case management includes all of the following except:

A. participating in interdisciplinary planning for clients.
B. serving as the expert for resource utilization.
C. consulting with the case management team to facilitate timely orders as needed.
D. contributing to the documentation of a client's needs for services.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The physician is an integral part of the case-management process in terms of assisting with defining the client's needs and the time frames for movement through the health care system; however, the physician is the expert for medical diagnosis and treatment rather than resource utilization.Coordinated Care

QUESTION 311
The nurse and a colleague are on the elevator after their shift, and they hear a group of health caregivers discussing a recent client scenario. Which client right might be breached?

A. right to refuse treatment
B. right to continuity of care
C. right to confidentiality
D. right to reasonable responses to requests

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The right to confidentiality of client information might be breached when client care situations are discussed in public areas or without regard to maintaining the information as private and confidential. The other rights listed have not been breached in this instance.Coordinated Care

QUESTION 312
The power a nurse exerts when he or she works to accomplish goals and effect change in an agency or in policy is considered what type of power?

A. political
B. personal
C. positional
D. professional

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Political power results from one's ability to work within systems, agencies, or through policy to affect change. Personal power is based on one's charisma and self-confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based on one's professional skills and abilities resulting from one's recognized expertise in an area of practice.Coordinated Care

QUESTION 313
While walking in the hallway of an acute care unit of the hospital, the nurse overhears the change of shift report. The nurse should:

A. make the charge nurse on the unit aware of the situation so that he or she can take the necessary steps to maintain the confidentiality of the information being reported.
B. disregard the information because it changes quickly on the acute care unit and is outdated within 23 hours anyway.
C. return to his or her own unit and not disclose that confidential information has been overheard.
D. ignore the situation.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
To protect the confidentiality of the information being reported, the nurse should make the charge nurse on the unit aware of the situation so that the information can be communicated in an appropriate way in privacy.
Coordinated Care

QUESTION 314
In the process of an annual physical exam, a client is diagnosed with Benign Prostatic Hypertrophy (BPH). This client is likely to have a consult with which type of physician?

A. gynecologist
B. physiatrist
C. urologist
D. proctologist

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A urologist is the physician who specializes in urinary tract and prostatic disease. A gynecologist specializes in disease of the female reproductive tract. A physiatrist specializes in rehabilitation care. A proctologist specializes in lower colonic digestive diseases.Coordinated Care

QUESTION 315
A nurse discharge planner is preparing a client for discharge from an acute care setting. The nurse assesses that skilled home care services are clinically indicated. This assessment is based on all of the following indicators except:

A. the client has been admitted to the hospital three times in the last 2 months.
B. the client has a Foley catheter.
C. the client's family is available to care for him 24 hours a day.
D. the client is ordered to continue IV antibiotics 5 days post discharge.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Family availability to provide care and assistance is not an indicator for skilled home care. In fact, the nurse might see some opportunity for family education in meeting the client's needs so that less community support is needed. This needs to be negotiated with the family. Frequent hospital readmissions imply that the client has not been able to manage either due to condition instability or lack of care needs being met. This is a red flag for home care services to be able to meet those needs and appropriately monitor the client. A Foley catheter is an indication for home health care due to infection potential and care requirements. IV antibiotics involve home care due to maintaining line patency and assessment of the site.Coordinated Care

QUESTION 316
As a type of quality indicator, an example of a structure standard is:

A. a written philosophy.
B. a procedure for a straight catheterization.
C. a protocol for treatment of a client with chest pain.
D. the diagnostic work-up for a client with abdominal pain.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Structure standards define all the conditions needed to operate, direct, and control a system. They do not address client care but rather describe structure with regard to purpose, such as philosophy, objectives, goals, hours of operation, and management responsibility.Coordinated Care

QUESTION 317
All of the following tasks could be delegated to a nursing assistant or unlicensed assistive personnel (UAP) except:

A. monitoring intravenous infusion.
B. assisting a client to the bathroom.
C. offering fluid intake every 12 hours.
D. monitoring/recording the amount of fluid taken.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Monitoring an intravenous infusion must be performed by an RN or LPN. Assisting during activity, offering fluids and recording intake are in the job scope of the nursing assistant.Coordinated Care

QUESTION 318
The nurse uses prioritization to determine all the following except:

A. time allotment for certain tasks.
B. appropriate interventions.
C. treatment procedures.
D. the need for client education.

Correct Answer: C
Section: (none)

Explanation

Explanation/Reference:
Explanation:

Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure to be compliant with practice standards. Established priorities contribute to the determination of time management, appropriate interventions, and the need for client education as a potential intervention.Coordinated Care

QUESTION 319
A day care center has asked the nurse to provide education for parents regarding safety in the home. What type of preventive care does this represent?

A. primary
B. secondary
C. tertiary
D. health promotion

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Primary prevention involves activities that are utilized to promote wellness or prevent illness or injury. There are many dangers in the home for small children. Providing education regarding the need for safety measures to prevent injury in the home is considered primary prevention. Secondary prevention involves early detection of a disease or illness and quick intervention to aid the client in maintenance of the disease or injury. Tertiary prevention involves the reduction of a disability and the promotion of the highest level of functioning for a client in relation to his or her disease or injury. Health promotion is any activity that increases a client's health and wellness.Health Promotion and Maintenance

QUESTION 320
A client has just returned from surgery where a femoral-popliteal bypass was performed. The nurse has assessed the client and is unable to feel a pulse at either the dorsalis pedis or the posterior tibial sites of the left foot. The foot feels warm and the color is pink. What action should the nurse perform next to prevent ischemia?

A. Notify the physician immediately.
B. Obtain a Doppler device to check for pulses, and notify the physician if they are still absent.
C. Wait 30 minutes and recheck the pulses.
D. Document the finding.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The nurse should immediately obtain a Doppler device and recheck the pulses. The dorsalis pedis and posterior tibial can be difficult to assess and might need to be verified with a Doppler. Because the client just had a surgery in which a complication is arterial insufficiency, the client must be monitored carefully. If the pulses are not found, the nurse should recognize that this is an emergent situation, and the physician must be notified immediately. If the nurse waits 30 minutes before determining if the pulses can be felt, this could compromise the viability of the client's foot due to ischemia. Documenting the findings is important but must be performed after the nurse locates the dorsalis pedis and posterior tibial pulses or any necessary interventions are made.Health Promotion and Maintenance

QUESTION 321

The ethical principle of keeping professional promises or obligations is:

A. veracity.
B. autonomy.
C. fidelity.
D. beneficence.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The ethical principle of veracity is truth-telling. Autonomy is client self-determination (that is, clients making their own decisions). Beneficence is the principle of doing good, which is a foundation of nursing care. Coordinated Care

QUESTION 322
A risk management program within a hospital is responsible for all of the following except:

A. identifying risks.
B. controlling financial loss due to malpractice claims.
C. making sure that staff follow their job descriptions.
D. analyzing risks and trends to guide further interventions or programs.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Risk management is an organizationwide program to identify risks and control incidents and legal liability. It does not have any direct supervisory or management responsibility for staff.Safety and Infection Control

QUESTION 323
Which of the following factors can impact an individual's ability to give informed consent?

A. IQ
B. educational level
C. pain medications
D. financial status

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pain medications might alter alertness, thought processes, and reactions. It is recommended that a client be approached for consent at least 4 hours after the last dose of pain medicine to allow minimal impact. Choices 1, 2, and 4 are incorrect. IQ and educational levels might have a bearing on how information is presented through the discussion process, but they do not have a bearing on informed-consent decision-making.Coordinated Care

QUESTION 324
There are many types of torts that can be committed against clients. They include all of the following except:

A. assault.
B. battery.
C. negligence.
D. felony.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Felonies are serious crimes punishable by time in prison. Types of torts are assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.Coordinated Care

QUESTION 325
American families are having difficulty adequately performing their vital health care function.
What are the basic reasons for this difficulty?

A. structure of the health care system and family structure
B. psychological factors for men and women seeking health care
C. conditions being labeleddisabilitiesand seen as too time consuming
D. health care organizations (HMOs) and disconnected families

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Scholars suggest that the reasons families are having difficulty providing health care for their members lies with both the structure of the health care system and the family structure. Major factors explaining differences in utilization patterns of medical services include the lack of healthcare insurance coverage, lack of services for special populations (that is, teenage males), perception by families of the health care system and the health care provider, and lack of partnership between health care providers and families in mutually addressing health care issues.Health Promotion and Maintenance

QUESTION 326
Kleinman's Explanatory Model of Health and Illness is significant because:

A. it explains what kind of health beliefs a family is likely to have.
B. it brings out the importance of culture in forming health explanations.
C. it discusses the important role that popular and folk domains of influence have.
D. it has an educational base to the structure.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The anthropologist Kleinman makes a distinction between disease and illness. Disease is the health care professionals' biomedical understanding of the health problem, while illness is the client's personal and unique understanding and definition of what is happening to him. The theorist states that cultural factors determine the importance of the various domains of influence.Health Promotion and Maintenance

QUESTION 327
An example of an extended care facility is a:

A. home health agency.
B. suicide prevention center.
C. state-owned psychiatric hospital.
D. nursing facility.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When an elderly client has been hospitalized for an illness, under Medicare he or she can be transferred to a nursing facility.Health Promotion and Maintenance

QUESTION 328
A client and his family facing the end stage of a terminal illness might be best served by:

A. a rehabilitation center.
B. an extended care facility.
C. Hospice.
D. a crisis intervention center.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hospice has the belief that more humanized alternative care for dying clients is needed than is being provided in hospitals, which focus mostly on medical cures. No matter where the care is delivered, Hospice provides a specialized interdisciplinary team of health care professionals who work together to manage client care.HealthPromotion and Maintenance

QUESTION 329
During a routine health screening, the nurse should talk to the parents of a 1-year-old child about which of the following?

A. the potential hazards of accidents
B. appropriate nutrition now that the child has been weaned from breast-feeding
C. toilet training
D. how to purchase appropriate shoes now that the child is walking

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Accidents are the primary source of injury in children and can be life threatening. Appropriate nutrition should have been discussed during the weaning process and while the purchase of appropriate shoes is important, it is not life threatening. One year of age is too early to discuss toilet training.Health Promotion and Maintenance

QUESTION 330
The school nurse is conducting health screenings on schoolchildren. During the screening, she identifies a child with the behavioral characteristics of attention deficit disorder. Which of the following behaviors is consistent with this disorder?

A. slow speech development
B. overreaction to stimuli from the surroundings
C. inability to carry on a conversation
D. concrete thinking

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Children with attention deficit disorder are easily distracted but are able to carry on a conversation. Concrete thinking is more indicative of age, and slow speech development has more to do with other learning disabilities.Health Promotion and Maintenance

QUESTION 331
Who should receive the hepatitis A vaccine?

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A. children who are 18 months of age
B. infants, who should receive the vaccination at birth
C. people who travel to other countries
D. individuals who might come into contact with blood

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hepatitis A is for individuals who travel or persons with chronic liver disease. Infants receive the hepatitis B vaccine at birth. DTaP is administered at 18 months of age. Individuals who come into contact with blood should be immunized against hepatitis B.Health Promotion and Maintenance

QUESTION 332
Which of the following vaccines are not part of the regular schedule of immunizations for children?

A. DTaP
B. MMR
C. Hib
D. hepatitis A

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hepatitis A is not part of the regular immunization schedule for children. DTaP, MMR, and Hib are all regularly scheduled vaccines for children.Health Promotion and Maintenance

QUESTION 333
The nurse is teaching a client about sleep and gives background information on normal sleep patterns. Which of the following substances promotes sleep?

A. serotonin
B. cortisone
C. alcohol
D. narcotics

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Serotonin is a substance that is in the body and promotes sleep. Serotonin might play a role in synthesis of a hypnogenic factor that directly causes sleep. Drugs and alcohol can disrupt REM sleep, although they might accelerate the onset of sleep.Basic Care and Comfort

QUESTION 334
A hospitalized adult client who routinely works from midnight until 8 a.m. has a temperature of 99.1° F at 4 a.m. The nurse determines that this is most likely due to:

A. delta sleep
B. slow brain waves
C. pneumonia
D. circadian rhythm

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Biological rhythms that follow a cycle lasting about 24 hours are termed circadian rhythm. The sleep-wake cycle is closely linked with cardiac rhythms, such as body temperature. While a person sleeps, core body temperature drops, often reaching the 24-hour low at 4 a.m. When the sleep period shifts, temperature fluctuations also shift to match the new sleep patterns.Basic Care and Comfort

QUESTION 335
Mrs. Peterson complains of difficulty falling asleep, awakening earlier than desired, and not feeling rested. She attributes these problems to leg pain that is secondary to her arthritis. What is the most appropriate nursing diagnosis for her?

A. Sleep Pattern Disturbances (related to arthritis)
B. Fatigue (related to leg pain)
C. Knowledge Deficit (regarding sleep hygiene measures)
D. Sleep Pattern Disturbances (related to chronic leg pain)

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client's sleep pattern is directly disturbed by the chronic leg pain, which is secondary to the arthritis. This nursing diagnosis is the appropriate one to directly deal with comfort measures and the like.Basic Care and Comfort

QUESTION 336
A client asks the nurse if all donor blood products are cross-matched with the recipient to prevent a transfusion reaction. Which of the following always requires cross-matching?

A. packed red blood cells
B. platelets
C. plasma
D. granulocytes

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Packed red blood cells contain antigens and antibodies that must be matched between donor and recipient. Choices 2, 3, and 4 do not contain red cells; thus, they require no cross-matching.Pharmacological Therapies

QUESTION 337
A client's central venous access device (CVAD) becomes infected. Why might the physician order antibiotics to be given through the line rather than through a peripheral IV line?

A. to prevent infiltration of the peripheral line
B. to reduce the pain and discomfort associated with antibiotic administration in a small vein
C. to lessen the chance of an allergic reaction to the antibiotic
D. to attempt to eliminate microorganisms in the catheter and prevent having to remove it

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Microorganisms that infect CVADs are often coagulase-negative staphylococci, which can be eliminated by antibiotic administration through the catheter. If unsuccessful in eliminating the microorganism, the CVAD must be removed. CVAD use lessens the need for peripheral IV lines and thus the risk of infiltration. In this case, however, the antibiotics are given to eradicate microorganisms from the CVAD. CVAD use has the effect described in Choice 2, but in this case, the antibiotics are given through the CVAD to eliminate the infective agent. The route does not prevent an allergic reaction.Pharmacological Therapies

QUESTION 338
Hormonal agents are used to treat some cancers. An example is:

A. thyroxine to treat thyroid cancer.
B. ACTH to treat adrenal carcinoma.
C. estrogen antagonists to treat breast cancer.
D. glucagon to treat pancreatic carcinoma.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Estrogen antagonists are used to treat estrogen hormone-dependent cancer, such as breast carcinoma. A wellknown estrogen antagonist used in breast cancer therapy is Tamoxifen (Nolvadex). This drug, in

combination with surgery and other chemotherapeutic drugs, reduces breast cancer recurrence by 30%. Estrogen antagonists can also be administered to prevent breast cancer in women who have a strong family history of the disease. Thyroxine is a natural thyroid hormone. It does not treat thyroid cancer. ACTH is an anterior pituitary hormone that stimulates the adrenal glands to release glucocorticoids; it does not treat adrenal cancer. Glucagon is a pancreatic alpha cell hormone that stimulates glycogenolysis and gluconeogenesis; it does not treat pancreatic cancer.Pharmacological Therapies

QUESTION 339
Some drugs are excreted into bile and delivered to the intestines. Prior to elimination from the body, the drug might be absorbed. This process is known as:

A. hepatic clearance.
B. total clearance.
C. enterohepatic cycling.
D. first-pass effect.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Drugs and drug metabolites with molecular weights higher than 300 can be excreted via the bile, stored in the gallbladder, delivered to the intestines by the bile duct, and then reabsorbed into the circulation. This process reduces the elimination of drugs and prolongs their half-life and duration of action in the body. Choice 1 is the amount of drug eliminated by the liver. Choice 2 is the sum of all types of clearance including renal, hepatic, and respiratory. Choice 4 is the amount of drug absorbed from the GI tract, then metabolized by the liver (reducing the amount of drug that makes it into circulation).Pharmacological Therapies

QUESTION 340
The intravenous route is potentially the most dangerous route of drug administration because:

A. the IV might infiltrate.
B. it is expensive and nursing intensive.
C. rapid administration of a drug can lead to toxicity.
D. the client always has more side effects.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The bioavailability of the injected medication is 100% and might lead to toxicity. An IV infiltration can cause serious problems with tissue necrosis, but this is not life threatening.Expensiveandtime consumingdo not equate withdangerous. Choice 4 is not always true.Pharmacological Therapies

QUESTION 341
A complication of total parenteral nutrition (TPN) is the development of cholestasis. What is this condition?

A. an inflammatory process of the extrahepatic bile ducts
B. an arrest of the normal flow of bile
C. an inflammation of the gallbladder
D. the formation of gallstones

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cholestasis due to TPN administration is an intrahepatic process that interrupts the normal flow of bile. Extrahepatic bile duct inflammation is cholangitis. Inflammation of the gallbladder is cholecystitis. Gallstones are formed by bile components.Pharmacological Therapies

QUESTION 342
Which of the following attitudes is essential in a nurse who assists clients during crises?

A. viewing crisis intervention as the first step in solving bigger problems
B. wanting to help clients solve all problems identified
C. taking an active role in guiding the process
D. feeling that work requires identification with all of a client's problems

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Viewing crisis intervention as the first step in solving bigger problems is essential in a nurse who assists clients during crises. Assessment of the present problem should be viewed as necessary. Time and limitations of crisis work need to be remembered. Complete diagnostic assessment is unnecessary, and unrelated material should not be explored. Referrals might be necessary for other identified problems.Psychosocial Integrity

QUESTION 343
The nurse is working with families who have been displaced by a fire in an apartment complex. What is the priority intervention during the initial assessment?

A. Provide a liaison to meet housing needs.
B. Attentively listen when clients describe their feelings.
C. Offer nurturing support for clients who are confused by the events.
D. Provide structure for clients exhibiting moderate to severe anxiety.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

After physical needs of housing, clothing and food are met, the nurse should focus on assisting clients to manage the psychological effects of loss.Psychosocial Integrity

QUESTION 344
The nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse's next action should be to:

A. do nothing; the client has the right to refuse treatment.
B. report the incident to the police.
C. arrange an appointment with the client's next of kin.
D. educate the client about available services.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Although clients do have the right to refuse treatment, the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.Psychosocial Integrity

QUESTION 345
When questioning an elder about suspected abuse, the nurse should keep the questions:

A. nonjudgmental.
B. probing.
C. confrontational.
D. indirect.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Questions about suspected should be direct and nonconfrontational. Indirect questions encourage denial. Psychosocial Integrity

QUESTION 346
The primary organ for drug elimination is the:

A. skin.
B. lung(s).
C. kidney(s).
D. liver.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.PharmacologicalTherapies

QUESTION 347
A 50 milliliter (ml) bolus of normal saline fluid is ordered by the physician. The physician wants it to infuse in 30 minutes. The nurse should set the pump rate at:

A. 100 ml per hour for one hour.
B. 60 ml per hour for one-half hour.
C. 120 ml per hour for one hour.
D. 50 ml per hour for one hour.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

One hundred ml in one hour equals 50 ml in 30 minutes, which is what the physician prescribed. Choice 2

is 10 ml more than the physician prescribed for 30 minutes. Choice 3 is the same asChoice 2; it is 10 ml more than the physician prescribed for 30 minutes. Choice 4 only provides 25 ml over 30 minutes, or half the volume prescribed.Pharmacological Therapies

QUESTION 348
Carrying a donor card for organ donation means that:

A. medical care is altered in the event of serious injuries to get organs for donation.
B. the family or legally responsible party of a client has no decision-making authority in the event that the client is considered for organ donation.
C. a client is allowed to revoke his decision for organ donation at any time.
D. a client is considered an organ donor for only one organ or tissue.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Revocation of the decision for organ donation may occur at any time, by either the client or his responsible party. When organ donation is considered, as many organs as the donor wished to donate are considered and accepted for donation if found appropriate. Medical care for an individual during immediate care and/or resuscitation is not altered to declare a client dead and ready for organ donation.Coordinated Care

QUESTION 349
Referral for client education in the community can be accomplished through all of the following except:

A. community agencies such as the American Heart Association.
B. parish nurses.
C. home health care agencies.
D. unlicensed massage therapists.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Client education should be completed by an individual or individuals with acknowledged expertise in the subject area and credentials to support activity within the health care community.Coordinated Care

QUESTION 350
The tendency of a drug to combine with its receptor is called:

A. potency.
B. efficacy.
C. kinetics.
D. affinity.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Affinity is a close relationship, mutual attraction, or similarity. The tendency of a drug to combine with its receptor is called affinity. Affinity is a measure of the strength of the drug- receptor bonding. Choices 1 and 2 describe the capability of a drug to produce the desired effect. Choice 3 is the branch of science that

deals with the effects of forces on the motions of material bodies or with changes in a physical or chemical system.Pharmacological Therapies

QUESTION 351
Levothyroxine (Synthroid) is the drug of choice for thyroid replacement therapy in clients with hypothyroidism because:

A. it is chemically stable, nonallergenic, and can be administered orally once a day.
B. it is available in a single 25mg tablet, which makes dosing simple.
C. it is not a prodrug.
D. it has a short half-life.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Levothyroxine is safe and effective with virtually no side effects when dosed properly. A single, daily dose is possible because of the long half-life (7 days). Levothyroxine tablets are available in a wide range of concentrations to meet individual client requirements. Levothyroxine (T4) is a prodrug of T3.Pharmacological Therapies

QUESTION 352
When medications have an additive, synergistic, or antagonistic effect on a tissue, a _____ reaction has occurred.

A. pharmaceutical
B. pharmacodynamic
C. pharmacokinetic
D. drug incompatibility

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pharmacodynamics pertain to the effect of a drug on receptors. Pharmaceutical reactions are chemical reactions between drugs prior to administration or absorption. Pharmacokinetic reactions refer to the body's effect on the drug. Drug incompatibilities are another term for pharmaceutical reactions.Pharmacological Therapies

QUESTION 353
Local anesthetics block the conduction of pain impulses to the spinal cord. Their duration of action:

A. is always longer than general anesthesia.
B. is determined by the rate of diffusion and absorption at the site of administration.
C. is usually short (10 minutes).
D. varies, depending on the client's weight.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Diffusion and absorption depend on the chemical properties of the anesthetic and other factors such as

local pH and blood flow. Duration might or might not be longer than general anesthesia. Duration can be short if the type of local anesthetic is a short-acting agent. Client weight is not a factor.Pharmacological Therapies

QUESTION 354
Which of the following clients should refrain from therapy with the thiazide diuretic hydrochlorothiazide (HCTZ)?

A. a client with renal impairment
B. a client with hypertension
C. a client with diabetes mellitus, type II
D. a client with renal calculi (kidney stones)

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The thiazide class of diuretics cause metabolic abnormalities such as elevated blood glucose levels. This elevation is caused in part by diuretic-induced potassium deficiency. Hypokalemia reduces the secretion of insulin by pancreatic beta cells, thereby increasing plasma glucose levels. Thiazides have been used for many years in clients with the conditions described in choices 1 and 2. Thiazides decrease calcium excretion, thus decreasing the likelihood of renal calculi.Pharmacological Therapies

QUESTION 355
Delegation of tasks to appropriate personnel allows the nurse to:

A. take a break.
B. keep other members of the team productive.
C. maintain tight control of all aspects of the workflow.
D. realize the importance of her role by making all decisions.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Maintaining the productivity of all team members by delegating tasks appropriate to the job descriptions of the personnel increases work effectiveness and efficiency.Coordinated Care

QUESTION 356
Activities of effective supervisors can be taskrelated or people-related activities. An example of a task-related supervisory activity is:

A. coaching.
B. evaluating.
C. delegating.
D. facilitating.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Delegating is the act (or task) of assigning work to those that are capable and competent to do the work.

Coaching, evaluating, and facilitating are supervisory activities that are people related.Coordinated Care

QUESTION 357
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

QUESTION 358
The nurse can best communicate to a client that he or she has been listening by:

A. restating the main feeling or thought the client has expressed.
B. making a judgment about the client's problem.
C. offering a leading question such as, "And then what happened?"
D. saying, "I understand what you're saying."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Restating allows the client to validate the nurse's understanding of what has been communicated. It's an active listening technique. Regarding Choice 2, judgments should be suspended in a nurse-client relationship. Choice 3 is incorrect because leading questions ask for more information rather than showing understanding. Choice 4 communicates understanding, but the client has no way of measuring the understanding.PsychosocialIntegrity

QUESTION 359
In the United States, several definitions of death are currently being used. The definition that uses apnea testing and pupillary responses to light is termed:

A. whole brain death.
B. heart-lung death.
C. circulatory death.
D. higher brain death.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Most protocols require two separate clinical examinations, including induction of painful stimuli, papillary responses to light, oculovestibular testing, and apnea testing. Choices 2 and 4 have no specific test

required. Choice 3 is not a current definition of death in the United States.Psychosocial Integrity

QUESTION 360
The nurse is caring for a dying client who has persistently requested that the nurse "help her to die and be in peace." According to the Code of Ethics for Nurses, the nurse should:

A. Ask the client whether she has signed the advance directives document.
B. Tell the client that he or she will ask another nurse to care for her.
C. Instruct the client that only a physician can legally assist a suicide.
D. Try to make the client as comfortable as possible, but refuse to assist in death.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Try to make the client as comfortable as possible but refuse to assist in death. One of the competencies necessary for nurses to have in giving high quality care to clients/families during the end of life care is: apply legal and ethical principles in the analysis of complex issues and end-of-life care, recognizing the influence of personal values, profession codes, and client preferences.Psychosocial Integrity

QUESTION 361
When caring for a Native-American family, the nurse needs to consider which of the following?

A. The family consists solely of the parents and children.
B. Native Americans tend to be future oriented.
C. Some Native Americans use herbs and psychologic treatment of illnesses.
D. Health care is usually prescribed by a medicine man (shaman).

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Symbols of health or traditions might include certain ritualistic items that are used to maintain, protect, or restore physical, mental, or spiritual health.Psychosocial Integrity

QUESTION 362
The three universal spiritual needs include all of the following except:

A. meaning and purpose.
B. love and relatedness.
C. forgiveness.
D. God's permission.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Religious teachings help to present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. God is the center of many religions (major), but not all.
Psychosocial Integrity

QUESTION 363
Acute hyphema is associated with what type of injury?

A. orthopedic
B. eye
C. insect sting or snakebite
D. gynecological trauma

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An acute hyphema occurs as a result of a blunt injury to the eye and is manifested by a half- moon appearance or a horizontal line across the globe when the client is upright (due to blood collected in the anterior chamber).Safety and Infection Control

QUESTION 364
A client has sustained a hyphema. What intervention should the nurse take?

A. Have the client wear ear protectors in the future.
B. Keep the client at bed rest, typically with the head of the bed propped up.
C. Apply atropine eye drops.
D. Apply an ice pack to the site of injury.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Initial care of the client involves preventing further damage and rebleeding. Clients are kept at bed rest if possible, usually with the head of the bed raised. TV watching is permitted but not reading. The use of atropine, ice, and eye shields are controversial, and a nurse should not administer a pharmacologic agent or thermal therapy without a physician's order.Safety and Infection Control

QUESTION 365
The nurse's first action upon discovery of an electrical fire should be which of the following?

A. Disconnect the electrical power if it can be performed safely.
B. Smother the source with an object such as a blanket.
C. Saturate the source with water or other readily available liquid.
D. Activate the fire alarm immediately.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If it is safe to do so, the nurse should disconnect electrical devices from the power source. Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire,just as water or other liquids might incite an explosion or flames. The fire alarm should be activated promptly, and this should be the next action after disconnecting the electrically powered equipment.Safety and Infection Control

QUESTION 366
A community health nurse is asked to organize a health promotion project that plans to provide glucose

screening. This activity is most beneficial within what realm?

A. testing that is performed by volunteers at a local department store and is open to the public
B. at a professional health fair activity available for selected persons who have been screened as being at risk
C. mass-marketing vouchers for free fingersticks at a local drug store, where the pharmacist makes recommendations on the findings
D. testing that is performed by a nurse professional, who immediately provides education regarding the findings

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Public glucose screening has been found to be an ineffective way to screen for diabetes unless based on health risk screening for those persons identified to be at risk or displaying symptoms.Safety and InfectionControl

QUESTION 367
Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. disability prevention.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The three levels of prevention address disease and disability across all phases, from absence of disease and at risk for disease, to preventing further impairment. Hearing impairment associatedwith prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.Safety and Infection Control

QUESTION 368
The nurse is preparing to administer IV Vancomycin to a client. Which of the following nursing actions should be taken first?

A. performing a physical assessment prior to administration
B. obtaining the most recent lab values regarding renal function
C. reviewing peaks and troughs for the past few days
D. ensuring the client is not allergic to the medication

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Even before the physical assessment (which might or might not be indicated at the time of administration of Vancomycin), ensuring that the client is not allergic to the medication is the most critical action the nurse must take before administering any drug. Lab values regarding renal functioning and therapeutic ranges via peaks and troughs are also important with some medications such as Vancomycin because renal damage

can occur if blood drug levels remain high over time.Safety and Infection Control

QUESTION 369
The orientation nurse educator reviewing the biohazard legend with a class of new employees states that the emblem is affixed to containers whenever:

A. there is presence of blood and body fluids.
B. there is the need for droplet precaution.
C. there is contact isolation.
D. there is the potential for airborne transmission.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When body substances are handled, the potential for transmission is increased; therefore, federal regulations require warning labels to communicate with other employees and/or waste collectors. The biohazard alert is a three-ring symbol overlaying a central concentric ring. Blood, drainagefrom wounds, feces, and urine are all body fluids that can transfer infection and disease to others.Safety and Infection Control

QUESTION 370
The emergency triage nurse should perform which action upon receiving the history that a client has a severe cough, fever, night sweats, and body wasting?

A. Place the client in the waiting room until an available cubicle is open.
B. Seclude the client from other clients and visitors.
C. Perform no intervention because it might not be necessary until tests confirm a disease.
D. Don gown, gloves, and mask immediately.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The client is describing signs and symptoms of tuberculosis. The client is potentially infectious to others and should be secluded. A respirator mask should be worn by caregivers, but it is not necessary for the nurse to don a gown and gloves. If the client is moved to other areas such as radiology, a mask should be worn by the client and a respirator mask should be worn by those working in close contact with the client.Safety and Infection Control

QUESTION 371
Which of the following clients require airborne precautions?

A. a client with fever, chills, vomiting, and diarrhea
B. a client suspected of varicella (chickenpox)
C. a client with abdominal pain and purpura
D. a client diagnosed with AIDS

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Chickenpox (varicella) is an acute, infectious, airborne illness that requires others in direct contact to wear

a respirator mask.Safety and Infection Control

QUESTION 372
A stool culture reveals Shigella. What corollary should the nurse recognize regarding this bacterial infection?

A. People who have been in contact with the client need to be tested.
B. Shigella is an airborne infection.
C. Shigella is a bacteria sometimes found in stagnant water.
D. The nurse should wear a one-way breathing apparatus when giving client care.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Shigella is a bacteria sometimes found in stagnant water. Transmission of Shigella is typically oral-fecal, so good hand washing and the use of gloves are the best means of prevention when caring for a client with Shigella. The bacteria can be found in food and water contaminated by fecal material. Incidences of Shigella are reportable in many states.Safety and Infection Control

QUESTION 373
A client asks the nurse what risk factors increase the changes of getting skin cancer. The risk factors include all except:

A. light or fair complexion.
B. exposure to sun for great periods of time.
C. certain diet and foods.
D. history of bad sunburns.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Conditions that increase risks for skin cancer are: light or fair complexion, history of having bad sunburns or scars from previous burns, personal or family history of skin cancer, frequently working or playing outdoors with exposure to the sun, exposure to X-rays or radiation, exposure to certain chemicals through work or hobbies (coal, pitch, asphalt, petroleum), repeated trauma or injury to an area resulting in scars, older than age 50, male gender, and living in a geographic location near the equator or at high altitudes. Ways to prevent skin cancer are avoiding exposure to the sun, wearing a hat to protect the face, avoiding all sun lamps, and using a sunscreen with a minimum of 15 sun protection factor (SPF) if exposure to the sun is unavoidable. Teaching clients how to recognize a potential problem involves inspecting the skin frequently; noting all birthmarks, freckles, and moles; and seeking medical assistance if any of the following are noted:
change in color, change in shape, change in surface texture, change in size, change in the surrounding skin, or a new mole or a sore that does not heal.HealthPromotion and Maintenance

QUESTION 374
To improve overall health, the nurse should place highest priority on assisting a client to make lifestyle changes for which of the following habits?

A. drinking a six-pack of beer each day
B. eating an occasional chocolate bar
C. exercising twice a week
D. using relaxation exercises to deal with stress

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Health promotion is motivated by the desire to increase people's well-being and health potential. The nurse promotes health by maximizing the client's own strengths. Identification and analysis of the client's strengths are a component of preventing illness, restoring health, and facilitating coping with disability or death. The nurse facilitates decisions about lifestyle that enhance one's quality of life and encourage acceptance of responsibility for one's own health.Health Promotion and Maintenance

QUESTION 375
The gag reflex test assesses which cranial nerves?

A. IX and X
B. V and VII
C. IX and XII
D. V and X

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Gagging during the gag reflex test indicates that cranial nerves IX and X (the glossopharyngeal and vagus nerves) are intact.Health Promotion and Maintenance

QUESTION 376
How many temporary teeth should the nurse expect to find in a 5-year-old client's mouth?

A. up to 10
B. up to 15
C. up to 20
D. up to 32

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A child can have up to 20 temporary (deciduous or baby) teeth. The first tooth usually erupts by age 6 months and the last by age 30 months. All temporary teeth usually are shed between 6 and 13 years of age.Preventionand Early Detection of Disease

QUESTION 377
When assessing a client with early impairment of oxygen perfusion, such as pulmonary embolus, the nurse should expect to find restlessness and which of the following symptoms?

A. warm, dry skin
B. bradychardia
C. tachycardia
D. eupnea

Correct Answer: C
Section: (none)

Explanation

Explanation/Reference:
Explanation:

The cardinal signs of respiratory problems and hypoxia are restlessness, diaphoresis, tachycardia, and cool skin.
Bradycardia might occur much later in the process when the condition is severe. Eupnea is normal respirations in rate and depth.Physiological Adaptation

QUESTION 378
One day postoperative, the client complains of dyspnea, and his respiratory rate (RR) is 35, slightly labored, and there are no breath sounds in the lower-right base. The nurse should suspect:

A. cor pulmonale.
B. atelectasis.
C. pulmonary embolus.
D. cardiac tamponade.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The first three symptoms could be indicative of any of the conditions. The distinguishing symptom is the lack of breath sounds in the lower-right base, which is assessed when a portion of the lung has collapsed.Physiological Adaptation

QUESTION 379
Which of the following needs immediate medical attention and emergency intervention? The client who:

A. complains of sharp pain upon taking a deep breath and excessive coughing.
B. exhibits yellow, productive sputum, lowgrade fever, and crackles.
C. has a shift of the trachea to the left, with no breath sounds on the right.
D. has asthma and complains of an inability to catch her breath after exercise.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Choice 3 is indicative of a tension pneumothorax, which is considered a medical emergency. The respiratory system is severely compromised and venous return to the heart is affected. The mediastinal shift is to the unaffected side. Choice 1 contains symptoms of pleurisy, and Choice 2 lists symptoms of bronchitis. Neither are emergencies. The client in Choice 4 should expect difficulty breathing after exercise when asthma is an existing condition and might need immediate attention if his rescue inhaler is ineffective.Physiological Adaptation

QUESTION 380
Which of the following symptoms is most characteristic of a client with cancer of the lungs?

A. exertional dyspnea
B. persistent changing cough
C. air hunger; dyspnea
D. cough with night sweats

Correct Answer: B

Section: (none)
Explanation

Explanation/Reference:
Explanation:

The most common sign of cancer of the lung is a persistent cough that changes. Other signs are dyspnea, bloody sputum, and long-term pulmonary infection. Choice 1 is common with chronic obstructive pulmonary disease (COPD). Choice 3 is common with asthma. Choice 4 is common with tuberculosis.PhysiologicalAdaptation

QUESTION 381
A neighbor telephones the nurse to tell her that her child has erythema infectiosum and asks for information. The nurse knows that another name for the disorder is:

A. Kawasaki disease.
B. rheumatic disease.
C. lupus erythematosus.
D. fifth disease.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The child has Fifth disease, a parvovirus flulike illness that is self-limiting but is contagious for twothree weeks.Safety and Infection Control

QUESTION 382
The nurse teaching a client about hepatitis and its transmission should explain that one type of hepatitis does not produce a carrier state after its acute phase. Which type is it?

A. hepatitis A
B. hepatitis B
C. hepatitis C
D. hepatitis D

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hepatitis A does not produce a carrier state. It is transmitted via contaminated water or food via the oral-fecal route and is not blood borne.Safety and Infection Control

QUESTION 383
The three major sequential maturational crises for females include:

A. puberty, pregnancy, and menopause.
B. death of a spouse, menopause, and childbirth.
C. rape, divorce, and menarche.
D. dating, engagement, and separation.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The three major sequential maturational crises affecting females are puberty, pregnancy, and menopause. These are life events that have been studied by many researchers and are considered the major events in a woman's life. Puberty is the onset menarche. Pregnancy is a turning point in one's life from which there is no return. Menopause is the cessation of menses. The nurse has the responsibility to assess, plan, implement appropriate concepts to facilitate effective functioning, and enhance growth and development. Choices 2, 3, and 4 are not sequential maturational crises.Psychosocial Integrity

QUESTION 384
A female having her first child is experiencing which type of crisis event?

A. situational
B. maturational
C. adventitious
D. reactive

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A maturational crisis occurs when an individual arrives at a new stage of development and must develop new coping strategies. Choice 1 arises from sources external to individuals. Choice 3 occurs when some event external to a person (floods, hurricanes) disrupts his or her coping behaviors. Choice 4 is not a crisis intervention.Psychosocial Integrity

QUESTION 385
Nursing care for a client undergoing chemotherapy includes assessment for signs of bone marrow depression. Which finding accounts for some of the symptoms related to bone marrow depression?

A. erythrocytosis
B. leukocytosis
C. polycythemia
D. thrombocytopenia

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Thrombocytopenia is an abnormal decrease in the number platelets, which results in bleeding tendencies. Erythrocytosis is an abnormal increase in the number of circulating red blood cells. Leukocytosis is an increase in the number of white blood cells in the blood. Polycythemia is also an excess of red blood cells and is a synonym for erythrocytosis. With chemotherapy there is a decrease in red and white blood cells, not an increase.Physiological Adaptation

QUESTION 386
A woman is in the active phase of labor. An external monitor has been applied, and a fetal heart deceleration of uniform shape is observed, beginning just as the contraction is under way and returning to the baseline at the end of the contraction. Which of the following nursing actions is most appropriate?

A. Administer O2.
B. Turn the client on her left side.
C. Notify the physician.
D. No action is necessary.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It is an early deceleration as a result of head compression, and at this time no action is necessary. Close observation of the mother and baby is needed.Physiological Adaptation

QUESTION 387
A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

A. pain on movement and weight bearing
B. hemorrhage
C. affected leg appearing 12 inches longer
D. edema in the area of the incision

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation. Other symptoms of dislocation include an inability to bear weight and a shortening of the affected leg. Edema is not a primary sign of displacement.Physiological Adaptation

QUESTION 388
Paula is a 32-year-old woman seeking evaluation and treatment of major depressive symptoms. A major nursing priority during the assessment process includes which of the following?

A. meaning of current stressors
B. possibility of self-harm
C. motivation to participate in treatment
D. presence of alcohol or other drug use

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Unless the client is first assessed for self-harm or suicide potential, the staff might not observe the necessary degree of vigilance needed in the client's environment. Physical needs are the second most critical concern with a depressive client. Though the client may be encouraged to attend group therapy as part of the treatment plan, the client's safety takes precedence. Response to medication takes time and is not an initial concern.Physiological Adaptation

QUESTION 389
A client is assessed by the nurse as experiencing a crisis. The nurse plans to:

A. allow the client to work through independent problem-solving.
B. complete an in-depth evaluation of stressors and responses to the situation.
C. focus on immediate stress reduction.
D. recommend ongoing therapy.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A crisis is an acute, time-limited state of disequilibrium resulting from a situational, developmental, or societal source of stress. Utilizing the nursing process, the nurse should assist clients to work through a crisis to its resolution and restore their precrisis level of functioning.Psychosocial Integrity

QUESTION 390
A client is having psychological counseling for problems communicating with his mother. Which model of stress is the most useful in reference to this stressor?

A. Adaptation Model
B. Stimulus-Based Model
C. Transaction-Based Model
D. Selye's Model of Stress

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The Transaction-Based Model is, according to R.S. Lazarus, a state that Stimulus theory and Response theory do not consider individual differences. He takes into account cognitive processes that intervene between the encounter and the reaction and the factors that affect the nature of this process. He includes mental and psychological components or responses as part of his concept of stress (Person--Environment Transactions).Psychosocial Integrity

QUESTION 391
During surgery, it is found that a client with adenocarcinoma of the rectum has positive peritoneal lymph nodes. What is the next most likely site of metastasis?

A. brain
B. bone
C. liver
D. mediastinum

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Colon tumors tend to spread through the lymphatics and portal vein to the liver. Although metastasis to the other sites listed is possible, the liver is most likely the first to be affected.Physiological Adaptation

Topic 5, Questions Set E

QUESTION 392
In a disaster, triage situation, the nurse should be least concerned with which of the following regarding a client in crisis?

A. ability to breathe
B. pallor or cyanosis of the skin
C. number of accompanying family members

D. motor function

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The least important factor (of those listed) during an emergency situation is the number of accompanying family members.Safety and Infection Control

QUESTION 393
All of the following clients are in need of an emergency assessment except:

A. a bleeding client who has an injury from falling debris.
B. an unresponsive client.
C. a client with an old injury.
D. a pregnant woman with imminent delivery.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client with an old injury does not need an emergency assessment because this is not a life- threatening or new situation or condition.Safety and Infection Control

QUESTION 394
All of the following are causes of vaginal bleeding in late pregnancy except:

A. placenta previa.
B. eclampsia.
C. abruptio placentae.
D. uterine rupture.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Eclampsia is a disorder of pregnancy characterized by hypertension, proteinuria, and edema. This condition can cause seizure and/or coma. Choices 1 and 3 are abnormal conditions that can cause bleeding, particularly in the third trimester. Choice 4 is a major obstetrical emergency that can cause bleeding internally and externally.Safety and Infection Control

QUESTION 395
Padding on a restraint helps:

A. with pressure distribution so that bony prominences do not receive pressure when a client pulls against the restraints.
B. the client feel more secure.
C. to keep infection and wounds down.
D. to keep restraints in place.

Correct Answer: A

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Padding distributes pressure so that bony prominences do not receive the brunt of pressure when a client pulls against the restraints. Pressure, especially over bony prominences, causes tissue damage due to ischemia.Safetyand Infection Control

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QUESTION 396
What does client and family communication and education concerning restraints do?

A. confuses both groups more
B. helps with coping and stress levels
C. encourages cooperation with the client and family
D. puts the responsibility on the client and family, not the nurse

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cooperation is more likely if the client and family understand the purpose of and expected gains from restraints.
Well-meaning family members might release restraints if their purpose is not clear.Safety and Infection Control

QUESTION 397
Which of the following statements describes the purpose of client restraint?

A. Restraints are a nursing measure used to maintain client control.
B. Restraints are an emergency intervention taken as a last resort to protect a client from imminent danger.
C. Restraints are a therapeutic measure designed to positively reinforce client behavior.
D. Restraints are an emergency measure that can only be taken by a nurse under the direct supervision of a physician.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The use of restraints as an emergency measure is taken primarily as a last resort to protect a client from harm. Typically, the nurse acts under a physician's order, but in an emergency, the nurse may restrain a client out of necessity for one hour prior to the client being seen by a physician or an advanced practice mental health provider.Safety and Infection Control

QUESTION 398
Support systems during the grieving process include all of the following except:

A. a despondent friend.
B. a nurse.
C. a social worker.
D. a family member.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A despondent friend, even though this could be a support to the grieving person, is in a state of despondency. Therefore, he or she might not do well with a grieving friend.Psychosocial Integrity

QUESTION 399
Mrs. Owens is the 81-year-old mother of Jonathan, who is 54 years old. Jonathan has had schizophrenia since he was 16 years old. Which of Mrs. Owens's concerns is likely to predominate?

A. "Will my retirement funds outlast me?"
B. "Who will handle my funeral arrangements?"
C. "What will become of Jonathan when I am gone?"
D. "How can I get Jonathan's physician to talk to me?"

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The mother's most prominent concern is likely to be what becomes of her son after she dies. Choice 1 is important but is not likely to be her most prominent concern. Choice 2 is also not likely to be her primary concern because the welfare of her son with schizophrenia is more important. Choice 4 is incorrect because Mrs. Owens has likely confronted and handled concerns about getting the physician to talk to her after 38 years of managing her son's care.Psychosocial Integrity

QUESTION 400
A client tells the nurse that his wife's nagging really gets on his nerves. He asks the nurse to talk with her about her nagging during their family session tomorrow afternoon. Which of the following responses is the most therapeutic for the client?

A. "Tell me more specifically about her complaints."
B. "Can you think why she might nag you so much?"
C. "I'll help you think about how to bring this up yourself tomorrow afternoon."
D. "Why do you want me to initiate this in tomorrow's session rather than you?"

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client needs to learn how to communicate directly with his wife about her behavior. The nurse's assistance enables him to practice a new skill and communicates confidence in his ability to confront this situation. Choices 1 and 2 inappropriately direct attention away from the clientand toward his wife, who isn't present. Choice 4 implies that there might be a legitimate reason for the nurse to assume responsibility for

something that rightfully belongs to the client. Instead of focusing on his problems, he'll waste precious time convincing the nurse that he or she should do his work.Psychosocial Integrity

QUESTION 401
During the work phase of the nurse-client relationship, the client says to her primary nurse, "You think that I could walk if I wanted to, don't you?" What is the best response by the nurse?

A. "Yes, if you really wanted to, you could."
B. "Tell me why you're concerned about what I think."
C. "Do you think you could walk if you wanted to?"
D. "I think you're unable to walk now, whatever the cause."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This response answers the question honestly and nonjudgmentally and helps to preserve the client's selfesteem.
Choice 1 is an open and candid response but diminishes the client's self-esteem. Choice 2 doesn't answer the client's question and is not helpful. Choice 3 increases the client's anxiety because her inability to walk might be directly related to an unconscious psychological conflict that has not been resolved.Psychosocial Integrity

QUESTION 402
A successful resolution of the nursing diagnosis Negative Self-Concept (related to unrealistic selfexpectations) is when the client can:

A. report a positive self-concept.
B. identify negative thoughts.
C. recognize positive thoughts.
D. give one positive cue with each negative cue.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The problem statement is Negative Self Concept. A successful resolution of the problem is when the client can report a positive self-concept. When the nurse determines how the client perceives himself, effort should be directed to reinforce self-worth and promote a positive self- concept,including helping a client to identify areas of strength. Assisting the client to evaluate himself and make behavior changes is a nursing intervention.Psychosocial Integrity

QUESTION 403
A client who recently lost 50 pounds just received news that she is pregnant. A possible nursing diagnosis is:

A. Actual Chronic Low Self-Esteem (related to obesity).
B. Potential Chronic Low Self-Esteem (related to obesity).
C. Actual Situational Low Self-Esteem (related to fear of weight regain and pregnancy).
D. Potential Situational Low Self-Esteem (related to fear of weight regain and pregnancy).

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If there are indications of a body image disturbance, the nursing care plan should include body disturbances, related to a functional or physical problem. The disturbance might be an anticipated one--that is, weight gain and pregnancy. Stressors can include a change in physical appearance, sexuality concerns, or an unrealistic ideal self.
Psychosocial Integrity

QUESTION 404
The nurse should utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

A. triceps skinfold measurement
B. fasting blood glucose level
C. hemoglobin A1c level
D. serum lipid profile results

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Objective anthropometric measurements such as triceps skinfold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. While all the other choicesrepresent tests that might provide useful information, they also might be affected by variables other than malnutrition.Physiological Adaptation

QUESTION 405
The nurse should make which of the following responses when questioned by a client about the role of leptin in the body?

A. It increases food intake in clients, thereby promoting obesity.
B. It assists in the regulation of steroids.
C. It increases the total fat mass of people who are obese.
D. It might decrease the total fat mass in the bodies of people who are obese.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Leptin (recessive obesity gene--protein hormone) is expressed in fat cell coding for the protein that reacts to the percentage of fat cells in the body. Leptin is associated with increased energy expenditure and decreased food intake via hypothalamic control. Obese clients might have insensitivity or resistance to the effects of leptin. Leptin can affect other body hormones such as insulin. Genetic factors include leptin, uncoupling proteins, and the amount of brown/white fat in the body.Physiological Adaptation

QUESTION 406
What are the implications for a client with renal insufficiency who wants to start a low- carbohydrate (CHO) diet?

A. As long as the client eats a minimum of 30g of CHO/day, there should be no problem.
B. The client's clinical condition is a contraindication to starting a low CHO diet.
C. Calcium supplements should be utilized to prevent the development of osteoporosis while on a low CHO diet.
D. As long as the client eats foods that are high biologic protein sources, a low CHO diet can be followed.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A client with renal insufficiency should not start a low CHO diet because it could result in an increased renal solute load. Clients who have renal disease (renal failure, endstage renal disease [ESRD], dialysis, and transplant) or liver disease (liver failure, hepatic encephalopathy, cirrhosis, transplant, and hepatitis) require some form of protein control in dietary patterns to preventcomplications from an inability to handle protein solute load. Proteins used in the diet must be of high biologic value, and protein intake is usually weight based, starting at 0.8 g/kg of dry weight, depending on the client's underlying clinical condition. Protein levels may be increased as necessary to account for metabolic response to dialysis and regeneration of liver tissue (1.52.0 g/kg/day). A minimum level of CHOs are needed in the diet (50100 g/day) to spare protein. Vitamin and mineral supplements might be indicated with clients who have liver failure. The dietician is instrumental in calculating specific nutrient requirements for these clients and reviewing fluid intake and output, medication profile, and daily weight to monitor client outcomes in conjunction with dialysis technicians and nurses.Physiological Adaptation

QUESTION 407
Herbal therapy has several indications for use. Primarily, herbal therapy is:

A. used to treat many common complaints and diseases.
B. used to promote certain types of low-carb diets.
C. used as an adjunct to medications.
D. used to create a diet without salt and carbohydrates.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Herbal therapy is used to treat many common complaints and diseases.Physiological Adaptation

QUESTION 408
The chemotherapeutic agent 5-fluorourcacil (5-FU) is ordered for a client as an adjunct measure to surgery. Which statement about chemotherapy is true?

A. It is a local treatment affecting only tumor cells.
B. It is a systemic treatment affecting both tumor and normal cells.
C. It has not yet been proved an effective treatment for cancer.
D. It is often the drug of choice because it causes few, if any, side effects.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

5-FU is an antieoplastic, antimetabolic drug that inhibits DNA synthesis and interferes with cell replication. It is given intravenously and acts systemically. It affects all rapidly growing cells,both malignant and normal. It is used as adjuvant therapy for treating cancer of the colon, rectum, stomach, breast, and pancreas. This drug has many side effects, including bone marrow depression, anorexia, stomatitis, nausea, and vomiting.Physiological Adaptation

QUESTION 409
When teaching a woman about possible side effects of hormone replacement therapy, the nurse should include information about all of the following except:

A. Hypoglycemia in diabetic women.
B. The possible return of monthly menses when taking combination hormones.
C. Increased risk of gallbladder disease.
D. Increased risk of breast, cervical, and ovarian cancer with long-term use.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When taking estrogen, there is an increased risk of diabetes or hyperglycemia due to lowered glucose tolerance. It is true that monthly menses might return when taking combination hormones. The progestin is responsible for this. There is also a risk of gallbladder disease. It is also true that there is an increased risk of breast, cervical, and ovarian cancer with long-term hormone replacement therapy.Health Promotion and Maintenance

QUESTION 410
After 12 months of cessation of menses, which of the following assessment findings in a client who is taking hormone replacement therapy should the nurse report to the physician immediately?

A. breast tenderness
B. weight gain
C. fluid retention
D. uterine bleeding

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Uterine bleeding on combination hormone replacement therapy, after 12 months of menses cessation, indicates an increased risk of carcinoma and should be reported to the physician immediately. Breast tenderness, weight gain, and fluid retention are all routine side effects ofhormone replacement therapy. They should be noted in the record and reported to the physician, but they are not urgent.Health Promotion and Maintenance

QUESTION 411
Which of the following statements by a client indicates adequate preparation for magnetic resonance imaging?

A. "I can leave my metal jewelry on during the test."
B. "I need to wear earplugs during the test."
C. "I can have the test even though I have a pacemaker."
D. "I can have the test even though I have an artificial hip."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Due to the loud noises from the scanner moving to obtain images, earplugs need to be worn. No metal objects are allowed, including jewelry, pacemakers, and artificial joints.Reduction of Risk Potential

QUESTION 412

A client expresses anxiety about having magnetic resonance imaging performed. Which of the following is an appropriate response by the nurse?

A. "You can receive a sedative to help you relax during the test."
B. "There is absolutely nothing to worry about."
C. "There is no discomfort with this test, so don't be anxious."
D. "The test won't last long, so you can handle it."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This statement reassures the client that there is a solution for relief of his anxiety. The other responses minimize the client's feelings.Reduction of Risk Potential

QUESTION 413
Which of the following is an indication for electroencephalography?

A. paralysis
B. neuropathy
C. seizure disorder
D. myocardial infarction

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Electroencephalography is indicated for assessing clients with a seizure disorder.Reduction of Risk Potential

QUESTION 414
When a client wishes to improve her appearance by removing excess skin from her face and neck, the nurse should provide teaching regarding which of the following procedures?

A. dermabrasion
B. rhinoplasty
C. blepharoplasty
D. rhytidectomy

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Rhytidectomy is the procedure for removing excess skin from the face and neck. It is commonly called a face-lift. Dermabrasion involves the spraying of a chemical to cause light freezing of the skin, which is then abraded with sandpaper or a revolving wire brush. It is used to remove facial scars, severe acne, and pigment from tattoos. Rhinoplasty is performed to improve the appearance of the nose and involves reshaping the nasal skeleton and overlying skin. Blepharoplasty is the procedure that removes loose and protruding fat from the upper and lower eyelids.Health Promotion and Maintenance

QUESTION 415
All of the following are clinical manifestations indicating male climacteric except:

A. hot flashes.
B. loss of reproductive ability.
C. headaches.
D. heart palpitations.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The likelihood of fathering children does decrease with aging and decreased testosterone production, but men do not lose their ability to reproduce during the climacteric. Many men do not experience any physical symptoms of climacteric but some men do report hot flashes, headaches, and heart palpitations, among other symptoms.Health Promotion and Maintenance

QUESTION 416
When a middle-age woman says to the nurse, "I'm really worried about menopause. When my mom went through it, she got really depressed." The nurse's best response is:

A. "It is a myth that women get depressed because of menopause."
B. "Menopause is a normal developmental process."
C. "It sounds like you are worried that you might become depressed during menopause."
D. "When women experience depression during menopause it is usually because of social stresses."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Choice 3 not only acknowledges the client's fear but invites more disclosure and discussion. Reflective listening is very therapeutic and in this case acknowledges the woman's unspoken fear that she might become depressed like her mother. When her fears have been acknowledged and she feels that the nurse understands, she will be more open to the teaching or interventions to follow. It is a myth that menopause causes depression, but to say that to this client does not acknowledge the fear she shared with the nurse and gives the impression the nurse doesn't care about her concern. It closes down communication. It is also true that menopause is a normal developmental process. This can certainly be used in teaching but not to address her immediate concern; the client might feel the nurse doesn't think her concern is appropriate because menopause is normal. If women experience depression during menopause, it is usually due to social stresses such as loss of loved ones, loss of roles, caregiver demands, and physical problems. Choice 4 is true but is a nontherapeutic response in this situation.Health Promotion and Maintenance

QUESTION 417
When a woman is receiving postpartum epidural morphine, the nurse should plan to observe for which of the following side effects to occur within the first 3 hours?

A. nausea and vomiting
B. itching
C. urinary retention
D. somnolence

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:

Explanation:
A side effect of postpartum epidural morphine is the onset of itching within 3 hours of injection and lasting up to 10 hours. Nausea and vomiting might occur 47 hours after injection. Urinary retention is a side effect of postpartum epidural morphine but is not assessed as such within the first 3 hours. Somnolence is a rare side effect.Health Promotion and Maintenance

QUESTION 418
The teaching plan for a postpartum client who is about to be discharged should include which of the following instructions?

A. "It is normal for your breasts to be tender. You should call the physician if you also have redness and fatigue."
B. "Because your baby was delivered vaginally, you might have to urinate more frequently."
C. "It is normal to run a low-grade temperature for a few days. If it is higher than 100°F, call your physician."
D. "Be sure to call your physician if your vaginal discharge becomes bright red."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The vaginal discharge after birth is called lochia, and it changes from red (rubra) to serosa (clear) on the third postpartum day. If it returns to red or contains clots, it could signal impending hemorrhage or infection and the physician should be notified. It is not normal for the breasts to be tender. If the breasts become engorged, they might be tender and the mother might need to be given additional instructions on breast care. Tenderness, redness, and fatigue are clinical manifestations of mastitis and should be reported to the physician. A woman should void in normal patterns and frequency after birth. Increased frequency is a sign of a urinary tract infection and should be reported to the physician. By the time of discharge, the woman's temperature should be normal. Elevations should be reported to the physician.Health Promotion and Maintenance

QUESTION 419
The parents of a 2-year-old child ask the nurse how they can teach their child to quit taking toys away from other children. Which of the following statements by the nurse offers the parents the best explanation of their child's behavior?

A. "Your child is egocentric. Egocentricity is normal for 2-year-old children. He believes other children want him to have their toys."
B. "Your child is showing negativity. He doesn't want other children to have the toys he wants."
C. "Your child is demonstrating magical thinking. He believes he can make the other children want him to play with their toys."
D. "Your child is engaging in domestic imitation. He is doing what he has seen other children do."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Two-year-old children are very egocentric. They believe everything and everyone is concerned about them. They believe other children want them to have their toys. This is different than believing they can make other children want them to have all the toys, as in magical thinking, which normally occurs in preschool-age children. Toddlers are very negative, but this is expressed by refusal of requests made to them. Domestic imitation does occur in preschool-age children, but it refers to the imitation of household chores and roles performed by adults, not the imitation of other children.Health Promotion and Maintenance

QUESTION 420
Which of the following infant behaviors demonstrates the concept of object permanence?

A. The infant cries when his mother leaves the room.
B. The infant looks at the floor to find a toy that he was playing with and dropped.
C. The infant picks up another toy after the one he was playing with rolls under the couch.
D. The infant participates in a game of patty-cake.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Object permanence occurs when the infant learns that something/someone still exists even though they might not be able to see it/them. This develops between 9 and 10 months of age. If the infant cries when his mother leaves the room, it might be because he believes she is no longer in the house when he can't see her. If an infant picks up another toy after the one he is playing with rolls under the couch and the infant fails to look for it, he believes the toy that rolled under the couch no longer exists. Patty-cake is a game infants engage in but, it has nothing to do with object permanence. An infant game that does show object permanence is peek-a-boo. In thisgame, an infant continues to hunt for a hidden face because he believes it is still there.Health Promotion andMaintenance

QUESTION 421
Which of the following home-care strategies is most likely to negatively impact the body image of a client with Cushing's syndrome?

A. providing safety measures to prevent falls
B. taking medications as prescribed
C. wearing a medical ID indicating Cushing's syndrome
D. having regular health assessments

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of the strategies listed are included in home care for the client with Cushing's syndrome. Choice 3 is the best answer because wearing a medical ID is a visible sign that something is wrong and a constant reminder to the client that he or she has a loss of body function. Choice 1 might enhance body image because it prevents falls that could cause further injury and debilitation. Taking medications as prescribed should enhance body image because it decreases the symptoms present. Having regular health assessments indicates an enhanced body image because it signals the desire to take care of the body and keep it at its best.Health Promotion and Maintenance

QUESTION 422
Which of the following medications should be held 2448 hours prior to an electroencephalogram (EEG)?

A. Lasix (furosemide)
B. Cardizem (diltiazem)
C. Lanoxin (digoxin)
D. Dilantin (phenytoin)

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Anticonvulsants (such as Dilantin), tranquilizers, barbiturates, and other sedatives should be held 2448 hours prior to an EEG. The other medications do not fall into these classifications.Reduction of Risk Potential

QUESTION 423
Which of the following statements by a client indicates adequate understanding of preparation for electroencephalography?

A. "I cannot eat or drink after midnight."
B. "I need to wash my hair before the test."
C. "I need to remove metal jewelry."
D. "I cannot take aspirin before the test."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client needs to wash his hair to remove hair spray, cream, or oil that might interfere with attaching the electrodes to the scalp. Food or fluids do not need to be restricted, with the exception of caffeinated fluids. There is no restriction on metal objects. Aspirin is not a medication that needs to be held before the test (just anticonvulsants, tranquilizers, barbiturates, and other sedatives).Reduction of Risk Potential

QUESTION 424
A nurse is caring for a client with an elevated urine osmolarity. The nurse should assess the client for:

A. fluid volume excess.
B. hyperkalemia.
C. hypercalcemia.
D. fluid volume deficit.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

For a client with an elevated urine osmolarity, the nurse should assess the client for fluid volume deficit.Physiological Adaptation

QUESTION 425
A physician orders a serum creatinine for a hospitalized client. The nurse should explain to the client and his family that this test:

A. is normal if the level is 4.0 to 5.5 mg/dl.
B. can be elevated with increased protein intake.
C. is a better indicator of renal function than the BUN.
D. reflects the fluid volume status of a person.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A serum creatinine level should be 0.7 to 1.5 mg/dl, and it does not vary with increased protein intake, so it is a better indicator of renal function than the BUN.Physiological Adaptation

QUESTION 426
One of the major functions of the kidneys in maintaining normal fluid balance is:

A. the manufacture of antidiuretic hormone.
B. the regulation of calcium and phosphate balance.
C. the regulation of the pH of the extracellular fluid.
D. the control of aldosterone levels.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Major functions of the kidneys in maintaining normal fluid balance include regulation of extracellular fluid and osmolarity by selective retention and excretion of fluids, regulation of pH of the extracellular fluid by retention of hydrogen ions, and excretion of metabolic wastes and toxic substances. ADH is manufactured by the pituitary, and the parathyroid regulates calcium and phosphate balance.Physiological Adaptation

QUESTION 427
A nurse is caring for a client with an elevated cortisol level. The nurse can expect the client to exhibit symptoms of:

A. urinary excess.
B. hyperpituitarism.
C. urinary deficit.
D. hyperthyroidism.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.Physiological Adaptation

QUESTION 428
The anemias most often associated with pregnancy are:

A. folic acid and iron deficiency.
B. folic acid deficiency and thalassemia.
C. iron deficiency and thalassemia.
D. thalassemia and B12 deficiency.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Folic acid and iron deficiency anemia are the most common anemias, prevalent in women of childbearing age with 50% of pregnant women having this type of anemia. Iron deficiency anemia during pregnancy is a result (usually) of the increase in the plasma level during pregnancy but not in the constituent level. Also, if a woman has this type of anemia prepregnancy, it gets worse during pregnancy.Physiological Adaptation

QUESTION 429
Neural tube defects in the fetus have been primarily associated with which deficiency in the mother?

A. iron
B. folic acid
C. vitamin B12
D. vitamin E

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Folic acid is essential for the development of the neural tube and might prevent the defect or failure of the tube to close (congenital anomalies).Physiological Adaptation

QUESTION 430
Elderly persons with pernicious anemia should be instructed:

A. to increase their dietary intake of foods high in B12.
B. that they do not need to return for follow-up for at least a month after initiation of treatment.
C. that oral B12 is safer and less expensive than parenteral replacement.
D. that diarrhea can be a transient side effect of B12 injections.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pernicious anemia is a megaloblastic, macrocytic, normochronic anemia caused by a deficiency of the intrinsic factor produced by the stomach. This results in malabsorption of vitamin B12, which is necessary for DNA synthesis and maturation of RBC. Education should include side effects of Vitamin B12, which can include pain and burning at the injection site, peripheral vascular thrombosis, and transient diarrhea.PhysiologicalAdaptation

QUESTION 431
Which of the following should be included in a diet rich in iron?

A. peaches, eggs, beef
B. cereals, kale, cheese
C. red beans, enriched breads, squash
D. legumes, green beans, eggs

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Home sources of iron that can be absorbed in the body include meat, poultry, and fish. In addition, these sources contain a factor that helps to enhance iron absorption of nonheme sources. Eating Vitamin C at the same time as iron sources also helps to promote iron absorption.High calcium intake in the diet promotes the absorption of iron because it helps to bind to phytates and thereby limits their effect.Physiological Adaptation

QUESTION 432
The presence of which hormone in the urine is specifically indicative of pregnancy?

A. estrogen
B. progesterone
C. testosterone
D. human chorionic gonadotropin

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Human chorionic gonadotropin is found in the urine during pregnancy and specifically indicates pregnancy. The other hormones do not.Reduction of Risk Potential

QUESTION 433
Increased cortisol levels might be found in a client with which condition?

A. Cushing's syndrome
B. Addison's disease
C. renal failure
D. congestive heart failure

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cushing's syndrome produces elevated cortisol levels. Addison's disease produces decreased cortisol levels. The other conditions are not associated with cortisol levels.Reduction of Risk Potential

QUESTION 434
Which of the following is not a function of parathyroid hormone?

A. moving calcium from bones to the bloodstream
B. promoting renal tubular reabsorption of phosphorus
C. promoting renal tubular reabsorption of calcium
D. enhancing renal production of vitamin D metabolites

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Parathyroid hormone depresses renal tubular reabsorption of phosphorus. All of the other choices are functions of parathyroid hormone.Reduction of Risk Potential

QUESTION 435
For which condition might a client's antidiuretic hormone (ADH) level be increased?

A. diabetes mellitus
B. diabetes insipidus
C. hypothyroidism
D. hyperthyroidism

Correct Answer: B

Section: (none)
Explanation

Explanation/Reference:
Explanation:

ADH level is increased in the client with nephrogenic diabetes insipidus.Reduction of Risk Potential

QUESTION 436
Which of the following represents a normal serum potassium level?

A. 1.5 mEq/L
B. 3.0 mEq/L
C. 4.0 mEq/L
D. 6.0 mEq/L

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Normal serum potassium levels fall in a range of 3.55.5mEq/L. The other choices listed fall below or above this range.Reduction of Risk Potential

QUESTION 437
In alcoholics with anemia:

A. pernicious anemia is more common than folic acid deficiency.
B. iron deficiency and folic acid deficiency can coexist.
C. the alcohol interferes with iron absorption.
D. oral vitamin replacement is contraindicated.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The ingestion of nonfood substances (alcohol) can lead to a clinical iron deficiency and might actually be the first sign of a problem. The client might substitute alcohol for a nutrition program that fosters a positive health habit.Physiological Adaptation

QUESTION 438
A female client complains to the nurse at the health department that she has fatigue, shortness of breath, and lightheadedness. Her history reveals no significant medical problems. She states that she is always on a fad diet without any vitamin supplements. Which tests should the nurse expect the client to have first?

A. peptic ulcer studies
B. complete blood count, including hematocrit and hemoglobin
C. genetic testing
D. hemoglobin electrophoresis

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The initial tests to determine the basis for her symptoms (considering her fad dieting) should be a complete blood count, urinalysis, blood sugar, and other tests. The decision about further testing is then made based on these results, her history, and other factors.Physiological Adaptation

QUESTION 439
The nurse should consider which of the following as a possible cause for the symptoms experienced by the client in Question 28?

A. iron deficiency
B. folate deficiency
C. peptic ulcer
D. iron overload

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Due to her symptoms of fatigue, shortness of breath, lightheadedness, her gender, and her fad dieting, the cause is most likely iron deficiency.Physiological Adaptation

QUESTION 440
What is pica?

A. dependency on alcohol
B. increased iron in the diet
C. the sickle cell trait
D. eating ice

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pica represents the ingestion of nonfood substances that leads to a clinical iron deficiency and might actually be the first sign of a problem. Clients eat a wide range of nonfood items, including ice, clay, dirt, and paste.Physiological Adaptation

QUESTION 441
Which of the following viruses is most likely to be acquired through casual contact with an infected individual?

A. influenza virus
B. herpes virus
C. cytomegalovirus (CMV)
D. human immunodeficiency virus (HIV)

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Influenza virus is transmitted through respiratory droplets. Herpes virus is transmitted by direct contact, and HIV is transmitted through blood and body fluids. Cytomeglaovirus is an opportunistic

infection.PhysiologicalAdaptation

QUESTION 442
A female prostitute enters a clinic for treatment of a sexually transmitted disease. This disease is the most prevalent STD in the United States. The nurse can anticipate that the woman has which of the following?

A. herpes
B. chlamydia
C. gonorrhea
D. syphilis

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Epidemiological studies indicate that chlamydia is the most prevalent sexually transmitted disease in the United States.Physiological Adaptation

QUESTION 443
Nurses should understand the chain of infection because it refers to:

A. the linkages between various forms of microorganisms.
B. the sequence required for transmission of disease.
C. the clustering of bacteria in a specific pattern.
D. increasing virulence patterns among species of microorganisms.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Infection occurs in a predictable sequence requiring virulence, movement from a reservoir, and entry into a susceptible host.Physiological Adaptation

QUESTION 444
Which of the following microorganisms is easily transmitted from client to client on the hands of health care workers?

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A. mycobacterium tuberculosis
B. clostridium tetani
C. staphylococcus aureus
D. human immunodeficiency virus

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Staphylococcus aureus microorganisms are ubiquitous and easily transmitted by health care workers who fail to conduct routine hand washing between clients. Tuberculosis is almost always transmitted by the airborne route, and tetanus usually results from exposure to dirt. HIV is a weak virus that does not live long outside the body.Physiological Adaptation

QUESTION 445
Which of the following blood pressure parameters indicates PIH? Elevation over a baseline of:

A. 30 mmHg systolic and/or 15 mmHg diastolic.
B. 40 mmHg systolic and/or 20 mmHg diastolic.
C. 10 mmHg systolic and/or 5 mmHg diastolic.
D. 20 mmHg systolic and/or 20 mmHg diastolic.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

These are the accepted parameters for mild PIH. Mild preclampsia includes an increase in systolic blood pressure higher than 30 mmHg or an increase in diastolic blood pressure higher than 15 mmHg, noted on two readings taken 6 hours apart (or 140/90).Physiological Adaptation

QUESTION 446
When discussing possible complications of pregnancy with a client, the nurse should explain that all of the following are symptoms of urinary tract infection (UTI). Which of the following is least indicative of UTI during pregnancy?

A. low-back pain
B. urinary frequency
C. GI distress
D. malaise

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Urinary frequency is least indicative of UTI during pregnancy because it is a common minor discomfort of pregnancy and is caused by pressure of the growing uterus on the bladder. As the uterus rises in the second trimester, there are no problems. Frequency returns in the third trimester when the uterus drops into the pelvic cavity. A UTI has the symptoms of frequency, back pain, supra pubic discomfort, and malaise and is diagnosed by laboratory findings.Physiological Adaptation

QUESTION 447
When assessing a client in the Emergency Department whose membranes have ruptured, the nurse notes that the fluid is a greenish color. What is the cause of this greenish coloration?

A. blood
B. meconium
C. hydramnios
D. caput

Correct Answer: B
Section: (none)

Explanation

Explanation/Reference:
Explanation:

Greenish amniotic fluid passed when the fetus is in a cephalic (head) presentation might indicate fetal distress. A fetus in the breech presentation passes meconium due to compression on the intestinal tract.Physiological Adaptation

QUESTION 448
With a breech presentation, the nurse must be particularly alert for which of the following?

A. quickening
B. ophthalmia neonatorum
C. pica
D. prolapsed umbilical cord

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Prolapsed umbilical cord is the descent of the umbilical cord into the vagina before the fetal presenting part and compression of the cord between the presenting part and the maternal pelvis, compromising or completely cutting off fetoplacental perfusion. This is an emergency situation; immediate delivery should be attempted to save the fetus.Physiological Adaptation

QUESTION 449
Which of the following diseases places a client at risk for developing cirrhosis?

A. type I diabetes
B. alcoholism
C. leukemia
D. glaucoma

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Alcoholism places a client at risk for developing cirrhosis. None of the other choices are related to cirrhosis.Physiological Adaptation

QUESTION 450
Which of the following nursing diagnoses is most appropriate for the client experiencing acute pancreatitis?

A. Confusion
B. Latex Allergy
C. Acute Pain
D. Constipation

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acute Pain is most appropriate for the client experiencing acute pancreatitis.Physiological Adaptation

QUESTION 451
Which of the following is not a primary function of the kidneys?

A. blood pressure control
B. vitamin D activation
C. erythropoietin production
D. reabsorbing waste products

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of the choices are functions of the kidneys except reabsorbing waste products. The kidneys excrete waste products.Physiological Adaptation

QUESTION 452
A client with urinary tract calculi needs to avoid which of the following foods?

A. lettuce
B. cheese
C. apples
D. broccoli

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client with urinary tract calculi needs to avoid cheese, which has high calcium content. The other foods do not.Physiological Adaptation

QUESTION 453
Which type of exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence?

A. Kegel
B. resistance
C. passive
D. stretching

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Kegel exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence.Physiological Adaptation

QUESTION 454
A standard walker is used when clients:

A. have poor balance, cannot stand up, have weak arms, and have good hand strength.
B. have poor balance, have a broken leg, or have experienced amputation.
C. have poor balance, have cardiac problems, or cannot use crutches or a cane.
D. have poor balance, have an autoimmune disease, or have weak arms.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A walker is used for clients who have balance problems, cardiac problems, or cannot use crutches or a cane. The client needs to bear partial weight and have strength in her wrists and arms. The client uses her upper body to propel the walker forward.Basic Care and Comfort

QUESTION 455
Safety measures for using crutches must be taught to clients. Safety measures for the use of crutches include:

A. properly fitting crutches with rubber tips at the end that provide a four-point gait.
B. properly fitting crutches, education in the appropriate gait, and strength in the arms.
C. crutches that fit the way the client chooses and a gait chosen by client.
D. both legs touching the floor for all gaits.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In addition to the rubber tips on the ends of the crutches, the client needs to know the appropriate gait. Arm strength exercises are important, and it is critical that the client be fitted properly for the crutches.BasicCare and Comfort

QUESTION 456
The hydraulic lift (Hoyer lift) is:

A. used for all clients who've had orthopedic surgery.
B. used for all clients who are not able to stand and for extremity obese clients.
C. used for all clients, both old and young, in a hospital setting.
D. not an assistive device for special needs.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The hydraulic lift is used for safe transfer when a client is not able to stand or is too heavy for the health care workers to lift safely.Basic Care and Comfort

QUESTION 457
An 80-year-old aphasic CVA client had abdominal surgery 2 days ago. Which of the following puts this client at the highest risk for inadequate pain management?

A. inability to turn, cough, and breathe deeply
B. inability to communicate pain

C. inability to ambulate freely
D. inability to use a bedside commode

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The client cannot speak to alert the nurse to his pain state. The nurse needs to provide alternate methods of communication with the client.Basic Care and Comfort

QUESTION 458
A client is to have an enema to reduce flatus. The enema tube should be inserted:

A. 4 inches.
B. 6 inches.
C. 2 inches.
D. 8 inches.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Enema tubing must be passed beyond the internal sphincter. Two inches is not far enough to pass the internal sphincter. Both 6 and 8 inches are too far and might cause trauma to the bowel.Basic Care and Comfort

QUESTION 459
A client with cirrhosis of the liver presents with ascites. The physician is to perform a parancentesis. For safety, the nurse should ask the client to:

A. drink 1000 cc prior to the procedure to affect fluid loss.
B. eat foods low in fat.
C. empty his bladder prior to the procedure.
D. assume the prone position.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When performing a parancentesis, the client must be sitting up to allow the fluid to settle to the lower abdomen. To prevent trauma to the bladder while inserting a needle to aspirate the fluid, the bladder must be empty.Basic Care and Comfort

QUESTION 460
A spinal change occurring with pregnancy that alters mobility is:

A. scoliosis.
B. kyphosis.
C. lordosis.
D. ankylosing spondylitis.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The spinal change occurring with pregnancy is lordosis. This occurs due to the weight of the enlarging uterus and the affect of gravity.Basic Care and Comfort

QUESTION 461
Physical examination of a client regarding mobility status should:

A. begin with gait.
B. be oriented to time, place, and person.
C. begin with the Romberg test.
D. begin with the Tandem Walk test.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Gait is usually assessed as the client walks into the room. Normal gait is smooth, flowing, and rhythmic without assistive devices.Basic Care and Comfort

QUESTION 462
The nurse is turning a client who has a new prosthetic hip. Which position should be avoided to prevent injury to the new prosthetic hip?

A. abduction of the hip
B. adduction of the hip
C. flexing the hip at 80°flexion
D. flexing the hip at 90°

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

New prosthetic hips should have an abduction pillow in place to avoid adduction.Basic Care and Comfort

QUESTION 463
Nail and foot care are essential in meeting basic hygiene needs of clients. Important assessments by the nurse in this area include:

A. all body assessment, including the feet and nails.
B. the essential lab work of the client.
C. the nail beds and the tissue surrounding the nails.
D. foot corns and calluses only.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:

Explanation:

The nail beds and the tissue surrounding the nails should be assessed for abnormal discoloration, lesions, paronychia (infection of tissue surrounding the nail), tissue dryness, breaks in the skin, pressure areas, or other abnormal appearances.Basic Care and Comfort

QUESTION 464
For a client requiring total oral care, it is important for the nurse to:

A. assemble all equipment, assist the client tosemi-Fowler's position, and place a towel on his chest.
B. place client in Fowler's position, prepare the equipment, and tell the client what to do.
C. assemble all equipment, place the client in a side-lying position, and place a towel under his chin.
D. use gloves and clean the client's mouth, including the tongue.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Assemble all equipment first; place the client in a side-lying position so that fluid can easily flow out or pool in the side of the mouth for suctioning (to prevent aspiration); and then place a towel under the client's chin and a curved basin against the chin. Gloves should be worn.Basic Care and Comfort

QUESTION 465
Client room environments should include:

A. a made bed, fresh water, thermostat regulation, and clean floors in all occupied client areas.
B. a made bed, comfort and safety, a clutter-free area, hygiene articles nearby.
C. accident prevention, comfort, a room (including furniture) that has been cleaned with chloroseptic wash, a bed that is made every other day.
D. odor control (by spraying the room with deodorizers), closet storage of all client objects, a clean room. (Gloves should be worn when cleaning.)

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Preparing a client's room environment should include making the client's bed, ensuring comfort and safety at all times, keeping the area free of clutter, and keeping the client's hygiene articles nearby. All procedures should be explained before they are performed, and the client should assist with personal arrangement of articles.Basic
Care and Comfort

QUESTION 466
When a client who is 25 years of age asks the nurse when she should seek fertility counseling, the best response by the nurse is:

A. "Fertility counseling should be sought when you have been unable to conceive after 1 year of unprotected intercourse."
B. "Fertility couseling should be sought when you have not been able to conceive after 69 months of unprotected intercourse."
C. "The average time it takes someone your age to conceive is 51/2 months, so if you haven't conceived by then, we can refer you."
D. "We can give you some guidance now on how to increase your chances of conceiving and then refer you if it doesn't happen within a year."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The guidelines for a fertility workup are to refer after the couple has not conceived after one year of unprotected intercourse. So, Choice 1 is technically correct, but it doesn't consider the immediate need for the couple to have some counseling. Choice 4 is the best answer because it gives the couple guidance now and the referral at the appropriate time. If the woman is over the age of 35, an earlier referral, at six to nine months of unprotected intercourse, is appropriate. It is true that the average time it takes a 25-year-old woman to conceive is 5.3 months, but that does not address the concern the client is expressing. Choice 4 is still the most caring and correctanswer. Couples conceive within the first month of unprotected intercourse 20% of the time.Health Promotion and Maintenance

QUESTION 467
When a couple experiencing infertility presents for a fertility workup, which of the following procedures should the nurse prepare the couple to have first?

A. hysterosalpingography
B. semen analysis
C. endometrial biopsy
D. transvaginal ultrasound

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Because semen analysis is the least invasive of the tests listed and because in 35% of the cases the infertility is related to a male factor, semen analysis should be one of the first diagnostic tests performed. Hysterosalpingography fills the uterus and fallopian tubes with a radiopaque substance that can be seen with an X ray. It demonstrates tubal patency or any distortion of the uterine cavity. Endometrial biopsy provides information about the effects of progesterone after ovulation and the endometrial receptivity. Transvaginal ultrasound is mostly used in the treatment of infertility. For diagnosis it allows the endocrinologist to evaluate the developing follicle, assess oocyte maturity, and diagnose luteal phase defects. All the tests listed in Choices 1, 3, and 4 are more invasive, require greater expertise to evaluate and treat, and are more costly. If the semen analysis is normal, the couple can expect to progress through these tests as well.Health Promotion and Maintenance

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QUESTION 468
Which of the following actions should a nurse take first for a client who has just vomited 300 cc of bright red blood?

A. Document the vomiting.
B. Increase the IV fluids.
C. Get a complete blood count.
D. Check the blood pressure.

Correct Answer: D

Section: (none)
Explanation

Explanation/Reference:
Explanation:

The blood pressure should be checked first for a client who has just vomited 300 cc of bright red blood, to determine whether the client is hypotensive. The other actions can be taken later.Reduction of Risk Potential

QUESTION 469
Which of the following statements indicates adequate dietary understanding in a client with constipation?

A. "I should decrease my intake of fluids."
B. "I should decrease my level of activity."
C. "I should increase my intake of apples."
D. "I should increase my intake of milk."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Apples are a source of high fiber, which decreases constipation. A constipated client needs to increase fluids and activity level. Milk is not a high-fiber food.Reduction of Risk Potential

QUESTION 470
Which cultural group has the highest incidence of inflammatory bowel disease (IBD)?

A. Asians
B. Caucasians
C. Hispanics
D. African Americans

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Caucasians have the highest incidence of inflammatory bowel disease (IBD).Reduction of Risk Potential

QUESTION 471
Which of the following nursing diagnoses is most appropriate for a client with a new colostomy?

A. Excess Fluid Volume
B. Risk for Aspiration
C. Disturbed Body Image
D. Urinary Retention

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Disturbed Body Image is the most appropriate nursing diagnosis for a client with a new colostomy, due to the adjustments that need to be made with the physical alteration of a colostomy. The other diagnoses are not applicable.Reduction of Risk Potential

QUESTION 472
Which of the following foods can cause diarrhea when eaten by a client with an ileostomy?

A. eggs
B. coffee
C. fish
D. garlic

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Coffee might cause diarrhea in a client with an ileostomy. The other foods might cause odor.Reduction of Risk Potential

QUESTION 473
In infants and children, the side effects of firstgeneration over-the counter (OTC) antihistamines, such as diphenhydramine (Benedryl) and hydroxyzine (Atarax), can include:

A. Reye's syndrome.
B. cholinergic effects.
C. paradoxical CNS stimulation.
D. nausea and diarrhea.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Typically, first-generation OTC antihistamines have a sedating effect because of passage into the CNS. However, in some individuals, especially infants and children, paradoxical CNS stimulation occurs and is manifested by excitement, euphoria, restlessness, and confusion. For this reason, use of first-generation OTC antihistamines has declined and second-generation product use has increased. Reye's syndrome is a systemic response to a virus. First-generation OTC antihistamines do not exhibit a cholinergic effect. Nausea and diarrhea are uncommon with first-generation OTC antihistamines.Pharmacological Therapies

QUESTION 474
The nurse can promote relief of muscle pain, spasms, and tension by:

A. having the client continue his activities as usual.
B. immobilizing the client.
C. applying heat, cold, pressure, or vibration to the painful area.
D. giving as much pain medication as needed to ease the muscle.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Superficial heat and cold, massage, pressure, or vibration can be applied to alleviate pain associated with muscle tension, pain, or spasms.Nonpharmacological Therapies

QUESTION 475
Nonpharmacological pain management involves all of the following except:

A. hypnosis alone.
B. psychological care, including support groups.
C. physical and psychological modalities.
D. pain-reducing drugs only.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All physical and psychosocial therapies can be used concurrently with drugs and other modalities to manage pain. These interventions can be carried out by the nurse with the client and family.Basic Care and Comfort

QUESTION 476
The nurse is using Cognitive-Behavioral methods of pain control and knows that the these methods can be expected to do all the following except:

A. completely relieve all pain.
B. provide benefit by restoring the client's sense of self-control.
C. help the client to control symptoms.
D. help the client actively participate in his or her own care.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

These interventions (strategies) help the client in all areas of client well-being. Focusing on perception and thought, cognitive techniques are designed to influence how one interprets events and bodily sensations.BasicCare and Comfort

QUESTION 477
Which is an appropriate outcome for the nursing diagnosis of Body Image Disturbance for a client with anorexia nervosa?

A. The client verbalizes knowledge of a maintenance diet.
B. The client demonstrates assertiveness with family.
C. The client verbalizes her body size accurately.
D. The client demonstrates control of obsessive behaviors.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Part of the problem for anorexic clients is an altered view of their body appearance (visualizing themselves as fat even when they are emaciated). Choice 1 involves a knowledge deficit. Choice 2 involves possible resolution of family-dynamic issues. Choice 4 involves psychological adaptation.Basic Care and Comfort

QUESTION 478

Which type of diet should the nurse provide to help a client who has major burns maintain a positive nitrogen balance?

A. high protein
B. high carbohydrate
C. low carbohydrate
D. low protein

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clients with burns are hypermetabolic and require increased protein levels to maintain a positive nitrogen balance. Choices 2 and 3 are incorrect; carbohydrate levels do not help clients to meet this goal. Choice 4 is incorrect; a client with major burns requires a high-protein diet.Basic Care and Comfort

QUESTION 479
As part of the teaching plan for a client with type I diabetes mellitus, the nurse should include that carbohydrate needs might increase when:

A. an infection is present.
B. there is an emotional upset.
C. a large meal is eaten.
D. active exercise is performed.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Active exercise increases insulin sensitivity, thus lowering blood glucose levels. Additional carbohydrates might be needed to balance the usual insulin dose. All of the other choices increase blood glucose levels.BasicCare and Comfort

QUESTION 480
The NSAID that is comparable to morphine in efficacy is:

A. Feldene.
B. Stodal.
C. Toradol.
D. Elavil.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Toradol is the first injectable NSAID equal to morphine in efficacy.Basic Care and Comfort

QUESTION 481
Pain tolerance in an elderly client with cancer should:

A. Stay the same.

B. Decrease.
C. Increase.
D. Cancer should have no effect on pain tolerance for an elderly client.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

There is potential for a lowered pain tolerance to exist with diminished adaptative capacity.Basic Care and Comfort

QUESTION 482
In administering NSAID adjunctive therapy to an elderly client with cancer, the nurse must monitor:

A. BUN and creatinine.
B. creatinine and calcium.
C. Hgb and Hct.
D. BUN and CFT.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Elder adults might be more at risk for gastric and renal toxicity, increasing among elder adults.Basic Care and Comfort

Topic 6, Questions Set F

QUESTION 483
Appropriate care for a client with neutropenia includes:

A. plenty of fresh fruits and vegetables.
B. a semi-private room.
C. wearing a mask when out of the room.
D. routine hand washing.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When a client is neutropenic (one type of white blood cell), they lack the ability to fight off infection. The mask is to prevent exposure to any upper-respiratory infections. Fresh fruits, vegetables, and flowers can contain pathogens that might infect the neutropenic client. All foods must be thoroughly cooked and plants/ flowers are not allowed. A neutropenic client needs a private room and carefully screened visitors--no one is to enter the room withanysymptoms of an illness (runny nose, sneezing, nausea, and so on). Meticulous, frequent hand washing is called for.Physiological Adaptation

QUESTION 484
The PN is caring for a client with diabetes insipidus. The nurse can expect the lab work to show:

A. elevated urine osmolarity and elevated serum osmolarity.

B. decreased urine osmolarity and decreased serum osmolarity.
C. elevated urine osmolarity and decreased serum osmolarity.
D. decreased urine osmolarity and elevated serum osmolarity.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In diabetes insipidus, the pituitary releases too much antidiuretic hormone (ADH) causing the client to produce a large amount of dilute (decreased osmolarity) urine and causing dehydration (elevated serum osmolarity). Choice 3 might be seen in a client with SIADH (syndrome ofinappropriate ADH). Choices 1 and 2 generally don't occur-- urine and serum osmolarity typically move in opposite directions.Physiological Adaptation

QUESTION 485
If a client is suffering from thyroid storm, the PN can expect to find on assessment:

A. tachycardia and hyperthermia.
B. bradycardia and hypothermia.
C. a large goiter.
D. a calm, quiet client.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In thyroid storm, there is too much thyroxine, causing the client to go faster. Atrial fibrillation and palpitations are also frequently seen. Choices 2, 3, and 4 are associated withhypothyroidism.Physiological Adaptation

QUESTION 486
The best nursing diagnosis for a client with newly diagnosed Diabetes Mellitus is:

A. Impaired Skin Integrity.
B. Knowledge Deficit: New Diabetes Diagnosis.
C. Alteration in Nutrition: More than Body Requirements.
D. Fluid Volume Deficit.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Newly diagnosed diabetics need to learn about their disease, medications, glucose testing, possibly insulin injections, foot care, sick-day plans, and so forth. Choices 1 and 4 are diagnoses to prevent, but no evidence suggests that they exist at this point. Diabetics might have more or less nutrition than body requirements--type II is likely to be more, but type I is likely to be less.Physiological Adaptation

QUESTION 487
After group therapy, the female victim of intimatepartner violence confides to the nurse that she does not feel in any immediate danger. Which of the following statements about victims of domestic violence is true?

A. Victims of domestic violence are often the best predictors of their risk of harm.

B. Victims of domestic violence often overestimate their safety risk.
C. Victims of domestic violence are typically in a state of denial.
D. Victims of domestic violence know that keeping peace with their partner is the best method of preventing another attack.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Victims of domestic violence are often correct at predicting their risk of harm. However, the nurse should ensure that the client is expressing herself authentically and is not trying to convince the nurse that there is no immediate danger. Further, proper authorities, such as the police, should be alerted to this reportable offense.Psychosocial Integrity

QUESTION 488
A 32-year-old female frequently comes to her primary care provider with vague complaints of headache, abdominal pain, and trouble sleeping. In the past, the physician has dutifully prescribed medication, but little else. Which of the following comments by the nurse to the physician is appropriate?

A. "Often women who are victims of domestic violence suffer vague symptoms such as abdominal pain."
B. "Often women become offended if asked about their safety in relationships."
C. "It is mandatory that all women be questioned about domestic violence."
D. "How would you feel to know that her partner is beating her and you didn't ask?"

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

There is a correlation between vague symptoms, such as abdominal pain, and battered syndrome. The astute clinician should question any woman who presents with suspicious symptoms such as these. Rarely are women offended by a properly worded question, such as, "Do you feel safe in your present relationship?" Studies show an increase in case finding when such questions are asked. It is not mandatory that all women are assessed for violence, but it is prudent that allpersons new to a clinician be assessed by at least the one question noted previously. Castigating or shaming the physician typically does not improve client outcomes and might make for a difficult working environment for the nurse. Tactless comments, like the one in Choice 4, are not collegial and should be avoided.Psychosocial Integrity

QUESTION 489
A client reports that someone is in the room and trying to kill him. The nurse's best response is:

A. "No one is in your room. Let's get you more medicine."
B. "I do not see anyone, but you seem to be very frightened."
C. "No one can hurt you here."
D. "Just tell the person to go away."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It is important to acknowledges the client's fear. The other responses deny the client's perceptions. Psychosocial Integrity

QUESTION 490
The nurse is developing a care plan for a client with severe anxiety. An appropriate outcome for the client is that within 4 days the client should:

A. Have decreased anxiety.
B. Talk to the nurse for 10 minutes.
C. Sit quietly for 30 minutes.
D. Develop an adaptive coping mechanism.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Outcome criteria need to be specific, measurable, and realistic. Talking for 10 minutes meets all of these conditions. It is not realistic to expect a severely anxious client to sit quietly for 30 minutes. The other statements
are vague and not measurable.Psychosocial Integrity

QUESTION 491
Which of the following services is not part of family consultation?

A. assisting with vocational rehabilitation
B. providing information about the client's illness
C. teaching effective communication
D. helping families solve problems

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Family consultation does not involve vocational rehabilitation. It involves helping families deal with their feelings, focus, and find solutions. Choices 2, 3, and 4 are components of family consultation.Psychosocial Integrity

QUESTION 492
A family member of a client with a diagnosis of Schizophrenia asks about the prognosis. The nurse's response is based on the knowledge that schizophrenia:

A. affects women more often than men.
B. is usually diagnosed between the ages of 15 and 45.
C. is a chronic, deteriorating disease with periods of remission.
D. is diagnosed later in women due to a protective hormone effect.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Although all of the choices are true about schizophrenia, only Choice 3 answers the question asked. Psychosocial Integrity

QUESTION 493
A client receiving preoperative instructions asks questions repeatedly about when to stop eating the night

before the procedure. The nurse tries torefocus the client. The nurse notes that the client is frequently startled by noises in the hall. Assessment reveals rapid speech, trembling hands, tachypnea, tachycardia, and elevated blood pressure. The client admits to feeling nervous and having trouble sleeping. Based on the assessment, the nurse documents that the client has:

A. mild anxiety.
B. moderate anxiety.
C. severe anxiety.
D. a panic attack.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In severe anxiety, a client focuses on small or scattered details. The person is unable to solve problems. With mild anxiety, stimuli are readily perceived and processed, and the ability to learn and solve problems is enhanced. Moderate anxiety narrows the perceptual field, but the client notices things brought to his attention. During a panic attack, the person is disorganized and might be hyperactive or unable to speak or act.Psychosocial Integrity

QUESTION 494
The highest incident of child abuse occurs in children in which age group?

A. birth3 years old
B. 46 years old
C. 610 years old
D. more than 10 years old

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Children between birth and 3 years of age have the highest rates of victimization (at 16 per 1,000 children). Girls are slightly more likely to be victims than boys.Psychosocial Integrity

QUESTION 495
An adult who had been abused as a child is discussing the group therapy program. Which statement indicates that the client has gained insight?

A. "I think I was a lonely child because I could not tell anyone about my abuse."
B. "I am now aware of how deep-seated my anger is. Before I did not realize I was angry."
C. "The program has given me the courage to tell my mother how I felt about her role in my hurt."
D. "There are so many people just like me, who are just normal people that had bad things happen to them."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Children who are abused learn to cope with the painful experiences by ignoring painful feelings and avoiding getting close to people. As adults, victims of abuse usually continue to repress feelings, avoid close interpersonal relationships, and frequently use alcohol or drugs to block painful memories. Long-term

effects in adults might include criminal/violent behavior (for adult males), substance abuse, and a variety of social and emotional problems (including suicidal thoughts, anxiety, hostility, dissociation, and interpersonal difficulties).Psychosocial Integrity

QUESTION 496
If a client has chronic renal failure, which of the following sexual complications is the client at risk of developing?

A. retrograde ejaculation
B. decreased plasma testosterone
C. hypertrophy of testicles
D. state of euphoria

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Untreated chronic renal failure causes decreased testosterone levels, atrophy of testicles, and decreased spermatogenesis. Retrograde ejaculation is not a complication of chronic renal failure. It is a complication of transurethral resection of the prostate. In chronic renal failure, the testicles atrophy; they do not hypertrophy. Chronic renal failure produces a state of depression, not euphoria.Health Promotion and Maintenance

QUESTION 497
When an elder client asks the nurse whether he will be capable of sexual activity in old age, the best response by the nurse is:

A. "Elder adults are psychologically and physically capable of engaging in sexual activity regardless of age-related changes."
B. "If you haven't been sexually active throughout your life, you will not be able to participate in sexual activity in old age."
C. "When intercourse isn't possible, many of your sexual needs can be met through intimacy and touch."
D. "You might find it takes longer for you to achieve an erection, but you can maintain it for a longer time."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

To provide the best response, the nurse must identify what the elder is asking. Concern is being expressed about whether elders can engage in sexual activity. The most therapeutic response by the nurse is Choice 1. In this choice, the nurse acknowledges that elders can physically engage in sexual activity and have no psychological barriers to the same. All of the other choices contain facts but are not the best initial response. Choice 1 opens the conversation for the expression of further concerns about sexual issues. Choice 2 is true; past sexual function is predictive of sexual function in elder adults. An elder adult must have been sexually active as a younger adult to engage in intercourse in old age. This does not mean, however, that the elder adult cannot experience sexual intimacy in other ways. The need for intimacy is especially important for elder adults. If they have lost meaningful relationships or are having difficulty with intercourse, they might be able to experience intimacy through touch. As males age, they find it takes longer to achieve an erection, but that when it's achieved, the erection lasts longer. In addition, elder males require direct stimulation to achieve an erection.HealthPromotion and Maintenance

QUESTION 498
The teaching plan for gay or lesbian parents who want to disclose their homosexuality to their children should include all of the following instructions except:

A. disclose the information before the child knows or suspects.

B. be comfortable with your sexual preference first.
C. have the discussion in a quiet place where interruptions are unlikely.
D. explain how your relationship with the child changes because of the discussion.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Children of gay and lesbian parents should be reassured that their relationship with their parent will not change because of the discussion. Choices 1, 2, and 3 are all important aspects of the disclosure. As children grow, they might have additional questions. Preschool children might not understand the absence of a father or mother. Schoolage children might be troubled that their family isn't like their friends' families. Adolescents might become reluctant to discuss it or accept it even though they expressed acceptance at an earlier age. In general the earlier children are informed, the easier it is for them to accept and assimilate the information. Nurses need to be nonjudgmental and learn how to express and accept these differences so that they can keep the nurse-child-family relationship intact.Health Promotion and Maintenance

QUESTION 499
When a client describes their family as having multiple wives, all of whom are sisters, married to one man, the nurse documents the family structure as?

A. polyandry
B. soronal
C. nonsororal
D. sororate

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The practice of polygamy refers to having multiple wives or husbands. When there are multiple wives who are sisters, the polygamy is designated as soronal. When the wives are not sisters it is nonsororal. Polyandry refers to multiple husbands and is rare. Some cultures practice a polygamy designated as sororate. Sororate polygamy specifies that a husband must marry his wife's sister if she dies. These marriages are successive rather than concurrent.Health Promotion and Maintenance

QUESTION 500
Which of the following syndromes associated with incomplete lesions of the spinal cord is a result of damage to one-half of the spinal cord?

A. Brown-Séquard syndrome
B. posterior cord syndrome
C. central cord syndrome
D. cauda equina syndrome

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Brown-Séquard syndrome is a result of damage to one-half of the spinal cord. The other choices are also incomplete lesions of the spinal cord, but they have different defining characteristics.Reduction of Risk Potential

QUESTION 501
A client with a spinal cord injury is preparing to return home from the rehabilitation unit. Which of the following statements by a family member indicates a need for further teaching regarding autonomic dysreflexia?

A. "I should raise him to a sitting position."
B. "I should check for a fecal impaction."
C. "I should look for a kink in the urinary catheter tubing."
D. "I should see whether symptoms worsen."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If the client develops signs or symptoms of autonomic dysreflexia, they need to be addressed immediately. If the family member is not able to relieve them, a health care provider needs to be notified immediately. The remaining choices are correct; they are all ways to relieve autonomic dysreflexia.Reduction of Risk Potential

QUESTION 502
Which of the following symptoms is not indicative of autonomic dysreflexia in the client with a spinal cord injury?

A. sudden onset of headache
B. flushed face
C. hypotension
D. nasal congestion

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hypotension is not indicative of autonomic dysreflexia; rather, hypertension is a sign of autonomic dysreflexia. The remaining choices are symptoms of autonomic dysreflexia.Reduction of Risk Potential

QUESTION 503
Which of the following statements by a client with spinal cord injury indicates a need for further teaching by the nurse regarding bowel management?

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A. "I should avoid eating foods that produce gas."
B. "I should drink more fluids like coffee and cola."
C. "I should set a regular schedule for bowel movements."
D. "I should sit in an upright position for bowel movements."

Correct Answer: B

Section: (none)
Explanation

Explanation/Reference:
Explanation:

This statement is incorrect because caffeinated fluids, such as coffee and cola, stimulate fluid loss through urination. Instead, fluids such as water and fruit juices should be taken. The remaining choices indicate correct understanding of bowel management.Reduction of Risk Potential

QUESTION 504
A 20-year-old male client had a diving accident with subsequent paraplegia. He says to the nurse, "No woman will ever want to marry me now." Which of the following responses by the nurse is most therapeutic?

A. "Don't worry. Maybe you'll meet a paraplegic woman."
B. "There is someone for everyone in this world."
C. "You are still an attractive man, even though you can't walk."
D. "Tell me more about your feelings on this issue."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This response is the most therapeutic because it allows the client to discuss his anxieties and fears with the nurse. The other responses do not allow for such a dialogue, so they are not as therapeutic.Reduction of Risk
Potential

QUESTION 505
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. The nurse who was not promoted tells a friend, "Oh, well, I really didn't want the job anyway." This is an example of:

A. rationalization.
B. denial.
C. projection.
D. compensation.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This is called the sour grapes form of rationalization. Rationalization is an unconscious form of self-deception in which excuses are made. Denial is an unconscious process that ignores the existence of the situation. Projection operates unconsciously and results in blaming behavior. Compensation is an attempt to make up for a perceived weakness by emphasizing a strong point.Psychosocial Integrity

QUESTION 506
The nurse who was not promoted tells another friend, "I knew I'd never get the job. The hospital administrator hates me." If she actually believes this of the administrator, who, in reality, knows little of her, she is demonstrating:

A. compensation.
B. reaction formation.

C. projection.
D. denial.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Projection results in unconsciously adopting blaming behavior. It attributes unacceptable attributes to other people. Compensation results in the nurse unconsciously attempting to emphasize a strong point in an attempt to make up for a perceived weakness. Reaction formation unconsciously adopts behavior that is opposite her actual feelings. Denial involves ignoring the existence of an unpleasant reality.Psychosocial Integrity

QUESTION 507
The Token Economy is a type of therapy that focuses on:

A. play therapy.
B. behavior modification.
C. milieu therapy.
D. associative.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Behavior modification gives positive feedback and rewards for appropriate behavior. Behavior modification requires negative behavior if it's not destructive or life threatening.Psychosocial Integrity

QUESTION 508
How does the ANA define the psychiatric nursing role?

A. a specialized area of nursing practice that employs theories of human behavior as its science and the powerful use of self as its art
B. assisting the therapist to relieve the symptoms of clients
C. to solve clients' problems and give them the answers
D. having a client committed to long-term therapy with the nurse

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The ANA sets standards of practice for psychiatric and mental health nursing roles. Quality of care, performance appraisal, education, ethics, collaboration, and research are covered through the use of the Nursing Process.Psychosocial Integrity

QUESTION 509
While admitting a client to an acute-care psychiatric unit, the nurse asks about substance abuse based on knowledge that:

A. psychiatric illness is more prevalent in addicted populations.
B. people with psychiatric disorders are more prone to substance abuse.
C. substance disorders are easily detected and diagnosed in acute-care psychiatric settings.

D. undetected substance problems have no real effect on treatment of psychiatric disorders.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The failure to address substance abuse among clients with psychiatric disorders interferes with treatment effectiveness and contributes to relapse. Misdiagnosis of a psychiatric disorder, suboptimal pharmacological treatment, neglect of appropriate interventions, or an inappropriate referral might also occur.PsychosocialIntegrity

QUESTION 510
When planning care of a client who has a been diagnosed with Amphetamine Abuse, the nurse should use the knowledge that:

A. amphetamines increase energy by increasing dopamine levels at neural synapses.
B. amphetamines have a low risk of tolerance or addiction.
C. amphetamines produce a 1020-second rush followed by a 24-hour high.
D. addiction to barbiturates and amphetamines is rare because they have opposite effects.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Amphetamines cause the release of norepinephrine and dopamine from storage vesicles into the synapse. The increased catecholamines at the receptors causes increased stimulation. Clear patterns of tolerance and withdrawal have not been described. Prolonged or excessive use of amphetamines can lead to psychosis. People use amphetamines for the feelings of euphoria, relief from fatigue, energy, and alertness. Overdose can cause seizures, cardiac arrhythmias, hypertension, and hyperthermia. When abstaining, the client might experience fatigue, depression, and irritability lasting for several weeks. Drug cravings are common and might lead to relapse.Psychosocial Integrity

QUESTION 511
A small amount of bubbling is seen in the water seal of a pleural drainage system when a client coughs. What should the nurse do?

A. Consider it a normal finding.
B. Check the system for leaks.
C. Clamp the chest tube.
D. Change the drainage system.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A small amount of bubbling is a normal finding in the water seal of a pleural drainage system when a client coughs. It is only a problem to find continuous, excessive bubbling in the waterseal, which indicates a leak.Reduction of Risk Potential

QUESTION 512
Which type of dressing is recommended to place over a site when a chest tube is removed by the physician?

A. transparent dressing
B. colloidal dressing
C. petrolatum gauze
D. nonadherent dressing

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Petrolatum gauze is recommended to place over a site when a chest tube is removed by the physician. This is because it forms an airtight seal, which the other choices do not.Reduction of Risk Potential

QUESTION 513
A client begins bleeding from the site of a previous arterial blood gas draw on the right wrist. What should the nurse do first?

A. Check the blood count.
B. Apply pressure to the site.
C. Document the bleeding.
D. Monitor the bleeding.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

If a client begins bleeding from the site of a previous arterial blood gas draw on the right wrist, the nurse should first apply pressure to the site. This prevents further bleeding. The remaining choices can be performed later.Reduction of Risk Potential

QUESTION 514
A nurse walks into a client's room to do an assessment and discovers that the client is unresponsive. The nurse shakes the client and calls his name, but he does not arouse. What should the nurse do next?

A. Open the airway.
B. Give defibrillation.
C. Check the pulse.
D. Call for help.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The first step after determining unresponsiveness is to call for help. The remaining steps might be indicated afterward.Reduction of Risk Potential

QUESTION 515
What is the appropriate ratio of cardiac compressions to ventilations in an adult client for one- person CPR?

A. 5:1

B. 1:5
C. 15:2
D. 2:15

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The appropriate ratio for adult CPR is 15 compressions to 2 ventilations.Reduction of Risk Potential

QUESTION 516
The nurse observes a staff member not following the plan of care for a client with an antisocial personality disorder. The nurse should:

A. confront the staff member immediately and say, "You know that is not the treatment plan."
B. write an incident report to create a paper trail of the staff member's failure to follow the planned program.
C. ask the staff member to talk in private, and reinforce how antisocial clients try to divide staff.
D. bring up the incident during the weekly conference so that this staff member is not assigned to work with antisocial persons again.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It is essential that the treatment program be followed exactly for clients with antisocial personality disorder because they are very manipulative and attempt to divide staff. However, confronting the staff member in front of the client enhances the division of staff. Talking with the staff member in private allows the person to develop skills to work with this client population.Psychosocial Integrity

QUESTION 517
A client diagnosed with Borderline Personality Disorder frequently attempts to burn herself. The best intervention to facilitate behavior change is:

A. constantly observing the client to prevent self-harm.
B. enlisting the client in defining and describing harmful behaviors.
C. checking on the client every 15 minutes to ensure she is not engaging in harmful behavior.
D. removing all items from the environment that the client could use to harm herself.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The challenge when intervening with clients who might harm themselves is to maintain client safety while facilitating behavior change. Enlisting the client to identify the triggers for self-harm makes the client an active participant in treatment. Nurses are less judgmental when they understand the source of the behavior and can be sensitive to client feelings.Psychosocial Integrity

QUESTION 518
During a well-baby check of a 6-month-old infant, the nurse notes abrasions and petechaie of the palate. The nurse should:

A. inquire about foods the child is eating.
B. ask about the possibility of sexual abuse.
C. request to see the type of bottle used for feedings.
D. question the parent about objects the child plays with.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Generally oral sex leaves little physical evidence. Injury to the soft palate (such as bruising, abrasions, and petechaie) and pharyngeal gonorrhea are the only signs. Infants are at risk for sexual abuse.Psychosocial Integrity

QUESTION 519
A woman seeks assistance because she recently remembered childhood sexual abuse. The nurse should include which of the following goals for this client?

A. prosecuting the perpetrator
B. managing symptoms of anxiety and fear
C. determining if the memories are real
D. collaborating the client's story

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
At least 10% of victims of childhood sexual abuse have periods of complete amnesia about the abuse, followed by delayed recall. Controversial evidence suggests that people who have recovered memories have had part of those memories reconstructed by therapists. The nurse's role is not to determine if the memories are real, but to help the client deal with the stress caused by the remembered abuse.Psychosocial Integrity

QUESTION 520
An advance directive is written and notarized according to law in the state of Colorado. This document is legal and binding:

A. internationally.
B. in the state of Colorado only.
C. in the continental United States.
D. in the county of origination only.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Choices 1, 3, and 4 are incorrect. Advance directive protocols and documents are defined by each state. Coordinated Care

QUESTION 521
A nursing advocate is one who:

A. makes decisions for others.

B. encourages persons to make decisions for themselves and acts with or on behalf of the person to support those decisions.
C. manages the care of others.
D. is the legal representative for a person.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nurse advocates work with clients to provide information and assistance is decision-making. The decisions and care that occur from these decisions are based on the right of the client to self- determination and the work of the nurse advocate supports this right.Coordinated Care

QUESTION 522
A case management clinical pathway for congestive heart failure might include all of the following except:

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A. physician follow-up appointments with transportation.
B. client education regarding medication use.
C. a nutritional consult for diet review and accommodation.
D. insurance review for reimbursement.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Clinical pathways include maps of care outcomes to be achieved prior to discharge or movement through a health care system. Insurance review for reimbursement is a function of an outside agency from the health care provider related to the amount of expected monetary compensation for services rendered to a client.CoordinatedCare

QUESTION 523
The nurse notices that a family is waiting at the nursing station desk for its loved one to be brought to the unit for admission during a change-of-shift report. The nurse should:

A. request that the family wait for its loved one in the client's room and wait to resume the report until the family has left the desk area.
B. request that a nursing assistant bring coffee for the family while it waits at the desk and continue with the report.
C. request that the family have a seat in the station rather than stand while awaiting its loved one.
D. request that the family wait for its loved one in the Emergency Department waiting room.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:

Explanation:

To protect the privacy of clients and the confidentiality of the information shared in a change-of- shift report, the family should be asked to wait in the client's room, and the report should be resumed only after it can no longer hear what is said.Coordinated Care

QUESTION 524
The nurse belongs to a professional nursing organization that provides social, educational, and political venues for nurses. The nurse has been active in this organization for almost two years, during which time she meets and works with nurses from several different nursing agencies and health care institutions to achieve a variety of
goals, including obtaining advice regarding a personal career choice. This is an example of:

A. professional nurturing.
B. networking.
C. mentoring.
D. collegiality.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Networking involves the process of developing and using contacts throughout one's professional career for information, advice, and support. Nurturing and mentoring are both examples of assistance to other colleagues in formal and informal relationships for support and career building. Collegiality is the professional camaraderie or rapport established among persons through shared experiences.Coordinated Care

QUESTION 525
A legal right to confidentiality of client information is waived when:

A. a court system subpoenas information.
B. a family member requests health care information of a client.
C. a living will takes effect.
D. the client is declared incompetent by the legal system.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The legal right to confidentiality is waived when the court requires information to be given to the court for legal proceedings to occur (summonses, court orders, litigation information necessary for the court, subpoenas, and so on), when the state requires mandatory reporting of certain illnesses, when sharing information is necessary because a client has revealed an intent to harm himself or others, or when a client cannot make a safe and rational decision (competence).Coordinated Care

QUESTION 526
A gastroenterologist should be consulted for clients suffering from:

A. digestive system diseases.
B. urinary system diseases.
C. female reproductive system diseases.
D. nervous system diseases.

Correct Answer: A

Section: (none)
Explanation

Explanation/Reference:
Explanation:

A gastroenterologist cares for clients with digestive system diseases. A urologist cares for clients with urinary system diseases. A gynecologist cares for clients with female reproductive system diseases. A neurologist cares for clients with nervous system diseases.Coordinated Care

QUESTION 527
A client has experienced a CVA with right hemiparesis and is ready for discharge from the hospital to a long-term care facility for rehab. To provide optimal continuity of care, the nurse should do all of the following except:

A. document current functional status.
B. have the physician phone a report to the receiving facility.
C. copy appropriate parts of the medical record for transport to the receiving facility.
D. phone a report to the facility.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It is the nurse's responsibility to communicate the client's condition and care plan to the receiving facility to support continuity of care. Documentation of the client's baseline functional status is important for the receiving facility to work with in further goal setting. A copy of select portions of the medical record (according to facility policy) is another form of communication and supports continuity. A physician might be asked to be involved if there are specific medical needs or orders that she believe are important, but is generally not involved.Coordinated Care

QUESTION 528
An example of a process standard on a med-surg unit is:

A. a procedure for changing IV tubing.
B. a policy for staffing.
C. the job description of the CEO (chief executive officer).
D. a procedure for checking waveforms on a client being treated on an intra-aortic balloon pump.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Process standards define the actions and behaviors required by staff to provide care. A procedure for changing IV tubing is a psychomotor skill that is applied to helping clients meet their goals.Coordinated Care

QUESTION 529
Which direction given to the nursing assistant is most likely to accomplish the task of getting a urine specimen delivered to the lab immediately after collection?

A. "Make it a stat delivery."
B. "Please do it as soon as you can after break."
C. "This client is delirious, and we're worried about a urinary sepsis."
D. "Take this client to the bathroom now and collect a urine specimen from this voiding. Take the

specimen to the lab immediately."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Effective delegation depends on clear, concise direction that leaves no room for question or interpretation on
the part of the one being delegated to. Nursing assistants have a limited understanding of medical conditions and
terminology, and should not be relied on to prioritize such tasks.Coordinated Care

QUESTION 530
Priorities to be considered intermediate are:

A. the nonemergency, non-life-threatening needs of the client.
B. those tasks that can be delegated to assistive personnel.
C. those tasks that can be performed at the end of the shift.
D. those task that can be performed at any time.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Priorities designated asintermediateby the nurse are those that are not urgent. They do not affect the client's immediate physiological status. This does not imply that they are not important or not necessary. Intermediate priorities might still require the skill level of an RN for completion. There might be specific time requirements for completion as well.Coordinated Care

QUESTION 531
A mother has come to the pediatric clinic concerned about the recent outbreak of West Nile Virus. The ages of her children are 5, 7, and 10. The mother has asked the nurse what she can do to prevent her children from contracting this illness. Which piece of information is best to provide the mother with?

A. The children should wear long sleeves and long pants while outside.
B. Apply insect repellant containing DEET when the children are outside.
C. Remove standing water from the property.
D. All of the above.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

It is recommended that the children wear insect repellant containing DEET and long-sleeve shirts and long pants when they are outside. Removing standing water from areas around where the children play can help decrease the number of breeding mosquitoes. These are the only known methods of prevention at this time.Health Promotion and Maintenance

QUESTION 532
The home health nurse has made a visit to an 85-year-old female client's home who has recently had surgery to replace her left knee. The client has been discharged from a rehab facility and has been able to walk on her own. The nurse assesses the need for teaching related to fall prevention. What should the nurse include in this teaching plan?

A. The client should remove all scatter rugs from the floor and minimize clutter.
B. The client should not get up and move around the house.
C. The client does not need to install a raised toilet and grab bar because she is able to walk on her own.
D. The client should wear a robe and socks while walking in the house.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Rugs and clutter are a primary cause of falls in the home and should be eliminated if possible to decrease the risk of a fall. The elderly and those with gait issues are at an increased risk for a fall at home. The client should have a raised toilet seat and grab bars available in the bathroom to aid in movement in this potential slippery area of the home. Some clients find it difficult to rise up and down from the toilet and to get in and out of the shower. These items are all important in maintaining safety in the home. The client should not limit her movement within the home unless ordered by the physician. This decreases the ability of the client to perform activities of daily living and hinders the client's return to a normal lifestyle after surgery. The client should notwear baggy clothing such as long robes, and the client should not wear socks on slippery floors. These items can cause the client to trip, slip, or fall.Health Promotion and Maintenance

QUESTION 533
Issues addressed in ethics committees include all of the following except:

A. nonpayment of bills.
B. euthanasia.
C. starting or stopping treatment.
D. use of feeding tubes.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Ethics committees do not deal with financial matters of payment. Euthanasia, starting or stopping treatment, and use of feeding tubes to maintain nutritional status are topics within the ethical scope of the committee's function.Coordinated Care

QUESTION 534
How is the information documented on incident reports used?

A. to analyze risk categories
B. to make sure procedures are in compliance with regulations
C. to identify the educational needs of the staff
D. all of the above

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Risk management plays a vital role as an arm of quality monitoring and improvement programs. It utilizes information obtained from incident reports, as well as audits, committee minutes, service complaints, and clientsatisfaction questionnaires to perform all of the tasks identified.Safety and Infection Control

QUESTION 535
The only time that an individual may receive medical care without giving informed consent is:

A. when the durable power of attorney for health care is not available.
B. in an emergency, life-or-death situation.
C. when the physician is not available for discussion with the client.
D. when they (clients) are not able to speak for themselves.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Treatment may be given without consent in a life-threatening situation. Choices 1, 3, and 4 are incorrect. All attempts to notify a durable power of attorney for health care should be made. If unavailable, the physician assumes responsibility for treatment within facility protocol. The physician is obligated to have a discussion with the client in all non-life-threatening situations. If clients are not able to speak for themselves, their power of attorney for health care or responsible party is involved in the consent process.Coordinated Care

QUESTION 536
The acts enacted by states to provide immunity from liability to persons who provide emergency care at an accident scene are called:

A. Good Samaritan laws.
B. HIPAA.
C. Patient Self-Determination Act (PSDA).
D. OBRA.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The Good Samaritan laws protect providers of care in an emergency situation. HIPAA's focus is confidentiality of information and right to privacy. The PSDA concerns a client's autonomous decision-making. OBRA was passed in the late 1980s to promote nursing home reform due to quality issues.Coordinated Care

QUESTION 537
Which of the following substances need to be assessed when completing a family health assessment?

A. coffee, tea, cola, and cocoa
B. alcohol, tobacco, and illegal substances
C. medicines prescribed by a physician
D. all of the above

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

When assessing drug, alcohol, and tobacco practices among family members, a thorough investigation of prescribed, over-the-counter and illegal substance-use practices should be made. Assessment of dietary practices should include the amount and types of food the family eats; the social behaviors associated with dietary practices; and the meal planning, shopping, and preparation practices of the family.Health Promotion and Maintenance

QUESTION 538
An appraisal of self-care practices involves an assessment of:

A. all diagnostic tests.
B. home treatment practices, including nurse visits for the sick or disabled.
C. the family's capability to get health insurance.
D. caregiving needs and the potential for strain.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Short-tem stressors impinging on a family include unemployment, being on welfare, the threat of termination, health, hospitalization, convalescence, depression, and suicidal thoughts. Long-term stressors impinging on the family include emotional distance, lack of communication in families (especially within marital relationships), continual geographical movement from one community to the next (so that no stable and sufficient social network is established), a spouse's minimal participation in family life, and excessive and frequent drinking bouts. Family strengths include the presence of a social support system, interest in and capability to provide child care, motivation for employment, and financial self-sufficiency, self-care beliefs, values, health- seeking behaviors, and realistic goals and limitations.Health Promotion and Maintenance

QUESTION 539
Which of the following is one of the main goals for Healthy People 2010?

A. reduction of health care costs
B. elimination of health disparities
C. investigation of substance abuse
D. determination of an acceptable morbidity rate

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Healthy People 2010has as its main goal elimination of health disparities among the U.S. population.Healthy People 2010is a set of health objectives for the nation to achieve over the first decade of the twenty-first centuryand was developed by the Surgeon General's office. Earlier editions of this report,Healthy PeopleandHealthy People 2000: National Health Promotion and Disease Prevention Objectivesestablished national health objectivesand served as the basis for the development of state and community plans.Health Promotion and Maintenance

QUESTION 540
A paraplegic client is in the hospital to be treated for an electrolyte imbalance. Which level of care is the client currently receiving?

A. primary prevention
B. secondary prevention
C. tertiary prevention
D. health promotion

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This client is receiving secondary prevention. The current focus of health care is on preventive care. Leavell and Clark (1965) described the three levels of preventive care as primary, secondary, and tertiary. Secondary preventive care focuses on early detection of disease, prompt intervention, and health maintenance for clients experiencing health problems. Examples of activities at this level are carrying out direct nursing actions (for example, providing wound care, giving medications, exercising arms and legs), assessing children for normal growth and development, and encouraging regular medical and dental screenings and care. Primary preventive care is directed toward health promotion and specific protections against illness. Activities at this level might focus on individuals or groups. Examples of primary-level activities are immunizations, family-planning services, teaching breast self-examination, poison-control information, and accident-prevention education. Tertiary preventive care begins after an illness is diagnosed and treated and is aimed at helping rehabilitate clients and restore them to their maximum level of functioning.Health Promotion and Maintenance

QUESTION 541
Which of the following developmental milestones for a 6-month-old child should be screened by the nurse during a routine office visit?

A. standing while holding something
B. rolling over
C. sitting up
D. creeping

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Rolling over occurs between 4 and 6 months of age. Sitting up occurs between 7 and 8 months, creeping between 9 and 10 months, and standing between 8 and 10 months.Health Promotion and Maintenance

QUESTION 542
During the health screening of an adolescent, which finding by the nurse requires further teaching?

A. The client started her first menses 2 years ago.
B. The client states she is currently on birth control pills.
C. The client states she recently lost 5 pounds.
D. The client states she is experiencing growing pains.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Because the client is on the pill, she requires further teaching regarding protection against STDs. The other findings are not abnormal for an adolescent.Health Promotion and Maintenance

QUESTION 543
A mother brings her 1-year-old child to the clinic. The child has no record of previous immunizations, and the mother confirms the child has not been immunized. Teaching by the nurse should include which of the following?

A. Immunizations may be started at any age.
B. The recommended immunization schedule must be followed exactly.
C. If a primary series of immunizations is interrupted, the series must be restarted.

D. This child is at increased risk for reaction to the vaccines, when they are started.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

While a recommended immunization schedule exists, immunizations may be started at any age. An interrupted series may be continued and need not be restarted. There is no increased risk for reaction to vaccines due to delay.Health Promotion and Maintenance

QUESTION 544
Which of the following vaccines is a live virus?

A. varicella
B. IPV
C. DTaP
D. hepatitis B

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Varicella is a live virus, as is OPV. IPV is an inactivated polio vaccine.Health Promotion and Maintenance

QUESTION 545
The nurse provides a postoperative client with an analgesic medication and darkens the room before the client goes to sleep for the night. The nurse's actions:

A. help the client's circadian rhythm.
B. stimulate hormonal changes in the brain.
C. decrease stimuli from the cerebral cortex.
D. alert the hypothalamus in the brain.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Reduction of environmental stimuli (particularly light and noise) from the cerebral cortex (which can be an area of arousal) facilitates sleep. Sleep occurs when there is a decreased input into this area.Basic Care and
Comfort

QUESTION 546
Following an automobile accident that caused a head injury to an adult client, the nurse observes that the client sleeps for long periods of time. The nurse determines that the client has experienced injury to the:

A. hypothalamus.
B. thalamus.
C. cortex.
D. medulla.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The hypothalamus, when injured, can cause fluctuations and disruptions in sleep patterns.Basic Care and Comfort

QUESTION 547
A nursing care plan for a client with sleep problems has been implemented. All of the following should be expected outcomes except:

A. the client reports no episodes of awakening during the night.
B. the client falls asleep within 1 hour of going to bed.
C. the client reports satisfaction with his amount of sleep.
D. the client rates sleep as an 8 or more on the visual analog scale.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An expected outcome is that the client falls asleep shortly after going to bed. The stages of sleep are defined by 4 stages. By stage 3 or 4 (within a short period of time--usually 1 hour) the client is considered to be in the deep part of sleep.Basic Care and Comfort

QUESTION 548
A month after receiving a blood transfusion, an immunocompromised client develops fever, liver abnormalities, a rash, and diarrhea. The nurse should suspect this client has:

A. nothing related to the blood transfusion.
B. graft-versus-host disease (GVHD).
C. myelosuppression.
D. an allergic response to a recent medication.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

GVHD occurs when white blood cells in donor blood attack the tissues of an immunocompromised recipient. This process can occur within a month of the transfusion. Choices 1 and 4 are possible, but the nurse must remember that immunocompromised transfusion recipients are at risk for GVHD.Pharmacological Therapies

QUESTION 549
An infection in a central venous access device is not eliminated by giving antibiotics through the catheter. How might bacterial glycocalyx contribute to this?

A. It protects the bacteria from antibiotic and immunologic destruction.
B. Glycocalyx neutralizes the antibiotic, rendering it ineffective.
C. It competes with the antibiotic for binding sites on the microbe.
D. Glycocalyx provides nutrients for microbial growth.

Correct Answer: A

Section: (none)
Explanation

Explanation/Reference:
Explanation:

Glycocalyx is a viscous polysaccharide or polypeptide slime that covers microbes. It enhances adherence to surfaces, resists phagocytic engulfment by the white blood cells, and prevents antibiotics from contacting the microbe. Glycocalyx does not have the effects described in Choices 2, 3, and 4.Pharmacological Therapies

QUESTION 550
Chemotherapeutic agents often produce a degree of myelosuppression including leukopenia. Leukopenia does not present immediately but is delayed several days or weeks because:

A. the client's hemoglobin and hematocrit are normal.
B. red blood cells are affected first.
C. folic acid levels are normal.
D. the current white cell count is not affected by chemotherapy.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Time is required to clear circulating cells before the effect that chemotherapeutic drugs have on precursor cellmaturation in the bone marrow becomes evident. Leukopenia is an abnormally low white blood cell count. Choices 1, 2, and 3 pertain to red blood cells.Pharmacological Therapies

QUESTION 551
A client has been taking a drug (Drug A) that is highly metabolized by the cytochrome p-450 system. He has been on this medication for 6 months. At this time, he is started on a second medication (Drug B) that is an inducer of the cytochrome p-450 system. You should monitor this client for:

A. increased therapeutic effects of Drug A.
B. increased adverse effects of Drug B.
C. decreased therapeutic effects of Drug A.
D. decreased therapeutic effects of Drug B.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Drug B induces the cytochrome p-450 enzyme system of the liver, thus increasing the metabolism of Drug A. Therefore, Drug A is broken down faster and exerts decreased therapeutic effects. Drug A is metabolized faster, thus reducing, not increasing, its therapeutic effect. Inducing the cytochrome p-450 system does not increase the adverse effects of Drug B. Drug B induces the cytochrome p-450 system but is not metabolized faster. Thus, the therapeutic effects of Drug B are not decreased.Pharmacological Therapies

QUESTION 552
Ten-year-old Jackie is admitted to the hospital with a medical diagnosis of Rheumatic Fever. She relates a history of "a sore throat about a month ago." Bed rest with bathroom privileges is prescribed. Which of the following nursing assessments should be given the highest priority when assessing Jackie's condition?

A. her response to being hospitalized
B. the presence of a macular rash on her trunk

C. her cardiac status
D. the presence of polyarthritis and pain in her joints

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Monitoring cardiac status is of the highest priority. Permanent cardiac damage can result from rheumatic fever. The second priority is assessing the client's joints for the presence of polyarthritis and accompanying pain.Physiological Adaptation

QUESTION 553
A 21-year-old college student has just learned that she contracted genital herpes from her sexual partner. After completing the initial history and assessment, the nurse has data concerning areas pertinent to the disease. The data is likely to include all but which of the following?

A. voiding patterns
B. characteristics of lesions
C. vaginal discharge
D. prior history of varicella

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The other choices are common reasons for which clients with herpes seek care.Physiological Adaptation

QUESTION 554
A client has been admitted in septic shock. Her nursing care plan includes the diagnosis High Risk for Injury (related to clotting disorder). Based on this diagnosis, all the following are appropriate entries in the nursing care plan except:

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A. obtain an order for a stool softener.
B. administer packed RBCs, if ordered.
C. encourage the client to rinse her mouth with mouthwash and scrub her teeth with an oral sponge.
D. dress venipuncture sites immediately to prevent infection.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Firm, direct pressure should be applied to venipuncture sites for 37 minutes before final dressing because of the clotting abnormality. Septic shock is a systemic infection of the bloodstream producing clinical manifestations--warm, flushed skin; high urine output; tachycardia; edema; respiratory problems;

restlessness; altered level of consciousness; life- threatening form of shock.Physiological Adaptation

QUESTION 555
A person using over-the-counter nasal decongestant drops who reports unrelieved and worsening nasal congestion should be instructed to:

A. switch to a stronger dose of the medication.
B. discontinue the medication for a few weeks.
C. continue taking the same medication, but use it more frequently.
D. use a combination of medications for better relief.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Prolonged use of decongestant drops (3 to 5 days) can lead to rebound congestion, which is relieved by discontinuing the medication for 2 to 3 weeks. Nasal congestion results from dilation of nasal blood vessels due to infection, inflammation, or allergy. With this dilation, there is a transudation of fluid into the tissue spaces, resulting in swelling of the nasal cavity. Nasal decongestants (sympathomimetic amines) stimulate the alphaadrenergic receptors, producing vascular constriction (vasoconstriction) of the capillaries within the nasal mucosa. The result is shrinking of the nasal mucous membranes and a reduction in fluid secretion (runny nose). Decongestants can make a client jittery, nervous, or restless. These side effects decrease or disappear as the body adjusts to the drug. When nasal decongestants are used for longer than 5days, instead of the nasal membranes constricting, vasodilation occurs, causing increased stuffy nose and nasal congestion. The nurse should emphasize the importance of limiting the use of nasal sprays and drops. As with any alpha-adrenergic drug (for example, decongestants), blood pressure and blood glucose levels can increase. These drugs are contraindicated and should only be used with extreme caution for clients with hypertension, cardiac disease, hyperthyroidism, and diabetes mellitus.Physiological Adaptation

QUESTION 556
A client has a 10% dextrose in water IV solution running. He is scheduled to receive his antiepileptic drug, phenytoin (Dilantin), at this time. The nurse knows that the phenytoin:

A. is given after the D10W is finished.
B. should be given at the time it is due in the medication port closest to the client.
C. can be piggybacked into the D10W solution now.
D. is incompatible with dextrose solutions.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Phenytoin and dextrose will precipitate. Normal saline is used to flush before andafter phenytoin administration.The administration of an antiepileptic drug cannot be delayed to maintain a therapeutic blood level.Pharmacological Therapies

QUESTION 557
The physician wants to know if a client is tolerating his total parenteral nutrition. Which of the following laboratory tests is likely to be ordered?

A. triglyceride level
B. liver function tests
C. a glucose tolerance test
D. a complete blood count

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The liver is the primary organ for digestion. Liver function tests measure the blood level of enzymes produced by the liver: prothrombin time/partial prothrombin time, serum glutamic oxaloacetic and pyruvic transaminases, gamma glutamyl transpeptidase, albumin, and alkalinephosphatase. Choice 1 measures the body's ability to clear triglycerides, the primary component of fats. Failure to clear triglycerides from the bloodstream indicates a problem with storage or the ingestion of too much fat. Choice 3 measures the blood glucose at intervals after a glucose-rich solution is ingested; it is used for diagnosing diabetes. Choice 4 is used to evaluate blood components.Pharmacological Therapies

QUESTION 558
When planning intervention for a client during a crisis, which of the following outcomes is most appropriate?

A. The client should explore deep psychological problems.
B. The client should express positive feelings about event.
C. The client should identify needs that are threatened by the event.
D. The client should use constructive coping mechanisms.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The primary goal of crisis intervention is to relieve the symptoms of anxietyand foster constructive coping.Previous psychological issues might recur during crisis, but the focus is onshort-term resolution of the currentproblem. At the end, the nurse credits a client for positive changes and helps him or her understand what was learned. This allows the client to use the learned coping mechanisms when new problems arise.Psychosocial Integrity

QUESTION 559
A man expresses surprise that his wife has become very withdrawn during hospitalization for pneumonia. Which response helps the husband understand how some people cope with hospitalization?

A. "Hospitalization might cause a crisis. Has your wife had to cope with problems before this?"
B. "Some people react that way. She will be more talkative when she feels better."
C. "Your wife might be feeling concern that she cannot fulfill her normal roles."
D. "This is typical behavior for someone who is as ill as your wife."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hospitalization might precipitate a crisis in either the client or family. Clients might become demanding or withdrawn. Family members might become demanding to help them cope with insecurity.Psychosocial Integrity

QUESTION 560
The nurse is assessing an elder who the nurse suspects is being physically abused. The most important question for nurse to ask is:

A. "How much money do you keep around the house?"
B. "Who provides your physical care?"
C. "How close does your nearest relative live?"
D. "What form of transportation do you use?"

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The most common abuser is a caregiver living with the client. Research reveals that the spouse is currently the most common abuser, followed by an adult child.Psychosocial Integrity

QUESTION 561
A nurse notes that an elderly client suddenly does not keep appointments and is not wearing appropriate clothing. Which statement by the client raises the suspicion of financial abuse?

A. "I am having difficulty paying for this new antibiotic the physician prescribed."
B. "I am a little short on cash since my daughter moved in to help me."
C. "I have not felt like shopping since the weather has gotten worse."
D. "People do not realize how difficult it is to make ends meet on a fixed income."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Elderly clients on fixed incomes have difficulty meeting new expenses, such as medicine. Signs of financial abuse include unexplained illnesses that are left untreated, an inability to pay rent or purchase clothes and food, and inaccurate knowledge about finances. Financial abuse is a form of elder abuse and requires investigation.Psychosocial Integrity

QUESTION 562
A client needs to rapidly achieve a therapeutic plasma drug concentration of a medication. Rather than wait for steady state to be achieved, the physician might order:

A. a maintenance dose.
B. a loading dose.
C. a medication with no first-pass effect.
D. the medication to be given intravenously.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A loading or priming dose rapidly establishes a therapeutic plasma drug level. It can be calculated by multiplying the volume of distribution by the desired plasma drug concentration. A maintenance dose maintains a therapeutic level after the loading dose. It takes five drug half- lives to achieve steady state if no loading dose is given. Choice 3 is similar to a maintenance dose. Intravenous administration provides excellent drug bioavailability, but one dose will not achieve a therapeutic plasma level.Pharmacological Therapies

QUESTION 563
In hanging a parenteral IV fluid that is to be infused by gravity, rather than with an infusion pump, the nurse

notes that the IV tubing is available in different drop factors. Which tubing is a microdrop set?

A. 15 drops per milliliter
B. 60 drops per milliliter
C. 20 drops per milliliter
D. 10 drops per milliliter

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All microdrop sets are calculated to give 60 drops for each milliliter of IV fluid. Macrodrop sets are calculated to give 10, 15, or 20 drops for each milliliter of IV fluid.Pharmacological Therapies

QUESTION 564
The ICU nurse caring for a client who has just been declared brain dead can expect to find evidence of the client's wishes regarding organ donation:

A. on the driver's license of the client.
B. in the client's safety deposit box.
C. in the client's last will and testament.
D. on the client's insurance card.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

In most states, indication of organ donor status is found on the driver's license. Evidence in a last will and testament or in a safety deposit box is not readily accessible for decision-making if the need arises. Insurance cards do not contain such information. Another source might be the client's primary care physician's health record documentation.Coordinated Care

QUESTION 565
An 85-year-old client is eligible for Medicarereimbursable home care services. Referral is contingent on meeting which of the following criteria?

A. homebound status, requiring skilled therapy care
B. immediate previous hospitalization for acute care
C. age
D. requirement of nursing and social work support

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The requirements for Medicare-reimbursable home care services include the client being homebound and requiring a skilled service, such as PT/OT/ST/nursing/social work.Coordinated Care

QUESTION 566
The factor that most determines drug distribution is:

A. vascular perfusion of the tissue or organ.

B. salt form.
C. drug interactions.
D. steady state.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Drugs are distributed via the circulatory system. Adequate perfusion is necessary for distribution of a drug.Choices 2, 3, and 4 are not as dependent on adequate perfusion.Pharmacological Therapies

QUESTION 567
Metformin (Glucophage) is administered to clients with type II diabetes mellitus. Metformin is an example of:

A. an antihyperglycemic agent.
B. a hypoglycemic agent.
C. an insulin analogue.
D. a pancreatic alpha cell stimulant.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

This antihyperglycemic agent prevents hyperglycemia by reducing hepatic glucose output and decreasing glucose absorption from the gut. A hypoglycemic drug stimulates insulin production. Metformin is not a type of insulin. Metformin is not a stimulant of any pancreatic cell.Pharmacological Therapies

QUESTION 568
A client was involved in a motor vehicle accident in which the seat belt was not worn. The client is exhibiting crepitus, decreased breath sounds on the left, complains of shortness of breath, and has a respiratory rate of 34/min. Which of the following assessment findings should concern the nurse the most?

A. temperature of 102°F and a productive cough
B. arterial blood gases (ABGs) with a PaO2 of 92 and PaCO2 of 40 mmHg
C. trachea deviating to the right
D. barrel-chested appearance

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A mediastinal shift is indicative of a tension pneumothorax along with theother symptoms in the question.Because the individual was involved in an MVA, assessment is targeted at acute traumatic injuries to the lungs, heart, or chest wall rather than other conditions indicated in the other choices. Choice 1 is common with pneumonia. Values in Choice 2 are not alarming. Choice 4 is typical of someone with chronic obstructive pulmonary disease (COPD). A tensionpneumothorax is a dangerous complication and a medical emergency where entering air cannot escape by the same route and pressure within the pleural cavity increases, resulting in complete collapse of the lung. A mediastinal shift to the unaffected side and a downward displacement of the diaphragm can be observed.Physiological Adaptation

QUESTION 569

A nurse is teaching a client newly diagnosed with Emphysema about the disease process. Which of the following statements best explains the problems associated with emphysema and could be adapted for use in the nurse's discussion with the client?

A. Hyperactivity of the medium-sized bronchi caused by an inflammatory response leads to wheezing and tightness in the chest.
B. Larger than normal air spaces and loss of elastic recoil cause air to be trapped in the lung and collapse airways.
C. Vasodilation, congestion, and mucosal edema cause a chronic cough and sputum production.
D. Chloride is not being transported properly, producing excess absorption of water and sodium, and thick viscous mucus.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Larger-than-normal air spaces and loss of elastic recoil cause air to be trapped in the lung and collapse airways. Emphysema is a breakdown of the elastin and fiber network of the alveoli where the alveoli enlarge or the walls are destroyed. This alveolar destruction leads to the formation of larger-than-normal air spaces. Emphysema is one of a group of pulmonary diseases of a chronic nature characterized by increased resistance to airflow; the entity is part of chronic obstructive pulmonary disease (COPD).Physiological Adaptation

QUESTION 570
A client admitted to the medical nursing unit has classic symptoms of tuberculosis (TB) and tests positive on the purified protein derivative (PPD) skin test. Several months later, the nurse who cared for the client also tests positive on an annual TB skin test for work. The most likely course of treatment if the chest X-ray (CXR) is negative is to:

A. repeat a TB skin test in six months.
B. treat the nurse with an anti-infective agent for six months.
C. monitor for signs and symptoms within the next year.
D. follow up in one year at the next annual physical with CXR only.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Exposure with a positive TB skin test usually requires six months of prophylactic treatment unless contraindicated. The TB skin test should not be repeated; the results will always be positive. A CXR is usually not required annually in the event that the skin test was positive. TB is a type of pneumonia caused by the acid-fast bacillus, mycobacterium tuberculosis, and is contracted by airborne droplets that enter the lungs and multiply in the pulmonary alveoli. Nursing Assessment: (1) Assessment includes symptom analysis of type and progression of symptoms; color, consistency, and amount of sputum; knowledge of the disease; weight pattern; vital signs; description of any pain; palpable lymph nodes; breath sounds; and activity tolerance. (2) Diagnostic tests:a) CXR (shows dense lesions in the upper lobes, enlarged lymph nodes, and formation of large cavities); b) CBC (presence of leukocytosis); c) Fiberoptic bronchoscopy and bronchial washing (for obtaining culture specimens); d) Tuberculin skin test (positive at 5 to 9 mm for clients with abnormal CXR or HIV; positive at 10 to 15 mm for clients with high-risk factors such as intravenous [IV] drug use; residence in a long-term facility, high-incidence country; positive at 15 mm for all other people); e) Three early-morning sputum collections for acid-fast staining, culture and sensitivity positive for M. tuberculosis. Results can take up to 10 days.Physiological Adaptation

QUESTION 571
A client who has a known history of cardiac problems and is still smoking enters the clinic complaining of sudden onset of sharp, stabbing pain that intensifies with a deep breath. The pain is occurring on only one

side and can be isolated upon general assessment. The nurse concludes that this description is most likely caused by:

A. pleurisy.
B. pleural effusion.
C. atelectasis.
D. tuberculosis.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pleurisy is an inflammation of the pleura and is often accompanied by abrupt onset of pain. Symptoms of pleurisy are abrupt pain that is usually unilateral and localized to a specific portion of the chest. The pain is sharp, stabbing, and might radiate to the neck or shoulder. Pressure changes caused by breathing, movement, or coughing intensify the pain. Other symptoms might include fever, cough (dry, hacking), localized tenderness, diminished breath sounds, tachypnea, and pleural friction rub.Physiological Adaptation

QUESTION 572
One drug can alter the absorption of another drug. One drug increases intestinal motility. Which effect does this have on the second drug?

A. None; absorption of the second drug is not affected.
B. The increased gut motility increases the absorption of the second drug.
C. The absorption of the second drug cannot be predicted.
D. Less of the second drug is absorbed.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Because most oral mediations are absorbed in the intestine, increased motility moves the second drug through the system faster, thus decreasing the absorption time and the amount taken up by the intestine.PharmacologicalTherapies

QUESTION 573
A client asks a nurse working in a dental office what type of drug the dentist uses to provide anesthesia during the extraction of the client's wisdom teeth. The dentist uses an anesthetic gas, also known as laughing gas. This agent is:

A. nitrous oxide.
B. nitrogen.
C. nitric oxide.
D. nitrogen dioxide.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nitrous oxide produces analgesia and is often used for minor surgery and dental procedures that do not require loss of consciousness. It can also produce a mild euphoria in some clients. Nitrogen is a nonmetallic element that constitutes nearly four-fifths of the air by volume, occurring as a colorless,

odorless, almost inert diatomic gas, N2, in various minerals and in all proteins. Nitric oxide is a potent vasodilator of vascular smooth muscle. It is produced from L arginine. Nitrogen dioxide is a poisonous brown gas, NO2, often found in smog and automobile exhaust fumes.Pharmacological Therapies

QUESTION 574
Why is it often necessary to draw a complete blood count and differential (CBC/differential) when a client is being treated with an antiepileptic drug (AED)?

A. The hematocrit is adversely affected because of an increased vascular volume.
B. AEDs affect immune modulators increasing the risk of infection.
C. AEDs induce white blood cell reduction.
D. A side effect of some AEDs is blood dyscrasia.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Some AEDs cause aplastic anemia and megaloblastic anemia. Choices 1, 2, and 3 are not side effects of AEDs.
Pharmacological Therapies

QUESTION 575
To manage time most effectively, the nurse responds to which of the following stimuli first:

A. the physician's loud verbal direction.
B. the nursing supervisor who is going to a meeting.
C. unit staff leaving on a break.
D. the care needs of the returning postoperative client just exiting the elevator.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

While many environmental stimuli might compete for attention and time, the client care needs of complex or unstable clients and those requiring assessment and care must take priority.Coordinated Care

QUESTION 576
People-related supervisory tasks include all of the following except:

A. coaching.
B. encouraging.
C. target setting.
D. rewarding.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Target-setting is the projection of goals or objectives to be accomplished and is considered to be a task-centered, supervisory responsibility. Coaching, encouraging, rewarding, evaluating, and facilitating are supervisory activities that are people related as they involve direct interaction with those doing the work.Coordinated Care

QUESTION 577
After the client discusses her relationship with her father, the nurse says, "Tell me whether I am understanding your relationship with your father. You feel dominated and controlled by him?" This is an example of:

A. verbalizing the implied.
B. seeking consensual validation.
C. encouraging evaluation.
D. suggesting collaboration.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Consensual validation is a technique used to check one's understanding of what the client has said. Consensual validation is the process by which people come to agreement about the meaning and significance of specific symbols. Through this experience, individuals develop the ability to relate effectively.Psychosocial Integrity

QUESTION 578
The best definition of communication is:

A. the sending and receiving of messages.
B. the effect of sending verbal messages.
C. an ongoing, interactive form of transmitting transactions.
D. the use of message variables to send information.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Communication is a personal, interactive system--a series of ever-changing, ongoing transactions in the environment. Transmissions are simultaneously received (decoded), sent (encoded), and influenced by the total of experiences and perceptions of the receivers and senders. Through communication and interaction with others, an individual develops a sense of identity and being. Communication is the basis of a person's self-concept and the relationship of this self to another individual, to a group of people, and to the world.Psychosocial Integrity

QUESTION 579
The nurse supporting a family who has just experienced a sudden and unexpected death needs to know:

A. that survivors have greater emotional turmoil and shock than when death is expected.
B. that survivors have less emotional turmoil and shock than when death is expected.
C. that survivors have the same emotional turmoil and shock as when death is expected.
D. that survivors have little emotional turmoil and shock because they were not there.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Sudden death produces greater emotional turmoil and shock in survivors thandoes a gradual, expected death.Survivors do not have time to engage in anticipatory grief. The most disturbing and unbalancing

feature of sudden death is its unexpectedness.Psychosocial Integrity

QUESTION 580
A mother has just given birth to a baby who died soon after. The mother has been crying and states, "I can't believe this has happened to me. I did everything right during this pregnancy." How should the nurse respond to this mother?

A. Tell her she did nothing wrong; it was God's will.
B. Tell her she can have another baby.
C. Tell her that her behavior is not going to solve anything.
D. Tell her nothing and let her mourn this loss in the manner she chooses.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Perinatal loss is a great tragedy for the parents. A bereaved mother must resolve the crisis of perinatal loss in addition to the crisis of pregnancy. Such a loss is described as losing part of one's self--loss of self-worth. The perinatal grief response must involve attachment and detachment as a part of the mourning process.Psychosocial Integrity

QUESTION 581
The difference between spirituality and religion is that spirituality is:

A. a belief about a higher power.
B. an individual's relationship with a higher power.
C. organized worship.
D. a belief in an invisible energy or ideal.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Religion can be considered a system of beliefs, practices, and ethical values about a divine or superhuman power or powers worshipped as the creator(s) and ruler(s) of the universe. Spirituality is a belief in or relationship with some higher power, creative force, driving being, or infinite source of energy.Psychosocial Integrity

QUESTION 582
Spirituality affects a client's life in all of the following areas except:

A. nutritional intake.
B. ability to handle stress.
C. sexual expression.
D. genetic makeup.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Spirituality is a belief in or relationship with some higher power, creative force, divine being, or infinite source of energy and does not have any effect on genetic makeup.Psychosocial Integrity

QUESTION 583
How many feet should separate the nurse and the source when extinguishing a small, wastebasket fire with an appropriate extinguisher?

A. 1 foot
B. 2 feet
C. 4 feet
D. 6 feet

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
The nurse should stand about 6 feet from the source of the fire. Getting closer might put the nurse in danger.Safety and Infection Control

QUESTION 584
While repositioning a comatose client, the nurse senses a tingling sensation as she lowers the bed. What action should she take?

A. Unplug the bed's power source.
B. Remove the client from the bed immediately.
C. Notify the biomedical department at once.
D. Turn off the oxygen.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Shutting off the bed's electricity should be the initial step. The nurse should not touch the client until the bed is checked for faulty grounding. An electrician should assess the equipment. Oxygen should be discontinued until the equipment is cleared.Safety and Infection Control

QUESTION 585
After securing the client's safety from a faulty electric bed, the nurse should take which action?

A. Discuss the matter with the client's significant others.
B. Document the incident in the client's record in detail.
C. Notify the physician.
D. Prepare an incident report.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

After the situation is safe for the client, the nurse should record the occurrence on an incident form according to the agency protocol.Safety and Infection Control

QUESTION 586
A client taking isotretinoin (Accutane) tells the nurse that she is pregnant. What should the nurse teach this client?

A. Her pregnancy is threatened, and the fetus is at risk for teratogenesis.
B. She has a reportable condition, and the pregnancy must be terminated.
C. Accutane is a Category D drug, which means it is unsafe in pregnancy.
D. Her pregnancy must be followed carefully by a genetic specialist.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Accutane is a Category X drug, which means pregnancy is contraindicated due to teratogenesis associated with the medication. The pharmaceutical manufacturer should be notified of any pregnancy occurring while taking the drug, but reporting is voluntary. Choosing to terminate the pregnancy is a personal decision that requires full information. Consultation with a genetic specialist or OB physician is indicated.Safety and Infection Control

QUESTION 587
When a drug is listed as Category X and prescribed to women of child-bearing age/capacity, the nurse and the interdisciplinary team should counsel the client that:

A. Pregnancy tests might be unreliable while taking the drug.
B. She must use a reliable form of birth control.
C. She should not take the Category X drug on days she has intercourse.
D. She must follow up with an endocrinologist.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Category X drugs have many practice limitations when prescribed and dispensed to women. For example, the prescription is valid for only seven days, and if not filled, it expires. The FDA provides a pregnancyprevention program for clients taking Isotretinoin (Accutane). Prior to prescribing a Category X drug, a pregnancy test should be performed.Safety and Infection Control

QUESTION 588
The nurse seeks to assess the renal function of an elderly client who is about to receive a nephrotoxic medication. Which of the following labs provides the best indicator for renal function?

A. urinalysis
B. creatinine and blood urea nitrogen
C. chemistry of electrolytes
D. creatinine clearance

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Due to decreases in lean body mass, blood creatinine is not as good an indicator of the elderly client's renal function as creatinine clearance. Urinalysis and blood urea nitrogen reflect hydration status and other clues to health but are not specific for renal function. The electrolytes might be deranged in renal failure but are not a direct correlation to the kidneys' capability to eliminate waste. Therefore, the best lab for renal function in the elderly is thought to be creatinine clearance, which is a widely used test for glomerular filtration rate.Safety andInfection Control

QUESTION 589
The nurse sustains a needle puncture that requires HIV prophylaxis. Which of the following medication regimens should be used?

A. an antibiotic such as Metronidazole and a protease inhibitor (Saquinivir)
B. two non-nucleoside reverse transcriptase inhibitors
C. one protease inhibitor such as Nelfinavir
D. two protease inhibitors

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Unless there is drug resistance, the initial prophylaxis based on CDC recommendations is 2 NNRTIs.Safety and Infection Control

QUESTION 590
A client is taking the fluoroquinolone Ciprofloxin for acute prostatitis. After a few doses of the agent, he develops severe muscle pain. The most likely cause of the adverse reaction is:

A. electrolyte imbalance.
B. impending tendon rupture.
C. calcium deposits.
D. antibiotic-associated colitis.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An untoward, adverse drug reaction associated with the quinolones is tendon rupture. Electrolyte imbalance has not been associated with the group, and antibiotic-associated colitis is most common in augmentin and penicillin groups.Safety and Infection Control

QUESTION 591
What is the primary goal of family education?

A. symptom reduction
B. improved quality of life
C. increased knowledge about mental illness
D. improved caregiving skills

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Improving quality of life is the primary goal of family education. Symptom reduction is a goal of psychoeducation, not family education. Increased knowledge about mental illness might accompany family education, but is not a goal of it. Improved quality of life and reduced family burden are the goals. Improved care-giving skills might accompany family education but are not a goal of it.Psychosocial Integrity

QUESTION 592

Acyclovir (Zovirax) is the agent of choice for which of the following infections?

A. HIV
B. AIDS
C. candida
D. herpes

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acyclovir is an antiviral effective in shortening the duration of infection in herpes. It is used in HIV and AIDS to treat opportunistic, viral infections but is not a primary AIDS drug. Candida is a fungus and is responsive to antifungal medication.Safety and Infection Control

QUESTION 593
The client on Floxin must be alerted to which of the following adverse effects?

A. stunting of height in teens and young adults
B. propensity of anovulatory uterine bleeding
C. intractable diarrhea
D. tendon rupture

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Floxin is a quinolone antibiotic used in respiratory infections and pelvic and reproductive infections. Rarely, quinolones can cause tendon sheath rupture, usually of the Achilles. At the first indication of tendon pain, the antibiotic should be discontinued.Safety and Infection Control

QUESTION 594
Serum Vancomycin levels are taken to measure which of the following?

A. renal function
B. therapeutic range
C. trough levels
D. antibiotic resistance

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vancomycin levels are monitored to ensure therapeutic effects by peak level. Trough level is that level of wash out or lowest level of drug just prior to the next dose. The blood is taken approximately 2 hours after an IV infusion. Renal function is measured by creatinine and BUN or creatinine clearance and resistance by sensitivity.Safety and Infection Control

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QUESTION 595
Which of the following is responsible for laws mandating the reporting of certain infections and diseases?

A. Centers for Disease Control and Prevention (CDC)
B. individual state laws
C. National Institute of Health Research (NIH)
D. Health and Human Services (HHS)

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Individual state laws mandate the reporting of infectious diseases. The list of reportable diseases varies from state to state and is overseen by state health departments. CDC reporting is voluntary and done via collaboration with state agencies. There are 58 emerging infectious diseases under surveillance by the CDC.Safety andInfection Control

QUESTION 596
A nurse who is assessing the health-related physical fitness of a client as part of a health assessment should focus on which of the following aspects of the assessment?

A. agility
B. speed
C. body composition
D. risk factors

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A health assessment should focus on possible risk factors of the client. A risk factor is something that increases a person's chance for illness or injury. A health-risk appraisal is an assessment of the total person, including lifestyle and health behaviors.Health Promotion and Maintenance

QUESTION 597
A nurse is trying to motivate a client toward more effective management of a therapeutic regimen. Which of the following actions by the nurse is most likely to be effective in increasing the client's motivation?

A. determining whether the client has any family or friends living nearby
B. developing a lengthy discharge plan and reviewing it carefully with the client
C. teaching the client about the disorder at the client's level of understanding
D. making a referral to an area agency for client followup

Correct Answer: C
Section: (none)

Explanation

Explanation/Reference:
Explanation:

For maximum effectiveness, teach the client about the disorder at the client's level of understanding.Health Promotion and Maintenance

QUESTION 598
Mr. Lee comes to the clinic with thick green drainage around his eyelids. The nurse examiner takes his history and performs a physical examination, beginning with an eye history. General information the nurse should seek is:

A. type of employment.
B. burning or itchy sensation in the eyes.
C. position of the eyelids.
D. existence of floaters.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Data belonging in a general health history of the eye includes employment, activities, allergies, medications, lenses, and protective devices used. Exposure to irritants and activity risks should be delineated. Routine care of eyes and eye devices should be explored.Health Promotion and Maintenance

QUESTION 599
If Ms. Barrett's distance vision is 20/30, which of the following statements is true?

A. The client can read from 20' what a person with normal vision can read at 30'.
B. The client can read from 30' what a person with normal vision can read at 20'.
C. The client can read the entire chart from 30'.
D. The client can read the chart from 20' with the left eye and from 30' with the right eye.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The numerator, which is always 20, is the distance in feet between the chart and the client. The denominator, which ranges from 10 to 200, indicates the distance at which a normal eye can read the chart. The eye chart the nurse uses is the Snellen chart, which assesses distance vision.Health Promotion and Maintenance

QUESTION 600
The nurse is teaching a client about communicable diseases and explains that a portal of entry is:

A. a vector.
B. a source, like contaminated water.
C. food.
D. the respiratory system.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The path by which a microorganism enters the body is the portal of entry. A vector is a carrier of disease, a source (like bad water or food) can be a reservoir of disease.Safety and Infection Control

QUESTION 601
Which of the following microorganisms are considered normal body flora?

A. staphylococcus on the skin
B. streptococcus in the nares
C. candida albicans in the vagina
D. pseudomonas in the blood

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Of the choices given, only staphylococcus is considered a normal resident of the body.Safety and Infection Control

QUESTION 602
Which intervention should the nurse take first to assist a woman who states that she feels incompetent as the mother of a teenage daughter?

A. Recommend that she discipline her daughter more strictly and consistently.
B. Make a list of things her husband can do to help her improve.
C. Assist the mother to identify what she believes is preventing her success and what she can do to improve.
D. Explore with the mother what the daughter can do to improve her behavior.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The intervention priority with a mother who feels incompetent to parent a teenage daughter is to assist the mother to identify what she feels her crisis events are and to help her develop better coping skills and improve her mothering skills. With a teenager, the growth and development parameters have to be concentrated on self as well as acquiring an added event. Choices 1, 2, and 4 do not directly address the mother's feelings of inadequacy.Psychosocial Integrity

QUESTION 603
The mother of a newborn child is very upset. The child has a cleft lip and palate. The type of crisis this mother is experiencing is:

A. reactive.
B. maturational.
C. situational.
D. adventitious.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The arrival of the imperfect child that the mother had not envisioned places the mother in a situational crisis.
Choice 1 is not an option. Choice 2 is an identified specific time period in normal development when anxiety and stress increase. Choice 4 is a crisis that occurs outside the person's control so that the person has a disruption in social norms.Psychosocial Integrity

QUESTION 604
A 26-year-old single woman is knocked down and robbed while walking her dog one evening. Three months later, she presents at the crisis clinic, stating that she cannot put this experience out of her mind. She complains of nightmares, extreme fear of being outside or alone, and difficulty eating and sleeping. What is the best response by the nurse?

A. "I will ask the physician to prescribe medication for you."
B. "That must have been a very difficult and frightening experience. It might be helpful to talk about it."
C. "In the future, you might walk your dog in a more populated area or hire someone else to take over this task."
D. "Have you thought of moving to a safer neighborhood?"

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Choice 2 gives the client support and an opportunity to discuss the experience. Choices 1, 3, and 4 do not validate her experience or permit discussion of her feelings.Psychosocial Integrity

QUESTION 605
A 60-year-old widower is hospitalized after complaining of difficulty sleeping, extreme apprehension, shortness of breath, and a sense of impending doom. What is the best response by the nurse?

A. "You have nothing to worry about. You are in a safe place. Try to relax."
B. "Has anything happened recently or in the past that might have triggered these feelings?"
C. "We have given you a medication that helps to decrease feelings of anxiety."
D. "Take some deep breaths and try to calm down."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Choice 2 provides support, reassurance, and an opportunity to gain insight into the cause of the anxiety. Choice 1 dismisses the client's feelings and offers false reassurance. Choices 3 and 4 do not allow the client to discuss his feelings, which he must do in order to understand and resolve the cause of his anxiety.PsychosocialIntegrity

QUESTION 606
A primigravida begins labor when her family is unavailable and she is alone. She is very upset that her family is not with her. Which approach can the nurse take to meet the client's needs at this time?

A. asking whether another individual wants to be her support person
B. assuring her that the nursing triage group will be with her at all times
C. telling her you will try to locate her family
D. reinforcing the woman's confidence in her own abilities to cope and maintain a sense of control

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Allow the client to select another individual to give support. This allows her to have someone with her until her family can be with her.Safety and Infection Control

QUESTION 607
Signs of internal bleeding include all of the following except:

A. painful or swollen extremities.
B. a tender, rigid abdomen.
C. vomiting bile.
D. bruising.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vomiting bile is usually not a sign of internal bleeding. Signs of internal bleeding include painful or swollen extremities; a tender, rigid abdomen; and bruising.Safety and Infection Control

QUESTION 608
A newborn has been delivered. An Apgar score is given. What does this scoring system indicate?

A. heart rate, respiratory effort, color, muscle tone, reflex irritability
B. heart rate, bleeding, cyanosis, edema
C. bleeding, reflex, edema
D. respiratory effort, heart rate, seizures

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The Apgar scoring system was put into place by Virginia Apgar, an anesthesiologist in New York, for the purpose of assessing newborns in the areas of heart rate, respiratory effort, color, muscle tone, and reflex irritability at 1, 5, and sometimes 10 minutes after birth.Safety and Infection Control

QUESTION 609
The nurse working with elderly clients should keep in mind that falls are most likely to happen to elderly who are:

A. in their 80s.
B. living at home.
C. hospitalized.
D. living on only Social Security income.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Elder people are particularly prone to falling and incurring serious injury, especially in new situations and

environments (such as the hospital).Safety and Infection Control

QUESTION 610
The nurse assesses a client for physiological risk factors for falls. The nurse should conclude that the client is not at risk if which of the following is discovered?

A. history of dizziness
B. need for wheelchair due to reduced mobility
C. weakness and fatigue noted when climbing stairs
D. intact recent and remote memory

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Intact recent and remote memory indicates that a client is not at risk for falls. Risk for falls can occur in elder clients, and the nurse should assess each client for the possibility of falls and take appropriate actions.Safety andInfection Control

QUESTION 611
The nurse should perform which intervention when a client is restrained?

A. Remove the restraints and provide skin care hourly.
B. Document the condition of the client's skin every 3 hours.
C. Assess the restraint every 30 minutes.
D. Tie the restraint to the side rails.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The minimum standard is to visually assess the restraint every 30 minutes. Documentation is typically performed per a checklist or flow sheet. The ends of the restraint are tied to a part of the bed that allows for position changes without unfastening them.Safety and Infection Control

QUESTION 612
A client receives a cervical intracavity radium implant as part of her therapy. A common side effect of a cervical implant is:

A. creamy, pink-tinged vaginal drainage.
B. stomatitis.
C. constipation.
D. xerostomia.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Creamy, pink-tinged vaginal drainage persists for 1 to 2 months after removal of a cervical implant. Diarrhea, not constipation, is usually a side effect of cervical implants. Stomatitis and xerostomia are local side effects of radiation to the mouth.Physiological Adaptation

QUESTION 613

An appropriate question when assessing a client's self-expectations about weight loss is:

A. "What makes you think you can change your eating habits?"
B. "How do you feel about losing weight?"
C. "How important is it that you lose weight?"
D. "What do you think is a realistic weekly weight loss for you?"

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nurses should assist clients to evaluate themselves and make behavior changes. Listening to clients, supporting clients' strengths, assisting clients to look at themselves in totality, and encouraging clients to set attainable goalsshould be part of the nurse-client relationship.Psychosocial Integrity

QUESTION 614
Which of the following statements should the nurse use to best describe a very low-calorie diet (VLCD) to a client?

A. "This diet can be used when there is close medical supervision."
B. "This is a long-term treatment measure that assists obese people who can't lose weight."
C. "The VLCD consists of solid food items that are pureed to facilitate digestion and absorption."
D. "A VLCD contains very little protein."

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

VLCDs are used in the clinical treatment of obesity under close medical supervision. The diet is low in calories, high in quality of protein, and has a minimum of carbohydrates to spare protein and prevent ketosis.Physiological Adaptation

QUESTION 615
A client has been placed in isolation because he is diagnosed with a contagious illness. The nurse should be aware that:

A. Linens from the client's bed should be double-bagged.
B. Meals should be served on washable dishes.
C. Extensive isolation rarely causes psychological problems.
D. Paper trays and plastic utensils prevent disease transmission.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Linens should be double-bagged. Isolation refers to techniques used to prevent orto limit the spread ofinfection. Some form of isolation has been used for centuries, whether to protect ahigh- risk person from exposureto pathogens or to prevent the transmission of pathogens from an infected personto others. Special handling ofarticles and linen soiled by any body fluid is indicated. These articles should be placed in impervious bags beforethey are removed from the client's bedside. Bagging in watertight containers is indicated to prevent exposure ofpersonnel and contamination of the environment. The outside of the bagshould not be contaminated when placingarticles inside it. Each hospital and community agency has

procedures for labeling and decontaminating exposedarticles. Items that are visibly soiled with body substances should be rinsed and placed in plastic bags or clearlymarked containers, often labeled "Contaminated." Ifthe outside of the bag becomescontaminated, placing that bagin another bag (double-bagging) is required.Safety and Infection Control

QUESTION 616
A nurse is working in an outpatient orthopedic clinic. During the patient's history the patient reports, "I tore 3 of my 4 Rotator cuff muscles in the past." Which of the following muscles cannot be considered as possibly being torn?

A. Teres minor
B. Teres major
C. Supraspinatus
D. Infraspinatus

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Teres Minor, Infraspinatus, Supraspinatus, and Subscapularis make up the Rotator Cuff.

QUESTION 617
A nurse at outpatient clinic is returning phone calls that have been made to the clinic. Which of the following calls should have the highest priority for medical intervention?

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A. A home health patient reports, "I am starting to have breakdown of my heels."
B. A patient that received an upper extremity cast yesterday reports, "I can't feel my fingers in my right hand today."
C. A young female reports, "I think I sprained my ankle about 2 weeks ago."
D. A middle-aged patient reports, "My knee is still hurting from the TKR."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The patient experiencing neurovascular changes should have the highest priority. Pain following a TKR is normal, and breakdown over the heels is a gradual process. Moreover, a subacute ankle sprain is almost never a medical emergency.

QUESTION 618
A nurse working a surgical unit, notices a patient is experiencing SOB, calf pain, and warmth over the posterior calf. All of these may indicate which of the following medical conditions?

A. Patient may have a DVT.
B. Patient may be exhibiting signs of dermatitis.
C. Patient may be in the late phases of CHF.

D. Patient may be experiencing anxiety after surgery.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of these factors indicate a DVT.

QUESTION 619
A nurse is performing a screening on a patient that has been casted recently on the left lower extremity. Which of the following statements should the nurse be most concerned about?

A. The patient reports, "I didn't keep my extremity elevated like the doctor asked me to."
B. The patient reports, "I have been having pain in my left calf."
C. The patient reports, "My left leg has really been itching."
D. The patient reports, "The arthritis in my wrists is flaring up, when I put weight on my crutches."

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pain may be indicating neurovascular complication.

QUESTION 620
A 93 year-old female with a history of Alzheimer's Disease gets admitted to an Alzheimer's unit. The patient has exhibited signs of increased confusion and limited stability with gait. Moreover, the patient is refusing to use a w/c. Which of the following is the most appropriate course of action for the nurse?

A. Recommend the patient remain in her room at all times.
B. Recommend family members bring pictures to the patient's room.
C. Recommend a speech therapy consult to the doctor.
D. Recommend the patient attempt to walk pushing the w/c for safety.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Stimulation in the form of pictures may decrease signs of confusion.

QUESTION 621
A nurse is covering a pediatric unit and is responsible for a 15 year-old male patient on the floor. The mother of the child states, "I think my son is sexually interested in girls." The most appropriate course of action of the nurse is to respond by stating:

A. "I will talk to the doctor about it."
B. "Has this been going on for a while?"
C. "How do you know this?"
D. "Teenagers often exhibit signs of sexual interest in females."

Correct Answer: D
Section: (none)

Explanation

Explanation/Reference:
Explanation:

Adolescents exhibiting signs of sexual development and interest are normal.

QUESTION 622
A high school nurse observes a 14 year-old female rubbing her scalp excessively in the gym. The most appropriate course of action for the nurse to do is:

A. Request a private evaluation of the female's scalp from her parents.
B. Contact the female's parents about the observations.
C. Observe the hairline and scalp for possible signs of lice.
D. Contact the student's physician.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Observation of the student's hair is the next step.

QUESTION 623
A nurse is caring for a patient who has recently been diagnosed with fibromyalgia and COPD. Which of the following tasks should the nurse delegate to a nursing assistant?

A. Transferring the patient to the shower.
B. Ambulating the patient for the first time.
C. Taking the patient's breath sounds
D. Educating the patient on monitoring fatigue

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Nursing assistants should be competent on all transfers.

QUESTION 624
A nurse has been instructed to place an IV line in a patient that has active TB and HIV. The nurse should wear which of the following safety equipment?

A. Sterile gloves, mask, and goggles
B. Surgical cap, gloves, mask, and proper shoewear
C. Double gloves, gown, and mask
D. Goggles, mask, gloves, and gown

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All protective measures must be worn, it is not required to double glove.

QUESTION 625
A nurse is instructing a person who had a left CVA and right lower extremity hemiparesis to use a quad cane. Which of the following is the most appropriate gait sequence?

A. Place the cane in the patient's left upper extremity, encourage cane, then right lowerextremity, then left upper extremity gait sequence.
B. Place the cane in the patient's left upper extremity, encourage cane, then leftlower extremity, then right upper extremity gait sequence.
C. Place the cane in the patient's right upperextremity, encourage cane, thenright lower extremity, then left upper extremity gait sequence.
D. Place the cane in the patient's right upper extremity, encourage cane, thenleft lower extremity, then right upper extremity gait sequence.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The cane should be placed in the patient's strong upper extremity, and left arm/right foot go together, for normal gait.

QUESTION 626
A nurse has just started on the 7PM surgical unit shift. Which of the following patients should the nurse check on first?

A. A 75 year-old female who is scheduled for an EGD in 10 hours.
B. A 34 year-old male who is complaining of low back pain following back surgery and has an onset of urinary incontinence in the last hour.
C. A 21 year-old male who had a lower extremity BKA yesterday, following a MVA and has phantom pain.
D. A 27 year-old female who has received 1.5 units of RBC's. via transfusion theprevious day.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The new onset of urinary incontinence may require additional medical assessment, and the physician needs to be notified.

QUESTION 627
A 64 year-old Alzheimer's patient has exhibited excessive cognitive decline resulting in harmful behaviors. The physician orders restraints to be placed on the patient. Which of the following is the appropriate procedure?

A. Secure the restraints to the bed rails on all extremities.
B. Notify the physician that restraints have been placed properly.
C. Communicate with the patient and family the need for restraints.
D. Position the head of the bed at a 45 degree angle.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Both the family and the patient should have the need for restraints explained to them.

QUESTION 628
A 22 year-old patient in a mental health lock-down unit under suicide watch appears happy about being discharged. Which of the following is probably happening?

A. The patient is excited about being around family again.
B. The patient's suicide plan has probably progressed.
C. The patient's plans for the future have been clarified.
D. The patient's mood is improving.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The suicide plan may have been decided.

QUESTION 629
A patient that has delivered a 8.2 lb. baby boy 3 days ago via c-section, reports white patches on her breast that aren't going away. Which of the following medications may be necessary?

A. Nystatin
B. Atropine
C. Amoxil
D. Loritab

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Thrush may be occurring and the patient may need Nystatin.

QUESTION 630
A 13 year old girl is admitted to the ER with lower right abdominal discomfort. The admitting nursing should take which the following measures first?

A. Administer Loritab to the patient for pain relief.
B. Place the patient in right sidelying position for pressure relief.
C. Start a Central Line.
D. Provide pain reduction techniques without administering medication.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Do not administer pain medication or start a central line without MD orders.

QUESTION 631
A 64 year-old male who has been diagnosed with COPD, and CHF exhibits an increase in total body weight of 10 lbs. over the last few days. The nurse should:

A. Contact the patient's physician immediately.

B. Check the intake and output on the patient's flow sheet.
C. Encourage the patient to ambulate to reduce lower extremity edema.
D. Check the patient's vitals every 2 hours.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Check the intake and output prior to making any decisions about patient care.

QUESTION 632
A 32 year-old male with a complaint of dizziness has an order for Morphine via. IV. The nurse should do which of the following first?

A. Check the patient's chest x-ray results.
B. Retake vitals including blood pressure.
C. Perform a neurological screen on the patient.
D. Request the physician on-call assess the patient.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Dizziness can be a sign of hypotension, that may a contraindication with Morphine.

QUESTION 633
A patient that has TB can be taken off restrictions after which of the following parameters have been met?

A. Negative culture results.
B. After 30 days of isolation.
C. Normal body temperature for 48 hours.
D. Non-productive cough for 72 hours.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Negative culture results would indicate absence of infection.

QUESTION 634
A nurse teaching a patient with COPD pulmonary exercises should do which of the following?

A. Teach pursed-lip breathing techniques.
B. Encourage repetitive heavy lifting exercises that will increase strength.
C. Limit exercises based on respiratory acidosis.
D. Take breaks every 10-20 minutes with exercises.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Purse lip breathing will help decrease the volume of air expelled by increased bronchial airways.

QUESTION 635
A patient asks a nurse the following question. Exposure to TB can be identified best with which of the following procedures? Which of the following tests is the most definitive of TB?

A. Chest x-ray
B. Mantoux test
C. Breath sounds examination
D. Sputum culture for gram-negative bacteria

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The Mantoux is the most accurate test to determine the presence of TB.

QUESTION 636
A thirty-seven year-old female in room 307 has a diagnosis of acquired immune deficiency syndrome (AIDS). Which of the following situations requires nurse intervention?

A. A certified nursing assistant states, "The patient in 307 is not wearing glovesshaving her legs."
B. A nursing assistant at the nursing station states, "The patient in 307 has arespiratory rate of 16."
C. A nursing student in the cafeteria states, "Dr.Jones told the patient in room307 that she was going to die."
D. A certified nursing assistant states, "Dr. Jones hasn't made rounds thismorning."

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Patient confidentiality should be observed, especially in public places. The nurse should tell the nursing student do not discuss confidential information in public.

QUESTION 637
A twenty-one year old man suffered a concussion and the MD ordered a MRI. The patient asks, "Will they allow me to sit up during the MRI?" The correct response by the nurse should be.

A. "I will have to talk to the doctor about letting you sit upright during the test."
B. "You will be positioned in the reverse Trendelenburg position to maximizethe view of the brain."
C. "The radiologist will let you know."
D. "You will have to lie down on your back during the test."

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The MRI will require supine positioning.

QUESTION 638
A fifty-five year-old man suffered a left frontal lobe CVA. The patient's family is not present in the room. Which of the following should the nurse watch most closely for?

A. Changes in emotion and behavior
B. Monitor loss of hearing
C. Observe appetite and vision deficits
D. Changes in facial muscle control

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The frontal lobe is responsible for behavior and emotions.

QUESTION 639
A nurse working in a pediatric clinic observes bruises on the body of a four year-old boy. The parents report the boy fell riding his bike. The bruises are located on his posterior chest wall and gluteal region. The nurse should:

A. Suggest a script for counseling for the family to the doctor on duty.
B. Recommend a warm bath for the boy to decrease healing time.
C. Notify the case manager in the clinic about possible child abuse concerns.
D. Recommend ROM to the patient's spine to decrease healing time.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The patient's safety should have the highest priority.

QUESTION 640
A central venous pressure reading of 11cm/H(2)0 of an IV of normal saline is determined by the nurse caring for the patient. The patient has a diagnosis of pericarditis. Which of the following is the most applicable:

A. The patient has a condition of hypovolemia.
B. Not enough fluid has been given to the patient.
C. Pericarditis may cause pressures greater than 10cm/H(2)0 with testing of CVP.
D. The patient may have a condition of arteriosclerosis.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

>10cm/H(2)0 may indicate a condition of pericarditis

QUESTION 641
A 14 year-old boy has been admitted to a mental health unit for observation and treatment. The boy becomes agitated and starts yelling at nursing staff members. What should the nurse first response be?

A. Create an atmosphere of seclusion for the boy according to procedures.
B. Remove other patients from the area via wheelchairs for added speed.
C. Ask the patient, "What is making you mad?"
D. Ask the patient, "Why are you doing this, have you thought about what yourparents might say?"

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Seclusion is your best option in this scenario.

QUESTION 642
A young female teenager describes a brutal assault and rape to the nurse on duty. Which of the following actions should the nurse take first?

A. Check with case manager on duty about possible police intervention.
B. Provide an environment of concern and emotional stabilization.
C. Clean the patient's wounds with normal saline and gauze.
D. Recommend a good attorney to the patient.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Emotional support is what that patient needs most at this point in time.

QUESTION 643
An nurse is instructing a patient on the order of sensations with the application of an ice water bath for a swollen right ankle. Which of the following is the correct order of sensations experienced with an ice water bath?

A. cold, burning, aching, and numbness
B. burning, aching, cold, and numbness
C. aching, cold, burning and numbness
D. cold, aching, burning and numbness

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

CBAN, cold, burn, ache, numbness

QUESTION 644
A nurse doing a home health visit consults with a male patient that has a diagnosis of CAD and COPD. The patient is currently taking Ventolin, Azmacort, Aspirin, and Theophylline. The patient complains of upset stomach, nausea and feeling uncomfortable. The nurse should:

A. Contact the patient's physician immediately
B. Recommend the patient position himself in right sidelying.
C. Recommend the patient schedule a doctor's visit the next day.
D. Recommend a hold on the drug-Azmacort

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Consult the physician immediately, due to the fact that theophylline toxicity may be occurring.

QUESTION 645
A nurse reviewed the arterial blood gas reading of a 25 year-old male. The nurse should be able to conclude the patient is experiencing which of the following conditions?

Bicarbonate ion-25 mEq/l
PH-7.41
PaCO2-29 mmHg
PaO2-54 mmHg
(FiO2)-.22

A. metabolic acidosis
B. respiratory acidosis
C. metabolic alkalosis
D. respiratory alkalosis

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Respiratory alkalosis-elevated pH, and low carbon dioxide levels, no compensation noted.

QUESTION 646
A nurse assesses a 83 year-old female's venous ulcer for the second time that is located near the right medial malleolus. The wound is exhibiting purulent drainage and the patient has limited mobility in her home. Which of the options is the best course of action?

A. Encourage warm water soaks to the right foot.
B. Notify the case manager of the purulent drainage.
C. Determine the patient's pulse in the right ankle.
D. Recommend increased activity to reduce the purulent drainage.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A determination of arterial blood flow should be made, prior to encouraging increased activity, or notifying additional team members.

QUESTION 647
Tricyclics (Antidepressants) sometimes have which of the following adverse affects on patients that have a diagnosis of depression?

A. Shortness of breath
B. Fainting
C. Large Intestine ulcers

D. Distal muscular weakness

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Fainting and hypotension can be caused by Tricyclics.

QUESTION 648
A nurse is instructing a patient about the warning signs of (Digitalis) side effects. Which of the following side effects should the nurse tell the patient are sometimes associated with excessive levels of Digitalis?

A. Seizures
B. Muscle weakness
C. Depression
D. Anxiety

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Palpitations and muscle weakness are found with excessive levels of Digitalis.

QUESTION 649
A nurse is assessing a patient's right lower extremity. The extremity is warm to touch, red and swollen. The patient is also running a low fever. Which of the following conditions would be the most likely cause of the patient's condition?

A. Herpes
B. Scleroderma
C. Dermatitis
D. Cellulitis

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Inflammation of cellular tissue associated with a fever most likely indicates cellulitis.

QUESTION 650
A nurse is assessing a patient's breath sounds. The patient has had a pneumonectomy to the right lung performed 48 hours ago. Which of the following conditions most likely exists?

A. Decreased breath sound volume
B. Elevated tidal volume
C. Elevated respiratory capacity
D. Wheezing

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Breath sounds would be softer.

QUESTION 651
A nurse is assessing a patient in the ICU. The patient has the following signs: weak pulse, quick respiration, acetone breath, and nausea. Which of the following conditions is most likely occurring?

A. Hypoglycemic patient
B. Hyperglycemic patient
C. Cardiac arrest
D. End-stage renal failure

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

All of the clinical signs indicate a hyperglycemic condition.

QUESTION 652
Medical records indicate a patient has developed a condition of respiratory alkalosis. Which of the following clinical signs would not apply to a condition of respiratory alkalosis?

A. Muscle tetany
B. Syncope
C. Numbness
D. Anxiety

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Anxiety is a clinical sign associated with respiratory acidosis.

QUESTION 653
Which of the following lab values would indicate symptomatic AIDS in the medical chart? (T4 cell count per deciliter)

A. Greater than 1000 cells per deciliter
B. Less than 500 cells per deciliter
C. Greater than 2000 cells per deciliter
D. Less than 200 cells per deciliter

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

<200 T4 cells/deciliter

QUESTION 654

A nurse is assessing a patient that has undergone a recent CABG. The nurse notices a mole with irregular edges with a bluish color. The nurse should:

A. Recommend a dermatological consult to the MD.
B. Note the location of the mole and contact the physician via the telephone.
C. Note the location of the mole and follow-up with the attending physician viathe medical record and phone call.
D. Remove the mole with a sharp's debridement technique, following chargenurse approval.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Contacting the attending physician via the medical record is appropriate due to the possibility of melanoma.

QUESTION 655
A nurse is assessing a 18 year-old female who has recently suffered a TBI. The nurse notes a slower pulse and impaired respiration. The nurse should report these findings immediately to the physician, due to the possibility the patient is experiencing which of the following conditions?

A. Increased intracranial pressure
B. Increased function of cranial nerve X
C. Sympathetic response to activity
D. Meningitis

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The patient is at high risk of developing increased intracranial pressure (ICP).

QUESTION 656
A nurse taking a patient's history realizes the patient is complaining of SOB and weakness in the lower extremities. The patient has a history of hyperlipidemia, and hypertension. Which of the following may be occurring?

A. The patient is developing CHF
B. The patient may be having a MI
C. The patient may be developing COPD
D. The patient may be having an onset of PVD

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Myocardial infarction may be associated with SOB and muscle weakness.

QUESTION 657
A nurse has been assigned a patient who has recently been diagnosed with Guillain-Barre' Syndrome. Which of the following statements is the most applicable when discussing the impairments with Guillain-Barre' Syndrome with the patient?

A. Guillain-Barre' Syndrome gets better after 5 years in almost all cases.
B. Guillain-Barre' Syndrome causes limited sensation in the abdominal region.
C. Guillain-Barre' Syndrome causes muscle weakness in the legs.
D. Guillain-Barre' Syndrome does not effect breathing in severe cases.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Muscle weakness in the lower extremities is found in acute cases of Guillain-Barre' Syndrome.

QUESTION 658
A nurse is returning phone calls in a pediatric clinic. Which of the following reports most requires the nurse's immediate attention and phone call?

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A. A 8 year-old boy has been vomiting and appears to have slower movements and has a history of an atrio-ventricular shunt placement.
B. A 10 year-old girl feels a dull pain in her abdomen after doing sit-ups in gym class.
C. A 7 year-old boy has been having a low fever and headache for the past 3 days that has history of an anterior knee wound.
D. A 7 year-old girl that had a cast on her right ankle is complaining of itching.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The shunt may be blocked and require immediate medical attention.

QUESTION 659
A 27 year-old woman has delivered twins in the OB unit. The patient develops a condition of 5 centimeter diastasis recti abdominis. Which of the following statements is the most accurate when instructing the patient?

A. Sit-ups are o.k. to do as long as you don't strain
B. This condition leads to surgery in 80% of cases.
C. Guarding the abdominal region is important at this time.
D. Antibiotics are required for this condition in 70% of patients.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Protection of the abdominal wall is critical at this point in time.

QUESTION 660
A nurse is assessing a patient in the rehab unit at shift change. The patient has suffered a TBI 3 weeks ago. Which of the following is the most distinguishing characteristic of a neurological disturbance?

A. LOC (level of consciousness)
B. Short term memory
C. + Babinski sign
D. + Clonus sign

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

LOC is the most critical indicator of impaired neurological capabilities.

QUESTION 661
A patient is currently having a petit mal seizure in the clinic on the floor. Which of the following criteria has the highest priority in this situation?

A. Provide a safe environment free of obstructions in the immediate area
B. Call a code
C. Contact the patient's physician
D. Prevent excessive movement of the extremities

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Patient safety should be the top concern about this patient.

QUESTION 662
A nurse is caring for a patient in the step down unit. The patient has signs of increased intracranial pressure. Which of the following is not a sign of increased intracranial pressure?

A. Bradycardia
B. Increased pupil size bilaterally
C. Change in LOC
D. Vomiting

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Unilateral pupil changes indicate changes in ICP.

QUESTION 663
The charge nurse on a cardiac unit tells you a patient is exhibiting signs of right-sided heart failure. Which of the following would not indicate right-sided heart failure?

A. Nausea

B. Anorexia
C. Rapid weight gain
D. SOB (shortness of breath)

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Left sided heart failure exhibits signs of pulmonary compromise (SOB).

QUESTION 664
A 62 year-old female is being seen on a home visit by a nurse. The patient reports she has been taking Premarin for years. Which of the following would indicate an over-dosage?

A. Lower extremity edema
B. Sensory changes in the upper extremities
C. Increased occurrence of fractures
D. Decreased peripheral blood flow

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Edema in the lower extremities may indicate a Premarin (over-dosage).

QUESTION 665
A 24 year-old man has been admitted to the hospital due to work-related back injury. The patient's wife would like to see the patient's chart. The nurse should:

A. Provide the chart to the patient's wife following verbal approval by the patient.
B. Provide the chart to the patient's wife after consulting with the patient's physician.
C. Get written approval from the patient prior to providing the wife with chart information and call the MD about the patient's request.
D. Tell the patient' wife, a copy of the patient's medical record is on-file with medical records.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Some facilities require the physician to be notified about a patient's request and written permission from the husband is required for the wife to view the chart.

QUESTION 666
A 46 year-old has returned from a heart catheterization and wants to get up to start walking 3 hours after the procedure. The nurse should:

A. Tell the patient to remain with the leg straight for at least another hour and check the chart for activity orders.
B. Allow the patient to begin limited ambulation with assistance.
C. Recommend a physical therapy consultation for ambulation.
D. Tell the patient to remain with leg straight for another 6 hours and check the chart for activity orders.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The patient should keep the leg straight for at least 4 hours.

QUESTION 667
A nurse is reviewing a patient's ECG report. The patient exhibits a flat T wave, depressed ST segment and short QT interval. Which of the following medications can cause all of the above effects?

A. Morphine
B. Atropine
C. Procardia
D. Digitalis

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Digitalis can cause all of the listed symptoms.

QUESTION 668
A patient has just been prescribed Minipress to control hypertension. The nurse should instruct the patient to be observant of the following:

A. Dizziness and light headed sensations
B. Weight gain
C. Sensory changes in the lower extremities
D. Fatigue

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hypotension may be result of over correction of a hypertensive condition.

QUESTION 669
A patient is complaining of severe chest pain during a stress test. Which of the following medications is the most appropriate to relieve this discomfort?

A. Aspirin
B. Diazoxide
C. Procardia
D. Mannitol

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:

Explanation:

Procardia can provide the quickest relief of ischemic chest pain that is severe in this case.

QUESTION 670
A 15 year-old high school wrestler has been taking diuretics to loose weight to compete in a lower weight class. Which of the following medical tests is most like to be given?

A. Lab values of Potassium and Sodium
B. Lab values of glucose and hemoglobin
C. ECG
D. CT scan

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Diuretics can disturb the sodium and potassium balance resulting in cardiac complications. An ECG is not indicated without evidence of cardiac conditions.

QUESTION 671
A 55 year-old female asks a nurse the following, "Which mineral/vitamin is the most important to prevent progression of osteoporosis. The nurse should state:

A. Potassium
B. Magnesium
C. Calcium
D. Vitamin B12

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Calcium is the most recognized osteoporosis treatment.

QUESTION 672
A patient has recently been diagnosed with symptomatic bradycardia. Which of the following medications is the most recognized for treatment of symptomatic bradycardia?

A. Questran
B. Digitalis
C. Nitroglycerin
D. Atropine

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Atropine encourages increased rate of conduction in the AV node.

QUESTION 673
A patient has recently been prescribed Lidocaine Hydrochloride. Which of the following symptoms may

occur with over dosage?

A. Memory loss and lack of appetite
B. Confusion and fatigue
C. Heightened reflexes
D. Tinnitus and spasticity

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Lidocaine Hydrochloride can cause fatigue and confusion if an over dosage occurs.

QUESTION 674
A patient has recently been prescribed Albuterol. Which of the following changes are not associated with Albuterol?

A. Tachycardia
B. Hypertension
C. Bronchodilation
D. Sensory changes

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Tachycardia, hypertension, and bronchodilation can all occur with Albuterol.

QUESTION 675
Which of the following arterial blood gas values indicates a patient may be experiencing a condition of metabolic acidosis?

A. PaO2 (90%)
B. Bicarbonate 159
C. CO(2) 47 mm Hg
D. pH 7.34

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The bicarbonate value is below normal, indicating a condition of metabolic acidosis.

QUESTION 676
A patient has suffered a left CVA and has developed severe hemiparesis resulting in a loss of mobility. The nurse notices on assessment that an area over the patient's left elbow appears as non-blanchable erythema and the skin is intact. The nurse should score the patient as having which of the following?

A. Stage I pressure ulcer
B. Stage II pressure ulcer
C. Stage III pressure ulcer

D. Stage IV pressure ulcer

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Erythema with the skin intact can indicate a Stage I pressure ulcer.

QUESTION 677
A newborn baby exhibits a reflex that includes: hand opening, abducted and extended extremities following a jarring motion. Which of the following correctly identifies the reflex?

A. ATNR reflex
B. Startle reflex
C. Grasping reflex
D. Moro reflex

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The moro reflex has all of the listed characteristics.

QUESTION 678
A mother that has never breast-feed a child before is having trouble getting the baby to latch on to the breast. The baby has lost 3% of its' birth weight within the first 2 days of life. The best statement is:

A. The baby will eventually take to the breast.
B. I can fix up a bottle if you want to try that.
C. A small amount of weight loss in the first few days is normal.
D. I can get the charge nurse to come and talk to you about breast-feeding.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

5-10% of birth weight loss following birth is normal for the first few days of life.

QUESTION 679
A nurse suspects a patient is developing Bell's Palsy. The nurse wants to test the function of cranial nerve VII. Which of the following would be the most appropriate testing procedures?

A. Test the taste sensation over the back of the tongue and activation of the facial muscles.
B. Test the taste sensation over the front of the tongue and activation of the facial muscles.
C. Test the sensation of the facial muscles and sensation of the back of the tongue.
D. Test the sensation of the facial muscles and sensation of the front of the tongue.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The facial nerve (VII) is motor to the face and sensory to the anterior tongue.

QUESTION 680
A patient has a history of cardiac arrhythmia. A nurse has been ordered to give 2 units of blood to this patient. The nurse should take which of the following actions?

A. Prep the patient with pain medication.
B. Notify the patient's family about the procedure via the telephone.
C. Decrease the temperature of the blood to be given.
D. Increase the temperature of the blood to be given.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Warming the blood will reduce the risk of additional cardiac arrhythmia.

QUESTION 681
A nurse is reviewing a patient's serum glucose levels. Which of the following scenarios would indicate abnormal serum glucose values for a 30 year-old male.

A. 70 mg/dl
B. 55 mg/dl
C. 110 mg/dl
D. 100 mg/dl

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

60-115 mg/dl is standard range for serum glucose levels.

QUESTION 682
A mother of a newborn notices a nurse placing liquid in her baby's eyes. Which of the following is an inaccurate statement about the need for eyedrops following birth?

A. Eyedrops following birth help reduce the risk of eye infection.
B. Eyedrops are required by the law.
C. Eyedrops will keep the eye moist.
D. Eyedrops are required by law every 6 hours following birth.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Laws do require placement of eyedrops; however, physicians indicate a timeframe.

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QUESTION 683
A two-year old has been in the hospital for 3 weeks and seldom seen family members due to isolation precautions. Which of the following hospitalization changes is most like to be occurring?

A. Guilt
B. Trust
C. Separation anxiety
D. Shame

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Separation anxiety can easily occur after six months during hospitalization.

QUESTION 684
A patient has recently been prescribed Zidovudine (Retrovir). The patient has AIDS. Which of the following side effects should the patient specifically watch out for?

A. Weakness and SOB
B. Fever and anemia
C. Hypertension and SOB
D. Fever and hypertension

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Anemia and fever are associated with Zidovudine's side effects.

QUESTION 685
A patient has recently been prescribed (Norvasc). Which of the following side effect/s should the patient specifically watch out for?

A. Hypotension and Angina
B. Hypertension
C. Lower extremity edema
D. Peripheral sensory loss and SOB

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Both angina and hypotension are associated with Norvasc's side effects.

QUESTION 686
A nurse is working in a pediatric clinic and a 25 year-old mother comes in with a 4 week-old baby. The mother is stress out about loss of sleep and the baby exhibits signs of colic. Which of the following techniques should the nurse teach the mother?

A. Distraction of the infant with a red object
B. Prone positioning techniques
C. Tapping reflex techniques
D. Neural warmth techniques

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Neural warmth will help to lower the baby's agitation level.

QUESTION 687
A nurse is working in a pediatric clinic and a mother brings in her 13 month old child who has Down Syndrome. The mother reports, "My child's muscles feel weak and he isn't moving well. My RN friend check his reflexes and she said they are diminished." Which of the following actions should the nurse take first?

A. Contact the physician immediately
B. Have the patient go to X-ray for a c-spine work-up.
C. Start an IV on the patient
D. Position the child's neck in a neutral position

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An atlanto-axial dislocation may have occurred. Position the child in a neutral c-spine posture and then contact the doctor immediately.

QUESTION 688
A nurse is reviewing a patient's arterial blood gas values. Which of the following conditions apply under the following values?
pH- 7.49
Bicarbonate ion 24 mEq/dl
PaCO2 31 mmHg
PaO2 52 mmHg
FiO2 - .22

A. respiratory acidosis
B. respiratory alkalosis
C. metabolic acidosis
D. metabolic alkalosis

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Elevated pH and low CO2 level indicate respiratory alkalosis, no compensation is noted.

QUESTION 689
A 28 year-old male has a diagnosis of AIDS. The patient has had a two year history of AIDS. The most likely cognitive deficits include which of the following?

A. Disorientation
B. Sensory changes
C. Inability to produce sound
D. Hearing deficits

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Cognitive changes may include confusion and disorientation.

QUESTION 690
A patient has been admitted to the hospital with a HNP L4-5 segment diagnosis. After 24 hours the patient is able to ambulate with assistance with reduced muscle spasms. Which of the following medications was the most beneficial in changing the patient's mobility status?

A. Mivacron
B. Atropine
C. Bethanechol
D. Flexeril

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Flexeril is a muscle relaxant for acute muscle pain and spasms.

QUESTION 691
Which of the following medications is not considered a neuromuscular blocker?

A. Anectine
B. Pavulon
C. Pitressin
D. Mivacron

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Pitressin is a hormone replacement medication.

QUESTION 692
A nurse is caring for a 10 year-old boy who has just been diagnosed with a congenital heart defect. Which

of the following clinical signs does not indicate CHF?

A. Increased body weight
B. Elevated heart rate
C. Lower extremity edema
D. Compulsive behavior

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Compulsive behavior does not indicate CHF.

QUESTION 693
A nurse working in a pediatric clinic and observes the following situations. Which of the following may indicate a delayed child to the nurse?

A. A 12-month old that does not "cruise".
B. A 8-month old that can sit upright unsupported.
C. A 6-month old that is rolling prone to supine.
D. A 3-month old that does not roll supine to prone.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

At 12 months a child should at least be "cruising" (holding on to objects to walk). Cruising is considered pre-walking.

QUESTION 694
A nurse is setting up a vision-screening program for a new school. At what age will vision be 20/20 in children?

A. 4 years old
B. 5 years old
C. 6 years old
D. 7 years old

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

6 years of age is the standard age of 20/20 vision potential.

QUESTION 695
A nurse is screening patients for various vaccines. Which of the following vaccines is contraindicated during pregnancy?

A. Diphtheria
B. Hepatitis B
C. Mumps

D. Tetanus

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Mumps and Rubella are contraindicated during pregnancy.

QUESTION 696
A nurse is screening patients for immunizations. Which of following is not a contraindication for immunization?

A. Seizures
B. Fever > 3 days
C. Malignancy >3 months
D. Illness >6 months

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Chronic conditions are not considered a contraindication for immunization.

QUESTION 697
A nurse has been ordered to administer Morphine to a patient. Which of the following effects is unrelated to Morphine's effects on the patient?

A. Depressed function of the CNS
B. Increased blood flow
C. Decreased venous capacity
D. Pain relief

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Venous capacity increases with morphine use.

QUESTION 698
A nurse is reviewing a patient's current Lithium levels. Which of the following values is outside the therapeutic range?

A. 1.0 mEq/L
B. 1.1 mEq/L
C. 1.2 mEq/L
D. 1.3 mEq/L

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

1.0-1.2 mEq/L is considered standard therapeutic range for patient care.

QUESTION 699
A client is going to have an endoscopy performed. Which of the following is not a probable reason for an endoscopy procedure?

A. Aspiration noted on honey thick diet.
B. Pain with a bowel movement
C. Pain felt in the left upper quadrant
D. Right shoulder pain

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Bowel movement pain should be examined with a colonoscopy not a endoscopy.

QUESTION 700
A patient has been ordered to get Tegretol for the first time. Which of the following side effects is not associated with Tegretol?

A. Sore throat
B. Vertigo
C. Fever
D. Shortness of breath

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A-C are associated side effects of Tegretol.

QUESTION 701
A patient has been ordered to get Klonapin for the first time. Which of the following side effects is not associated with Klonapin?

A. Drowsiness
B. Ataxia
C. Salivation elevated
D. Diplopia

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A-C are associated side effects of Klonapin.

QUESTION 702
A patient has been diagnosed with diabetes mellitus. Which of the following is not a clinical sign of diabetes

mellitus?

A. Polyphagia
B. Polyuria
C. Metabolic acidosis
D. Lower extremity edema

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A-C are associated with diabetes mellitus.

QUESTION 703
A patient has fallen off a bicycle and fractured the head of the proximal fibula. A cast was placed on the patient's lower extremity. Which of the following is the most probable result of the fall?

A. Peroneal nerve injury
B. Tibial nerve injury
C. Sciatic nerve injury
D. Femoral nerve injury

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The head of the proximal fibula is in close proximity to the peroneal nerve.

QUESTION 704
A nurse has been ordered to set-up Buck's traction on a patient's lower extremity due to a femur fracture. Which of the following applies to Buck's traction?

A. A weight greater than 10 lbs. should be used.
B. The line of pull is upward at an angle.
C. The line of pull is straight
D. A weight greater than 20 lbs. should be used.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A straight line of pull is indicated with Buck's traction.

QUESTION 705
Which of the following motions is identified with the corresponding action? (Action- Turning palm of hand over to face in the anterior direction, dorsum of the hand is pointed downward toward the floor.)

A. Pronation
B. Supination
C. Abduction
D. Adduction

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Supination- "Holding a bowl of soup in your hand."

QUESTION 706
A nurse is caring for a retired MD. The MD asks the question, "What type of cells secrete insulin?" The correct answer is:

A. alpha cells
B. beta cells
C. CD4 cells
D. helper cells

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Beta cells secrete insulin.

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QUESTION 707
Which of the following is not considered one of the main mechanisms of Type II Diabetes treatment?

A. Medications
B. Nutrition
C. Increased activity
D. Continuous Insulin

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Insulin is not required in continuous treatment for every Type II diabetic.

QUESTION 708
A nurse is caring for a retired MD. The MD asks the question, "What type of cells create exocrine secretions?" The correct answer is:

A. alpha cells
B. beta cells
C. acinar cells

D. plasma cells

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Acinar cells create exocrine secretions.

QUESTION 709
A nurse is caring for a patient who has experienced burns to the right lower extremity. According to the Rule of Nines which of the following percents most accurately describes the severity of the injury?

A. 36%
B. 27%
C. 18%
D. 9%

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Each lower extremity is scored as 18% according to the Rule of Nines.

QUESTION 710
A patient has experienced a severe third degree burn to the trunk in the last 36 hours. Which phase of burn management is the patient in?

A. Shock phase
B. Emergent phase
C. Healing phase
D. Wound proliferation phase

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The shock phase is considered the first 24-48 hours in wound management.

QUESTION 711
A nurse is reviewing a patient's medical record. The record indicates the patient has limited shoulder flexion on the left. Which plane of movement is limited?

A. Horizontal
B. Sagittal
C. Frontal
D. Vertical

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Sagittal motion occurs in the midline plane of the body.

QUESTION 712
Which of the following is not considered one of the five rights of medication administration?

A. client
B. drug
C. dose
D. routine

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Dose, client, drug, route and time are considered the five rights of medication.

QUESTION 713
When giving an intramuscular injection to an infant. Which of the following sites is preferred?

A. Ventrogluteal region
B. Deltoid
C. Vastus lateralis
D. Dorsogluteal region

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Vastus lateralis is the ideal choice for infants.

QUESTION 714
When choosing a needle gauge for an intramuscular injection in a 12 year old boy. Which of the following gauges would you choose?

A. 27 gauge
B. 25 gauge
C. 22 gauge
D. 20 gauge

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

22 gauge is recommended for school age children, toddlers, and adolescents while 23-25 gauge is recommended for infants.

QUESTION 715
A nurse is administering an antibiotic to a 4 year old girl, who does not have an identification bracelet. What action should the nurse take?

A. Ask another staff member who the child is.
B. Ask the child's mother to state the child's name.
C. Ask the child for her name.
D. Withhold the medication until an ID bracelet can be set-up.

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Timely delivery of medication can be given if the mother provides the child's name. Do not rely on children to identify their name correctly.

QUESTION 716
A client is 36 hours post-op a TKR surgery. 270 cc's of sero-sanguinous accumulates in the surgical drains. What action should the nurse take?

A. Notify the doctor
B. Empty the drain
C. Do nothing
D. Remove the drain

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The physician should be notified if excessive drainage is noted from the surgical site.

QUESTION 717
A patient 3 hours post-op from a hysterectomy is complaining of intense pain at the incision site. When assessing the patient the nurse notes a BP of 169/93, pulse 145 bpm and regular. What action should the nurse take?

A. Reassure patient that pain is normal following surgery.
B. Administer prn Nifedipine and assess client's response.
C. Administer prn Meperidine HCL and assess client's response.
D. Recheck BP and pulse rate every 20 minutes for the next hour.

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

A sinus tachycardia is a physiological response to pain. Treating the cause of the increased pulse rate requires pain medication.

QUESTION 718
A nurse is assigned to do pre-operative teaching on a blind patient who is scheduled for surgery the following morning. What teaching strategy would best fit the situation?

A. Verbal teaching in short sessions throughout the day
B. Pre-operative booklet on the surgery in Braille
C. Provide a tape for the client

D. Have the blind patient's family member instruct the patient.

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Information is smaller amounts is easier to retain. Teaching the day before the procedure is best accomplished in a one on one format.

QUESTION 719
A nurse gave medications to the wrong client. She stated the client responded to the name called. What is the nurse's appropriate documentation?

A. Note in medication records the drug given
B. The client was not hurt, no need for documentation
C. Note the client's orientation
D. Completely fill out an incident report

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The incident report should always be filled out involving medication errors.

QUESTION 720
A violation of a patient's confidentiality occurs if two nurses are discussing client information in which of the following scenarios?

A. With a physical therapist treating the patient
B. With a social worker planning for discharge
C. With another nurse on duty to plan for break time
D. In the hallway outside the patient's room.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Hallway discussions should not occur, because you do not who is listening, even though it may be a professional discussion.

QUESTION 721
If your patient is acutely psychotic, which of the following independent nursing interventions would not be appropriate?

A. Conveying calmness with one on one interaction
B. Recognizing and dealing with your own feelings to prevent escalation of thepatient's anxiety level
C. Encourage client participation in group therapy
D. Listen and identify causes of their behavior

Correct Answer: C
Section: (none)

Explanation

Explanation/Reference:
Explanation:

Acutely psychotic patients will disrupt group activities.

QUESTION 722
A nurse runs into the significant other of a patient with end stage AIDS crying during her smoke break. Which of the following is most appropriate action for the nurse to take?

A. Allow her to grieve by herself.
B. Tell her go ahead and cry, after all your husband's pretty bad off.
C. Tell her you realize how upset she is, but you don't want to talk about it now.
D. Approach her, offering tissues and encourage her to verbalize her feelings.

Correct Answer: D
Section: (none)
Explanation

Explanation/Reference:
Explanation:
Being left alone during the grief process, isolates individuals. These individuals need an outlet for their feelings and to talk to someone who is empathetic.

QUESTION 723
A patient is scheduled for electro-convulsive therapy treatment scheduled in the morning. What must the evening nurse do to provide the client ECT treatment possible?

A. Patient signs an informed consent form
B. Patient is given morning medications
C. Patient gets a good night's sleep
D. Patient has a good breakfast

Correct Answer: A
Section: (none)
Explanation

Explanation/Reference:
Explanation:

An informed consent is required prior to surgery.

QUESTION 724
A nurse is teaching a client about self-administration of Haldol 15 mg po hs. For which side effect/s must the client seek medical attention?

A. SOB and fatigue
B. restlessness and muscle spasms
C. dry mouth
D. diarrhea

Correct Answer: B
Section: (none)
Explanation

Explanation/Reference:
Explanation:

Muscle spasms and restlessness are side effects of Haldol

QUESTION 725
A nurse is implementing a community awareness campaign about accidental poisoning. Which of the following should she teach in the class?

A. The child should be given milk.
B. The child should be given syrup of Ipecac
C. The poison control center should be contacted
D. The child should be taken to the ER

Correct Answer: C
Section: (none)
Explanation

Explanation/Reference:
Explanation:

The poison control center should be contacted first.

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