1. Mrs. Chua a 78 year old client is admitted with the diagnosis of mild chronic heart failure. The nurse expects to hear when listening to client’s lungs indicative of chronic heart failure would be:

a. Stridor  
b. Crackles  
c. Wheezes  
d. Friction rubs

2. Patrick who is hospitalized following a myocardial infarction asks the nurse why he is taking morphine. The nurse explains that morphine:

a. Decrease anxiety and restlessness  
b. Prevents shock and relieves pain  
c. Dilates coronary blood vessels  
d. Helps prevent fibrillation of the heart

3. Which of the following should the nurse teach the client about the signs of digitalis toxicity?

a. Increased appetite  
b. Elevated blood pressure  
c. Skin rash over the chest and back  
d. Visual disturbances such as seeing yellow spots

4. Nurse Trisha teaches a client with heart failure to take oral Furosemide in the morning. The reason for this is to help:

a. Retard rapid drug absorption  
b. Excrete excessive fluids accumulated at night  
c. Prevents sleep disturbances during night  
d. Prevention of electrolyte imbalance

5. What would be the primary goal of therapy for a client with pulmonary edema and heart failure?

a. Enhance comfort  
b. Increase cardiac output  
c. Improve respiratory status  
d. Peripheral edema decreased

6. Nurse Linda is caring for a client with head injury and monitoring the client with decerebrate posturing. Which of the following is a characteristic of this type of posturing?
a. Upper extremity flexion with lower extremity flexion
b. Upper extremity flexion with lower extremity extension
c. Extension of the extremities after a stimulus
d. Flexion of the extremities after stimulus

7. A female client is taking Cascara Sagrada. Nurse Betty informs the client that the following may be experienced as side effects of this medication:

a. GI bleeding
b. Peptic ulcer disease
c. Abdominal cramps
d. Partial bowel obstruction

8. Dr. Marquez orders a continuous intravenous nitroglycerin infusion for the client suffering from myocardial infarction. Which of the following is the most essential nursing action?

a. Monitoring urine output frequently
b. Monitoring blood pressure every 4 hours
c. Obtaining serum potassium levels daily
d. Obtaining infusion pump for the medication

9. During the second day of hospitalization of the client after a Myocardial Infarction. Which of the following is an expected outcome?

a. Able to perform self-care activities without pain
b. Severe chest pain
c. Can recognize the risk factors of Myocardial Infarction
d. Can participate in cardiac rehabilitation walking program

10. A 68 year old client is diagnosed with a right-sided brain attack and is admitted to the hospital. In caring for this client, the nurse should plan to:

a. Application of elastic stockings to prevent flaccid by muscle
b. Use hand roll and extend the left upper extremity on a pillow to prevent contractions
c. Use a bed cradle to prevent dorsiflexion of feet
d. Do passive range of motion exercise

11. Nurse Liza is assigned to care for a client who has returned to the nursing unit after left nephrectomy. Nurse Liza’s highest priority would be:

a. Hourly urine output
b. Temperature
c. Able to turn side to side
d. Able to sips clear liquid
12. A 64 year old male client with a long history of cardiovascular problem including hypertension and angina is to be scheduled for cardiac catheterization. During pre cardiac catheterization teaching, Nurse Cherry should inform the client that the primary purpose of the procedure is…..

a. To determine the existence of CHD  
b. To visualize the disease process in the coronary arteries  
c. To obtain the heart chambers pressure  
d. To measure oxygen content of different heart chambers

13. During the first several hours after a cardiac catheterization, it would be most essential for nurse Cherry to…

a. Elevate clients bed at 45°  
b. Instruct the client to cough and deep breathe every 2 hours  
c. Frequently monitor client’s apical pulse and blood pressure  
d. Monitor clients temperature every hour

14. Kate who has undergone mitral valve replacement suddenly experiences continuous bleeding from the surgical incision during postoperative period. Which of the following pharmaceutical agents should Nurse Aiza prepare to administer to Kate?

a. Protamine Sulfate  
b. Quinidine Sulfate  
c. Vitamin C  
d. Coumadin

15. In reducing the risk of endocarditis, good dental care is an important measure. To promote good dental care in client with mitral stenosis in teaching plan should include proper use of…

a. Dental floss  
b. Electric toothbrush  
c. Manual toothbrush  
d. Irrigation device

16. Among the following signs and symptoms, which would most likely be present in a client with mitral gurgitation?

a. Altered level of consciousness  
b. Exceptional Dyspnea  
c. Increase creatine phosphokinase concentration  
d. Chest pain

17. Kris with a history of chronic infection of the urinary system complains of urinary frequency and burning sensation. To figure out whether the current problem is in
renal origin, the nurse should assess whether the client has discomfort or pain in
the…

a. Urinary meatus
b. Pain in the Labium
c. Suprapubic area
d. Right or left costovertebral angle

18. Nurse Perry is evaluating the renal function of a male client. After documenting urine
volume and characteristics, Nurse Perry assesses which signs as the best indicator of
renal function.

a. Blood pressure
b. Consciousness
c. Distension of the bladder
d. Pulse rate

19. John suddenly experiences a seizure, and Nurse Gina notice that John exhibits
uncontrollable jerking movements. Nurse Gina documents that John experienced
which type of seizure?

a. Tonic seizure
b. Absence seizure
c. Myoclonic seizure
d. Clonic seizure

20. Smoking cessation is critical strategy for the client with Burgher’s disease, Nurse
Jasmin anticipates that the male client will go home with a prescription for which
medication?

a. Paracetamol
b. Ibuprofen
c. Nitroglycerin
d. Nicotine (Nicotrol)

21. Nurse Lilly has been assigned to a client with Raynaud’s disease. Nurse Lilly realizes
that the etiology of the disease is unknown but it is characterized by:

a. Episodic vasospastic disorder of capillaries
b. Episodic vasospastic disorder of small veins
c. Episodic vasospastic disorder of the aorta
d. Episodic vasospastic disorder of the small arteries

22. Nurse Jamie should explain to male client with diabetes that self-monitoring of blood
glucose is preferred to urine glucose testing because…
a. More accurate  
b. Can be done by the client  
c. It is easy to perform  
d. It is not influenced by drugs  

23. Jessie weighed 210 pounds on admission to the hospital. After 2 days of diuretic therapy, Jessie weighs 205.5 pounds. The nurse could estimate the amount of fluid Jessie has lost…

a. 0.3 L  
b. 1.5 L  
c. 2.0 L  
d. 3.5 L  

24. Nurse Donna is aware that the shift of body fluids associated with Intravenous administration of albumin occurs in the process of:

a. Osmosis  
b. Diffusion  
c. Active transport  
d. Filtration  

25. Myrna a 52 year old client with a fractured left tibia has a long leg cast and she is using crutches to ambulate. Nurse Joy assesses for which sign and symptom that indicates complication associated with crutch walking?

a. Left leg discomfort  
b. Weak biceps brachii  
c. Triceps muscle spasm  
d. Forearm weakness  

26. Which of the following statements should the nurse teach the neutropenic client and his family to avoid?

a. Performing oral hygiene after every meal  
b. Using suppositories or enemas  
c. Performing perineal hygiene after each bowel movement  
d. Using a filter mask  

27. A female client is experiencing painful and rigid abdomen and is diagnosed with perforated peptic ulcer. A surgery has been scheduled and a nasogastric tube is inserted. The nurse should place the client before surgery in

a. Sims position  
b. Supine position  
c. Semi-fowlers position
28. Which nursing intervention ensures adequate ventilating exchange after surgery?

a. Remove the airway only when client is fully conscious
b. Assess for hypoventilation by auscultating the lungs
c. Position client laterally with the neck extended
d. Maintain humidified oxygen via nasal canula

29. George who has undergone thoracic surgery has chest tube connected to a water-seal drainage system attached to suction. Presence of excessive bubbling is identified in water-seal chamber, the nurse should…

a. “Strip” the chest tube catheter
b. Check the system for air leaks
c. Recognize the system is functioning correctly
d. Decrease the amount of suction pressure

30. A client who has been diagnosed of hypertension is being taught to restrict intake of sodium. The nurse would know that the teachings are effective if the client states that…

a. I can eat celery sticks and carrots
b. I can eat broiled scallops
c. I can eat shredded wheat cereal
d. I can eat spaghetti on rye bread

31. A male client with a history of cirrhosis and alcoholism is admitted with severe dyspnea resulted to ascites. The nurse should be aware that the ascites is most likely the result of increased…

a. Pressure in the portal vein
b. Production of serum albumin
c. Secretion of bile salts
d. Interstitial osmotic pressure

32. A newly admitted client is diagnosed with Hodgkin’s disease undergoes an excisional cervical lymph node biopsy under local anesthesia. What does the nurse assess first after the procedure?

a. Vital signs
b. Incision site
c. Airway
d. Level of consciousness
33. A client has 15% blood loss. Which of the following nursing assessment findings indicates hypovolemic shock?

a. Systolic blood pressure less than 90mm Hg  
b. Pupils unequally dilated  
c. Respiratory rate of 4 breath/min  
d. Pulse rate less than 60bpm

34. Nurse Lucy is planning to give pre operative teaching to a client who will be undergoing rhinoplasty. Which of the following should be included?

a. Results of the surgery will be immediately noticeable postoperatively  
b. Normal saline nose drops will need to be administered preoperatively  
c. After surgery, nasal packing will be in place 8 to 10 days  
d. Aspirin containing medications should not be taken 14 days before surgery

35. Paul is admitted to the hospital due to metabolic acidosis caused by Diabetic ketoacidosis (DKA). The nurse prepares which of the following medications as an initial treatment for this problem?

a. Regular insulin  
b. Potassium  
c. Sodium bicarbonate  
d. Calcium gluconate

36. Dr. Marquez tells a client that an increase intake of foods that are rich in Vitamin E and beta-carotene are important for healthier skin. The nurse teaches the client that excellent food sources of both of these substances are:

a. Fish and fruit jam  
b. Oranges and grapefruit  
c. Carrots and potatoes  
d. Spinach and mangoes

37. A client has Gastroesophageal Reflux Disease (GERD). The nurse should teach the client that after every meals, the client should…

a. Rest in sitting position  
b. Take a short walk  
c. Drink plenty of water  
d. Lie down at least 30 minutes

38. After gastroscopy, an adaptation that indicates major complication would be:

a. Nausea and vomiting  
b. Abdominal distention
c. Increased GI motility
d. Difficulty in swallowing

39. A client who has undergone a cholecystectomy asks the nurse whether there are any dietary restrictions that must be followed. Nurse Hilary would recognize that the dietary teaching was well understood when the client tells a family member that:

a. “Most people need to eat a high protein diet for 12 months after surgery”
b. “I should not eat those foods that upset me before the surgery”
c. “I should avoid fatty foods as long as I live”
d. “Most people can tolerate regular diet after this type of surgery”

40. Nurse Rachel teaches a client who has been recently diagnosed with hepatitis A about untoward signs and symptoms related to Hepatitis that may develop. The one that should be reported immediately to the physician is:

a. Restlessness
b. Yellow urine
c. Nausea
d. Clay-colored stools

41. Which of the following antituberculosis drugs can damage the 8th cranial nerve?

a. Isoniazid (INH)
b. Paraaminosalicylic acid (PAS)
c. Ethambutol hydrochloride (myambutol)
d. Streptomycin

42. The client asks Nurse Annie the causes of peptic ulcer. Nurse Annie responds that recent research indicates that peptic ulcers are the result of which of the following:

a. Genetic defect in gastric mucosa
b. Stress
c. Diet high in fat
d. Helicobacter pylori infection

43. Ryan has undergone subtotal gastrectomy. The nurse should expect that nasogastric tube drainage will be what color for about 12 to 24 hours after surgery?

a. Bile green
b. Bright red
c. Cloudy white
d. Dark brown
44. Nurse Joan is assigned to come for client who has just undergone eye surgery. Nurse Joan plans to teach the client activities that are permitted during the post operative period. Which of the following is best recommended for the client?

a. Watching circus  
b. Bending over  
c. Watching TV  
d. Lifting objects

45. A client suffered from a lower leg injury and seeks treatment in the emergency room. There is a prominent deformity to the lower aspect of the leg, and the injured leg appears shorter than the other leg. The affected leg is painful, swollen and beginning to become ecchymotic. The nurse interprets that the client is experiencing:

a. Fracture  
b. Strain  
c. Sprain  
d. Contusion

46. Nurse Jenny is instilling an otic solution into an adult male client left ear. Nurse Jenny avoids doing which of the following as part of the procedure

a. Pulling the auricle backward and upward  
b. Warming the solution to room temperature  
c. Pacing the tip of the dropper on the edge of ear canal  
d. Placing client in side lying position

47. Nurse Bea should instruct the male client with an ileostomy to report immediately which of the following symptom?

a. Absence of drainage from the ileostomy for 6 or more hours  
b. Passage of liquid stool in the stoma  
c. Occasional presence of undigested food  
d. A temperature of 37.6 °C

48. Jerry has diagnosed with appendicitis. He develops a fever, hypotension and tachycardia. The nurse suspects which of the following complications?

a. Intestinal obstruction  
b. Peritonitis  
c. Bowel ischemia  
d. Deficient fluid volume

49. Which of the following compilations should the nurse carefully monitors a client with acute pancreatitis.
50. Which of the following symptoms during the icteric phase of viral hepatitis should the nurse expect the client to inhibit?

a. Watery stool
b. Yellow sclera
c. Tarry stool
d. Shortness of breath

1. **B.** Left sided heart failure causes fluid accumulation in the capillary network of the lung. Fluid eventually enters alveolar spaces and causes crackling sounds at the end of inspiration.
2. **B.** Morphine is a central nervous system depressant used to relieve the pain associated with myocardial infarction, it also decreases apprehension and prevents cardiogenic shock.
3. **D.** Seeing yellow spots and colored vision are common symptoms of digitalis toxicity.
4. **C.** When diuretics are taken in the morning, client will void frequently during daytime and will not need to void frequently at night.
5. **B.** The primary goal of therapy for the client with pulmonary edema or heart failure is increasing cardiac output. Pulmonary edema is an acute medical emergency requiring immediate intervention.
6. **C.** Decerebrate posturing is the extension of the extremities after a stimulus which may occur with upper brain stem injury.
7. **C.** The most frequent side effects of Cascara Sagrada (Laxative) is abdominal cramps and nausea.
8. **D.** Administration of Intravenous Nitroglycerin infusion requires pump for accurate control of medication.
9. **A.** By the 2nd day of hospitalization after suffering a Myocardial Infarction, Clients are able to perform care without chest pain.
10. **B.** The left side of the body will be affected in a right-sided brain attack.
11. **A.** After nephrectomy, it is necessary to measure urine output hourly. This is done to assess the effectiveness of the remaining kidney also to detect renal failure early.
12. **B.** The lumen of the arteries can be assessed by cardiac catheterization. Angina is usually caused by narrowing of the coronary arteries.
13. **C.** Blood pressure is monitored to detect hypotension which may indicate shock or hemorrhage. Apical pulse is taken to detect dysrhythmias related to cardiac irritability.
14. A. Protamine Sulfate is used to prevent continuous bleeding in client who has undergone open heart surgery.
15. C. The use of electronic toothbrush, irrigation device or dental floss may cause bleeding of gums, allowing bacteria to enter and increasing the risk of endocarditis.
16. B. Weight gain due to retention of fluids and worsening heart failure causes exertional dyspnea in clients with mitral regurgitation.
17. D. Discomfort or pain is a problem that originates in the kidney. It is felt at the costovertebral angle on the affected side.
18. A. Perfusion can be best estimated by blood pressure, which is an indirect reflection of the adequacy of cardiac output.
19. C. Myoclonic seizure is characterized by sudden uncontrollable jerking movements of a single or multiple muscle group.
20. D. Nicotine (Nicotrol) is given in controlled and decreasing doses for the management of nicotine withdrawal syndrome.
21. D. Raynaud’s disease is characterized by vasospasms of the small cutaneous arteries that involves fingers and toes.
22. A. Urine testing provides an indirect measure that maybe influenced by kidney function while blood glucose testing is a more direct and accurate measure.
23. C. One liter of fluid approximately weighs 2.2 pounds. A 4.5 pound weight loss equals to approximately 2L.
24. A. Osmosis is the movement of fluid from an area of lesser solute concentration to an area of greater solute concentration.
25. D. Forearm muscle weakness is a probable sign of radial nerve injury caused by crutch pressure on the axillae.
26. B. Neutropenic client is at risk for infection especially bacterial infection of the gastrointestinal and respiratory tract.
27. C. Semi-fowlers position will localize the spilled stomach contents in the lower part of the abdominal cavity.
28. C. Positioning the client laterally with the neck extended does not obstruct the airway so that drainage of secretions and oxygen and carbon dioxide exchange can occur.
29. B. Excessive bubbling indicates an air leak which must be eliminated to permit lung expansion.
30. C. Wheat cereal has a low sodium content.
31. A. Enlarged cirrhotic liver impinges the portal system causing increased hydrostatic pressure resulting to ascites.
32. C. Assessing for an open airway is the priority. The procedure involves the neck, the anesthesia may have affected the swallowing reflex or the inflammation may have closed in on the airway leading to ineffective air exchange.
33. A. Typical signs and symptoms of hypovolemic shock includes systolic blood pressure of less than 90 mm Hg.
34. D. Aspirin containing medications should not be taken 14 days before surgery to decrease the risk of bleeding.
35. A. Metabolic acidosis is anaerobic metabolism caused by lack of ability of the body to use circulating glucose. Administration of insulin corrects this problem.
36. **D.** Beta-carotene and Vitamin E are antioxidants which help to inhibit oxidation. Vitamin E is found in the following foods: wheat germ, corn, nuts, seeds, olives, **spinach**, asparagus and other green leafy vegetables. Food sources of beta-carotene include dark green vegetables, carrots, **mangoes** and tomatoes.

37. **A.** Gravity speeds up digestion and prevents reflux of stomach contents into the esophagus.

38. **B.** Abdominal distension may be associated with pain, may indicate perforation, a complication that could lead to peritonitis.

39. **D.** It may take 4 to 6 months to eat anything, but most people can eat anything they want.

40. **D.** Clay colored stools are indicative of hepatic obstruction

41. **D.** Streptomycin is an aminoglycoside and damage on the 8th cranial nerve (ototoxicity) is a common side effect of aminoglycosides.

42. **D.** Most peptic ulcer is caused by Helicobacter pylori which is a gram negative bacterium.

43. **D.** 12 to 24 hours after subtotal gastrectomy gastric drainage is normally brown, which indicates digested food.

44. **C.** Watching TV is permissible because the eye does not need to move rapidly with this activity, and it does not increase intraocular pressure.

45. **A.** Common signs and symptoms of fracture include pain, deformity, shortening of the extremity, crepitus and swelling.

46. **C.** The dropper should not touch any object or any part of the client’s ear.

47. **A.** Sudden decrease in drainage or onset of severe abdominal pain should be reported immediately to the physician because it could mean that obstruction has been developed.

48. **B.** Complications of acute appendicitis are peritonitis, perforation and abscess development.

49. **D.** A client with acute pancreatitis is prone to complications associated with respiratory system.

50. **B.** Liver inflammation and obstruction block the normal flow of bile. Excess bilirubin turns the skin and sclera yellow and the urine dark and frothy.

**Medical Surgical Nursing Practice Test Part 2 (Moderate)**

1. Marco who was diagnosed with brain tumor was scheduled for craniotomy. In preventing the development of cerebral edema after surgery, the nurse should expect the use of:

   a. Diuretics
   b. Antihypertensive
   c. Steroids
   d. Anticonvulsants

2. Halfway through the administration of blood, the female client complains of lumbar pain. After stopping the infusion Nurse Hazel should:
a. Increase the flow of normal saline
b. Assess the pain further
c. Notify the blood bank
d. Obtain vital signs.

3. Nurse Maureen knows that the positive diagnosis for HIV infection is made based on which of the following:

a. A history of high risk sexual behaviors.
b. Positive ELISA and western blot tests
c. Identification of an associated opportunistic infection
d. Evidence of extreme weight loss and high fever

4. Nurse Maureen is aware that a client who has been diagnosed with chronic renal failure recognizes an adequate amount of high-biologic-value protein when the food the client selected from the menu was:

a. Raw carrots
b. Apple juice
c. Whole wheat bread
d. Cottage cheese

5. Kenneth who has diagnosed with uremic syndrome has the potential to develop complications. Which among the following complications should the nurse anticipates:

a. Flapping hand tremors
b. An elevated hematocrit level
c. Hypotension
d. Hypokalemia

6. A client is admitted to the hospital with benign prostatic hyperplasia, the nurse most relevant assessment would be:

a. Flank pain radiating in the groin
b. Distention of the lower abdomen
c. Perineal edema
d. Urethral discharge

7. A client has undergone with penile implant. After 24 hrs of surgery, the client’s scrotum was edematous and painful. The nurse should:

a. Assist the client with sitz bath
b. Apply war soaks in the scrotum
c. Elevate the scrotum using a soft support
d. Prepare for a possible incision and drainage.
8. Nurse Hazel receives emergency laboratory results for a client with chest pain and immediately informs the physician. An increased myoglobin level suggests which of the following?

a. Liver disease  
b. Myocardial damage  
c. Hypertension  
d. Cancer

9. Nurse Maureen would expect the a client with mitral stenosis would demonstrate symptoms associated with congestion in the:

a. Right atrium  
b. Superior vena cava  
c. Aorta  
d. Pulmonary

10. A client has been diagnosed with hypertension. The nurse priority nursing diagnosis would be:

a. Ineffective health maintenance  
b. Impaired skin integrity  
c. Deficient fluid volume  
d. Pain

11. Nurse Hazel teaches the client with angina about common expected side effects of nitroglycerin including:

a. high blood pressure  
b. stomach cramps  
c. headache  
d. shortness of breath

12. The following are lipid abnormalities. Which of the following is a risk factor for the development of atherosclerosis and PVD?

a. High levels of low density lipid (LDL) cholesterol  
b. High levels of high density lipid (HDL) cholesterol  
c. Low concentration triglycerides  
d. Low levels of LDL cholesterol.

13. Which of the following represents a significant risk immediately after surgery for repair of aortic aneurysm?

a. Potential wound infection  
b. Potential ineffective coping
c. Potential electrolyte balance
d. Potential alteration in renal perfusion

14. Nurse Josie should instruct the client to eat which of the following foods to obtain the best supply of Vitamin B12?

a. dairy products  
b. vegetables  
c. Grains  
d. Broccoli

15. Karen has been diagnosed with aplastic anemia. The nurse monitors for changes in which of the following physiologic functions?

a. Bowel function  
b. Peripheral sensation  
c. Bleeding tendencies  
d. Intake and out put

16. Lydia is scheduled for elective splenectomy. Before the clients goes to surgery, the nurse in charge final assessment would be:

a. signed consent  
b. vital signs  
c. name band  
d. empty bladder

17. What is the peak age range in acquiring acute lymphocytic leukemia (ALL)?

a. 4 to 12 years.  
b. 20 to 30 years  
c. 40 to 50 years  
d. 60 60 70 years

18. Marie with acute lymphocytic leukemia suffers from nausea and headache. These clinical manifestations may indicate all of the following except

a. effects of radiation  
b. chemotherapy side effects  
c. meningeal irritation  
d. gastric distension

19. A client has been diagnosed with Disseminated Intravascular Coagulation (DIC). Which of the following is contraindicated with the client?

a. Administering Heparin
b. Administering Coumadin  
c. Treating the underlying cause  
d. Replacing depleted blood products  

20. Which of the following findings is the best indication that fluid replacement for the client with hypovolemic shock is adequate? 

a. Urine output greater than 30ml/hr  
b. Respiratory rate of 21 breaths/minute  
c. Diastolic blood pressure greater than 90 mmhg  
d. Systolic blood pressure greater than 110 mmhg  

21. Which of the following signs and symptoms would Nurse Maureen include in teaching plan as an early manifestation of laryngeal cancer?  

a. Stomatitis  
b. Airway obstruction  
c. Hoarseness  
d. Dysphagia  

22. Karina a client with myasthenia gravis is to receive immunosuppressive therapy. The nurse understands that this therapy is effective because it:  

a. Promotes the removal of antibodies that impair the transmission of impulses  
b. Stimulates the production of acetylcholine at the neuromuscular junction.  
c. Decreases the production of autoantibodies that attack the acetylcholine receptors.  
d. Inhibits the breakdown of acetylcholine at the neuromuscular junction.  

23. A female client is receiving IV Mannitol. An assessment specific to safe administration of the said drug is:  

a. Vital signs q4h  
b. Weighing daily  
c. Urine output hourly  
d. Level of consciousness q4h  

24. Patricia a 20 year old college student with diabetes mellitus requests additional information about the advantages of using a pen like insulin delivery devices. The nurse explains that the advantages of these devices over syringes includes:  

a. Accurate dose delivery  
b. Shorter injection time  
c. Lower cost with reusable insulin cartridges  
d. Use of smaller gauge needle.
25. A male client’s left tibia was fractured in an automobile accident, and a cast is applied. To assess for damage to major blood vessels from the fracture tibia, the nurse in charge should monitor the client for:

a. Swelling of the left thigh  
b. Increased skin temperature of the foot  
c. Prolonged reperfusion of the toes after blanching  
d. Increased blood pressure

26. After a long leg cast is removed, the male client should:

a. Cleanse the leg by scrubbing with a brisk motion  
b. Put leg through full range of motion twice daily  
c. Report any discomfort or stiffness to the physician  
d. Elevate the leg when sitting for long periods of time.

27. While performing a physical assessment of a male client with gout of the great toe, Nurse Vivian should assess for additional tophi (urate deposits) on the:

a. Buttocks  
b. Ears  
c. Face  
d. Abdomen

28. Nurse Katrina would recognize that the demonstration of crutch walking with tripod gait was understood when the client places weight on the:

a. Palms of the hands and axillary regions  
b. Palms of the hand  
c. Axillary regions  
d. Feet, which are set apart

29. Mang Jose with rheumatoid arthritis states, “the only time I am without pain is when I lie in bed perfectly still”. During the convalescent stage, the nurse in charge with Mang Jose should encourage:

a. Active joint flexion and extension  
b. Continued immobility until pain subsides  
c. Range of motion exercises twice daily  
d. Flexion exercises three times daily

30. A male client has undergone spinal surgery, the nurse should:

a. Observe the client’s bowel movement and voiding patterns  
b. Log-roll the client to prone position  
c. Assess the client’s feet for sensation and circulation
d. Encourage client to drink plenty of fluids

31. Marina with acute renal failure moves into the diuretic phase after one week of therapy. During this phase the client must be assessed for signs of developing:

a. Hypovolemia
b. renal failure
c. metabolic acidosis
d. hyperkalemia

32. Nurse Judith obtains a specimen of clear nasal drainage from a client with a head injury. Which of the following tests differentiates mucus from cerebrospinal fluid (CSF)?

a. Protein
b. Specific gravity
c. Glucose
d. Microorganism

33. A 22 year old client suffered from his first tonic-clonic seizure. Upon awakening the client asks the nurse, “What caused me to have a seizure? Which of the following would the nurse include in the primary cause of tonic clonic seizures in adults more the 20 years?

a. Electrolyte imbalance
b. Head trauma
c. Epilepsy
d. Congenital defect

34. What is the priority nursing assessment in the first 24 hours after admission of the client with thrombotic CVA?

a. Pupil size and papillary response
b. cholesterol level
c. Echocardiogram
d. Bowel sounds

35. Nurse Linda is preparing a client with multiple sclerosis for discharge from the hospital to home. Which of the following instruction is most appropriate?

a. “Practice using the mechanical aids that you will need when future disabilities arise”.
b. “Follow good health habits to change the course of the disease”.
c. “Keep active, use stress reduction strategies, and avoid fatigue.
d. “You will need to accept the necessity for a quiet and inactive lifestyle”.
36. The nurse is aware the early indicator of hypoxia in the unconscious client is:

a. Cyanosis  
b. Increased respirations  
c. Hypertension  
d. Restlessness

37. A client is experiencing spinal shock. Nurse Myrna should expect the function of the bladder to be which of the following?

a. Normal  
b. Atonic  
c. Spastic  
d. Uncontrolled

38. Which of the following stage the carcinogen is irreversible?

a. Progression stage  
b. Initiation stage  
c. Regression stage  
d. Promotion stage

39. Among the following components thorough pain assessment, which is the most significant?

a. Effect  
b. Cause  
c. Causing factors  
d. Intensity

40. A 65 year old female is experiencing flare up of pruritus. Which of the client’s action could aggravate the cause of flare ups?

a. Sleeping in cool and humidified environment  
b. Daily baths with fragrant soap  
c. Using clothes made from 100% cotton  
d. Increasing fluid intake

41. Atropine sulfate (Atropine) is contraindicated in all but one of the following client?

a. A client with high blood  
b. A client with bowel obstruction  
c. A client with glaucoma  
d. A client with U.T.I
42. Among the following clients, which among them is high risk for potential hazards from the surgical experience?

a. 67-year-old client  
b. 49-year-old client  
c. 33-year-old client  
d. 15-year-old client

43. Nurse Jon assesses vital signs on a client undergone epidural anesthesia. Which of the following would the nurse assess next?

a. Headache  
b. Bladder distension  
c. Dizziness  
d. Ability to move legs

44. Nurse Katrina should anticipate that all of the following drugs may be used in the attempt to control the symptoms of Meniere’s disease except:

a. Antiemetics  
b. Diuretics  
c. Antihistamines  
d. Glucocorticoids

45. Which of the following complications associated with tracheostomy tube?

a. Increased cardiac output  
b. Acute respiratory distress syndrome (ARDS)  
c. Increased blood pressure  
d. Damage to laryngeal nerves

46. Nurse Faith should recognize that fluid shift in an client with burn injury results from increase in the:

a. Total volume of circulating whole blood  
b. Total volume of intravascular plasma  
c. Permeability of capillary walls  
d. Permeability of kidney tubules

47. An 83-year-old woman has several ecchymotic areas on her right arm. The bruises are probably caused by:

a. increased capillary fragility and permeability  
b. increased blood supply to the skin  
c. self inflicted injury  
d. elder abuse
48. Nurse Anna is aware that early adaptation of client with renal carcinoma is:

a. Nausea and vomiting  
b. flank pain  
c. weight gain  
d. intermittent hematuria

49. A male client with tuberculosis asks Nurse Brian how long the chemotherapy must be continued. Nurse Brian’s accurate reply would be:

a. 1 to 3 weeks  
b. 6 to 12 months  
c. 3 to 5 months  
d. 3 years and more

50. A client has undergone laryngectomy. The immediate nursing priority would be:

a. Keep trachea free of secretions  
b. Monitor for signs of infection  
c. Provide emotional support  
d. Promote means of communication

**Answers and Rationale Medical Surgical Nursing Practice Test Part2**

1. C. Glucocorticoids (steroids) are used for their anti-inflammatory action, which decreases the development of edema.

2. A. The blood must be stopped at once, and then normal saline should be infused to keep the line patent and maintain blood volume.

3. B. These tests confirm the presence of HIV antibodies that occur in response to the presence of the human immunodeficiency virus (HIV).

4. D. One cup of cottage cheese contains approximately 225 calories, 27 g of protein, 9 g of fat, 30 mg cholesterol, and 6 g of carbohydrate. Proteins of high biologic value (HBV) contain optimal levels of amino acids essential for life.

5. A. Elevation of uremic waste products causes irritation of the nerves, resulting in flapping hand tremors.

6. B. This indicates that the bladder is distended with urine, therefore palpable.

7. C. Elevation increases lymphatic drainage, reducing edema and pain.

8. B. Detection of myoglobin is a diagnostic tool to determine whether myocardial damage has occurred.
9. **D.** When mitral stenosis is present, the left atrium has difficulty emptying its contents into the left ventricle because there is no valve to prevent back ward flow into the pulmonary vein, the pulmonary circulation is under pressure.

10. **A.** Managing hypertension is the priority for the client with hypertension. Clients with hypertension frequently do not experience pain, deficient volume, or impaired skin integrity. It is the asymptomatic nature of hypertension that makes it so difficult to treat.

11. **C.** Because of its widespread vasodilating effects, nitroglycerin often produces side effects such as headache, hypotension and dizziness.

12. **A.** An increased in LDL cholesterol concentration has been documented at risk factor for the development of atherosclerosis. LDL cholesterol is not broken down into the liver but is deposited into the wall of the blood vessels.

13. **D.** There is a potential alteration in renal perfusion manifested by decreased urine output. The altered renal perfusion may be related to renal artery embolism, prolonged hypotension, or prolonged aortic cross-clamping during the surgery.

14. **A.** Good source of vitamin B12 are dairy products and meats.

15. **C.** Aplastic anemia decreases the bone marrow production of RBC’s, white blood cells, and platelets. The client is at risk for bruising and bleeding tendencies.

16. **B.** An elective procedure is scheduled in advance so that all preparations can be completed ahead of time. The vital signs are the final check that must be completed before the client leaves the room so that continuity of care and assessment is provided for.

17. **A.** The peak incidence of Acute Lymphocytic Leukemia (ALL) is 4 years of age. It is uncommon after 15 years of age.

18. **D.** Acute Lymphocytic Leukemia (ALL) does not cause gastric distention. It does invade the central nervous system, and clients experience headaches and vomiting from meningeal irritation.

19. **B.** Disseminated Intravascular Coagulation (DIC) has not been found to respond to oral anticoagulants such as Coumadin.

20. **A.** Urine output provides the most sensitive indication of the client’s response to therapy for hypovolemic shock. Urine output should be consistently greater than 30 to 35 mL/hr.
21. **C.** Early warning signs of laryngeal cancer can vary depending on tumor location. Hoarseness lasting 2 weeks should be evaluated because it is one of the most common warning signs.

22. **C.** Steroids decrease the body’s immune response thus decreasing the production of antibodies that attack the acetylcholine receptors at the neuromuscular junction.

23. **C.** The osmotic diuretic mannitol is contraindicated in the presence of inadequate renal function or heart failure because it increases the intravascular volume that must be filtered and excreted by the kidney.

24. **A.** These devices are more accurate because they are easily to used and have improved adherence in insulin regimens by young people because the medication can be administered discreetly.

25. **C.** Damage to blood vessels may decrease the circulatory perfusion of the toes, this would indicate the lack of blood supply to the extremity.

26. **D.** Elevation will help control the edema that usually occurs.

27. **B.** Uric acid has a low solubility, it tends to precipitate and form deposits at various sites where blood flow is least active, including cartilaginous tissue such as the ears.

28. **B.** The palms should bear the client’s weight to avoid damage to the nerves in the axilla.

29. **A.** Active exercises, alternating extension, flexion, abduction, and adduction, mobilize exudates in the joints relieves stiffness and pain.

30. **C.** Alteration in sensation and circulation indicates damage to the spinal cord, if these occurs notify physician immediately.

31. **A.** In the diuretic phase fluid retained during the oliguric phase is excreted and may reach 3 to 5 liters daily, hypovolemia may occur and fluids should be replaced.

32. **C.** The constituents of CSF are similar to those of blood plasma. An examination for glucose content is done to determine whether a body fluid is a mucus or a CSF. A CSF normally contains glucose.

33. **B.** Trauma is one of the primary cause of brain damage and seizure activity in adults. Other common causes of seizure activity in adults include neoplasms, withdrawal from drugs and alcohol, and vascular disease.

34. **A.** It is crucial to monitor the pupil size and papillary response to indicate changes around the cranial nerves.
35. **C.** The nurse most positive approach is to encourage the client with multiple sclerosis to stay active, use stress reduction techniques and avoid fatigue because it is important to support the immune system while remaining active.

36. **D.** Restlessness is an early indicator of hypoxia. The nurse should suspect hypoxia in unconscious client who suddenly becomes restless.

37. **B.** In spinal shock, the bladder becomes completely atonic and will continue to fill unless the client is catheterized.

38. **A.** Progression stage is the change of tumor from the preneoplastic state or low degree of malignancy to a fast growing tumor that cannot be reversed.

39. **D.** Intensity is the major indicative of severity of pain and it is important for the evaluation of the treatment.

40. **B.** The use of fragrant soap is very drying to skin hence causing the pruritus.

41. **C.** Atropine sulfate is contraindicated with glaucoma patients because it increases intraocular pressure.

42. **A.** A 67 year old client is greater risk because the older adult client is more likely to have a less-effective immune system.

43. **B.** The last area to return sensation is in the perineal area, and the nurse in charge should monitor the client for distended bladder.

44. **D.** Glucocorticoids play no significant role in disease treatment.

45. **D.** Tracheostomy tube has several potential complications including bleeding, infection and laryngeal nerve damage.

46. **C.** In burn, the capillaries and small vessels dilate, and cell damage cause the release of a histamine-like substance. The substance causes the capillary walls to become more permeable and significant quantities of fluid are lost.

47. **A.** Aging process involves increased capillary fragility and permeability. Older adults have a decreased amount of subcutaneous fat and cause an increased incidence of bruise like lesions caused by collection of extravascular blood in loosely structured dermis.

48. **D.** Intermittent pain is the classic sign of renal carcinoma. It is primarily due to capillary erosion by the cancerous growth.
49. **B.** Tubercle bacillus is a drug resistant organism and takes a long time to be eradicated. Usually a combination of three drugs is used for minimum of 6 months and at least six months beyond culture conversion.

50. **A.** Patent airway is the most priority; therefore removal of secretions is necessary.

**Medical Surgical Nursing Practice Test Part 3 (HARD)**

1. A client is scheduled for insertion of an inferior vena cava (IVC) filter. Nurse Patricia consults the physician about withholding which regularly scheduled medication on the day before the surgery?

   a. Potassium Chloride  
   b. Warfarin Sodium  
   c. Furosemide  
   d. Docusate

2. A nurse is planning to assess the corneal reflex on unconscious client. Which of the following is the safest stimulus to touch the client’s cornea?

   a. Cotton buds  
   b. Sterile glove  
   c. Sterile tongue depressor  
   d. Wisp of cotton

3. A female client develops an infection at the catheter insertion site. The nurse in charge uses the term “iatrogenic” when describing the infection because it resulted from:

   a. Client’s developmental level  
   b. Therapeutic procedure  
   c. Poor hygiene  
   d. Inadequate dietary patterns

4. Nurse Carol is assessing a client with Parkinson’s disease. The nurse recognize bradykinesia when the client exhibits:

   a. Intentional tremor  
   b. Paralysis of limbs  
   c. Muscle spasm  
   d. Lack of spontaneous movement

5. A client who suffered from automobile accident complains of seeing frequent flashes of light. The nurse should expect:

   a. Myopia
b. Detached retina  
c. Glaucoma  
d. Scleroderma  

6. Kate with severe head injury is being monitored by the nurse for increasing intracranial pressure (ICP). Which finding should be most indicative sign of increasing intracranial pressure?  

a. Intermittent tachycardia  
b. Polydipsia  
c. Tachypnea  
d. Increased restlessness  

7. A hospitalized client had a tonic-clonic seizure while walking in the hall. During the seizure the nurse priority should be:  
a. Hold the client’s arms and leg firmly  
b. Place the client immediately to soft surface  
c. Protects the client’s head from injury  
d. Attempt to insert a tongue depressor between the client’s teeth  

8. A client has undergone right pneumonectomy. When turning the client, the nurse should plan to position the client either:  
a. Right side-lying position or supine  
b. High fowlers  
c. Right or left side lying position  
d. Low fowler’s position  

9. Nurse Jenny should caution a female client who is sexually active in taking Isoniazid (INH) because the drug has which of the following side effects?  
a. Prevents ovulation  
b. Has a mutagenic effect on ova  
c. Decreases the effectiveness of oral contraceptives  
d. Increases the risk of vaginal infection  

10. A client has undergone gastrectomy. Nurse Jovy is aware that the best position for the client is:  
a. Left side lying  
b. Low fowler’s  
c. Prone  
d. Supine  

11. During the initial postoperative period of the client’s stoma. The nurse evaluates which of the following observations should be reported immediately to the physician?  
a. Stoma is dark red to purple
b. Stoma is oozes a small amount of blood
  c. Stoma is lightly edematous
  d. Stoma does not expel stool

12. Kate which has diagnosed with ulcerative colitis is following physician’s order for
bed rest with bathroom privileges. What is the rationale for this activity restriction?

a. Prevent injury
b. Promote rest and comfort
c. Reduce intestinal peristalsis
d. Conserve energy

13. Nurse KC should regularly assess the client’s ability to metabolize the total parenteral
nutrition (TPN) solution adequately by monitoring the client for which of the following
signs:

a. Hyperglycemia
b. Hypoglycemia
  c. Hypertension
d. Elevate blood urea nitrogen concentration

14. A female client has an acute pancreatitis. Which of the following signs and symptoms
the nurse would expect to see?

a. Constipation
b. Hypertension
c. Ascites
d. Jaundice

15. A client is suspected to develop tetany after a subtotal thyroidectomy. Which of the
following symptoms might indicate tetany?

a. Tingling in the fingers
b. Pain in hands and feet
c. Tension on the suture lines
d. Bleeding on the back of the dressing

16. A 58 year old woman has newly diagnosed with hypothyroidism. The nurse is aware
that the signs and symptoms of hypothyroidism include:

a. Diarrhea
b. Vomiting
c. Tachycardia
d. Weight gain
17. A client has undergone for an ileal conduit, the nurse in charge should closely monitor the client for occurrence of which of the following complications related to pelvic surgery?

a. Ascites
b. Thrombophlebitis
c. Inguinal hernia
d. Peritonitis

18. Dr. Marquez is about to defibrillate a client in ventricular fibrillation and says in a loud voice “clear”. What should be the action of the nurse?

a. Places conductive gel pads for defibrillation on the client’s chest
b. Turn off the mechanical ventilator
c. Shuts off the client’s IV infusion
d. Steps away from the bed and make sure all others have done the same

19. A client has been diagnosed with glomerulonephritis complains of thirst. The nurse should offer:

a. Juice
b. Ginger ale
c. Milk shake
d. Hard candy

20. A client with acute renal failure is aware that the most serious complication of this condition is:

a. Constipation
b. Anemia
c. Infection
d. Platelet dysfunction

21. Nurse Karen is caring for clients in the OR. The nurse is aware that the last physiologic function that the client loss during the induction of anesthesia is:

a. Consciousness
b. Gag reflex
c. Respiratory movement
d. Corneal reflex

22. The nurse is assessing a client with pleural effusion. The nurse expect to find:

a. Deviation of the trachea towards the involved side
b. Reduced or absent of breath sounds at the base of the lung
c. Moist crackles at the posterior of the lungs
23. A client admitted with newly diagnosed with Hodgkin’s disease. Which of the following would the nurse expect the client to report?

a. Lymph node pain  
b. Weight gain  
c. Night sweats  
d. Headache

24. A client has suffered from fall and sustained a leg injury. Which appropriate question would the nurse ask the client to help determine if the injury caused fracture?

a. “Is the pain sharp and continuous?”  
b. “Is the pain dull ache?”  
c. “Does the discomfort feel like a cramp?”  
d. “Does the pain feel like the muscle was stretched?”

25. The Nurse is assessing the client’s casted extremity for signs of infection. Which of the following findings is indicative of infection?

a. Edema  
b. Weak distal pulse  
c. Coolness of the skin  
d. Presence of “hot spot” on the cast

26. Nurse Rhia is performing an otoscopic examination on a female client with a suspected diagnosis of mastoiditis. Nurse Rhia would expect to note which of the following if this disorder is present?

a. Transparent tympanic membrane  
b. Thick and immobile tympanic membrane  
c. Pearly colored tympanic membrane  
d. Mobile tympanic membrane

27. Nurse Jocelyn is caring for a client with nasogastric tube that is attached to low suction. Nurse Jocelyn assesses the client for symptoms of which acid-base disorder?

a. Respiratory alkalosis  
b. Respiratory acidosis  
c. Metabolic acidosis  
d. Metabolic alkalosis

28. A male adult client has undergone a lumbar puncture to obtain cerebrospinal fluid (CSF) for analysis. Which of the following values should be negative if the CSF is normal?
a. Red blood cells  
b. White blood cells  
c. Insulin  
d. Protein  

29. A client is suspected of developing diabetes insipidus. Which of the following is the most effective assessment?
   a. Taking vital signs every 4 hours  
   b. Monitoring blood glucose  
   c. Assessing ABG values every other day  
   d. Measuring urine output hourly  

30. A 58 year old client is suffering from acute phase of rheumatoid arthritis. Which of the following would the nurse in charge identify as the lowest priority of the plan of care?
   a. Prevent joint deformity  
   b. Maintaining usual ways of accomplishing task  
   c. Relieving pain  
   d. Preserving joint function  

31. Among the following, which client is autotransfusion possible?
   a. Client with AIDS  
   b. Client with ruptured bowel  
   c. Client who is in danger of cardiac arrest  
   d. Client with wound infection  

32. Which of the following is not a sign of thromboembolism?
   a. Edema  
   b. Swelling  
   c. Redness  
   d. Coolness  

33. Nurse Becky is caring for client who begins to experience seizure while in bed. Which action should the nurse implement to prevent aspiration?
   a. Position the client on the side with head flexed forward  
   b. Elevate the head  
   c. Use tongue depressor between teeth  
   d. Loosen restrictive clothing  

34. A client has undergone bone biopsy. Which nursing action should the nurse provide after the procedure?
a. Administer analgesics via IM
b. Monitor vital signs
c. Monitor the site for bleeding, swelling and hematoma formation
d. Keep area in neutral position

35. A client is suffering from low back pain. Which of the following exercises will strengthen the lower back muscle of the client?

a. Tennis
b. Basketball
c. Diving
d. Swimming

36. A client with peptic ulcer is being assessed by the nurse for gastrointestinal perforation. The nurse should monitor for:

a. (+) guaiac stool test
b. Slow, strong pulse
c. Sudden, severe abdominal pain
d. Increased bowel sounds

37. A client has undergone surgery for retinal detachment. Which of the following goal should be prioritized?

a. Prevent an increase intraocular pressure
b. Alleviate pain
c. Maintain darkened room
d. Promote low-sodium diet

38. A client with glaucoma has been prescribed with miotics. The nurse is aware that miotics is for:

a. Constricting pupil
b. Relaxing ciliary muscle
c. Constricting intraocular vessel
d. Paralyzing ciliary muscle

39. When suctioning an unconscious client, which nursing intervention should the nurse prioritize in maintaining cerebral perfusion?

a. Administer diuretics
b. Administer analgesics
c. Provide hygiene
d. Hyperoxygenate before and after suctioning
40. When discussing breathing exercises with a postoperative client, Nurse Hazel should include which of the following teaching?

- a. Short frequent breaths
- b. Exhale with mouth open
- c. Exercise twice a day
- d. Place hand on the abdomen and feel it rise

41. Louie, with burns over 35% of the body, complains of chills. In promoting the client’s comfort, the nurse should:

- a. Maintain room humidity below 40%
- b. Place top sheet on the client
- c. Limit the occurrence of drafts
- d. Keep room temperature at 80 degrees

42. Nurse Trish is aware that temporary heterograft (pig skin) is used to treat burns because this graft will:

- a. Relieve pain and promote rapid epithelialization
- b. Be sutured in place for better adherence
- c. Debride necrotic epithelium
- d. Concurrently used with topical antimicrobials

43. Mark has multiple abrasions and a laceration to the trunk and all four extremities says, “I can’t eat all this food”. The food that the nurse should suggest to be eaten first should be:

- a. Meat loaf and coffee
- b. Meat loaf and strawberries
- c. Tomato soup and apple pie
- d. Tomato soup and buttered bread

44. Tony returns from surgery with permanent colostomy. During the first 24 hours the colostomy does not drain. The nurse should be aware that:

- a. Proper functioning of nasogastric suction
- b. Presurgical decrease in fluid intake
- c. Absence of gastrointestinal motility
- d. Intestinal edema following surgery

45. When teaching a client about the signs of colorectal cancer, Nurse Trish stresses that the most common complaint of persons with colorectal cancer is:

- a. Abdominal pain
- b. Hemorrhoids
- c. Change in caliber of stools
d. Change in bowel habits

46. Louis develops peritonitis and sepsis after surgical repair of ruptures diverticulum. The nurse in charge should expect an assessment of the client to reveal:

a. Tachycardia  
b. Abdominal rigidity  
c. Bradycardia  
d. Increased bowel sounds

47. Immediately after liver biopsy, the client is placed on the right side, the nurse is aware that this position should be maintained because it will:

a. Help stop bleeding if any occurs  
b. Reduce the fluid trapped in the biliary ducts  
c. Position with greatest comfort  
d. Promote circulating blood volume

48. Tony has diagnosed with hepatitis A. The information from the health history that is most likely linked to hepatitis A is:

a. Exposed with arsenic compounds at work  
b. Working as local plumber  
c. Working at hemodialysis clinic  
d. Dish washer in restaurants

49. Nurse Trish is aware that the laboratory test result that most likely would indicate acute pancreatitis is an elevated:

a. Serum bilirubin level  
b. Serum amylase level  
c. Potassium level  
d. Sodium level

50. Dr. Marquez orders serum electrolytes. To determine the effect of persistent vomiting, Nurse Trish should be most concerned with monitoring the:

a. Chloride and sodium levels  
b. Phosphate and calcium levels  
c. Protein and magnesium levels  
d. Sulfate and bicarbonate levels

1. C. Glucocorticoids (steroids) are used for their anti-inflammatory action, which decreases the development of edema.
2. **A.** The blood must be stopped at once, and then normal saline should be infused to keep the line patent and maintain blood volume.

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Medical Surgical Nursing Practice Answer Part 3

1. B. In preoperative period, the nurse should consult with the physician about withholding Warfarin Sodium to avoid occurrence of hemorrhage.

2. D. A client who is unconscious is at greater risk for corneal abrasion. For this reason, the safest way to test the corneal reflex is by touching the cornea lightly with a wisp of cotton.

3. B. Iatrogenic infection is caused by the heath care provider or is induced inadvertently by medical treatment or procedures.

4. D. Bradykinesia is slowing down from the initiation and execution of movement.

5. B. This symptom is caused by stimulation of retinal cells by ocular movement.
6. **D.** Restlessness indicates a lack of oxygen to the brain stem which impairs the reticular activating system.

7. **C.** Rhythmic contraction and relaxation associated with tonic-clonic seizure can cause repeated banging of head.

8. **A.** Right side lying position or supine position permits ventilation of the remaining lung and prevent fluid from draining into sutured bronchial stump.

9. **C.** Isoniazid (INH) interferes in the effectiveness of oral contraceptives and clients of childbearing age should be counseled to use an alternative form of birth control while taking this drug.

10. **B.** A client who has had abdominal surgery is best placed in a low fowler’s position. This relaxes abdominal muscles and provides maximum respiratory and cardiovascular function.

11. **A.** Dark red to purple stoma indicates inadequate blood supply.

12. **C.** The rationale for activity restriction is to help reduce the hypermotility of the colon.

13. **A.** During Total Parenteral Nutrition (TPN) administration, the client should be monitored regularly for hyperglycemia.

14. **D.** Jaundice may be present in acute pancreatitis owing to obstruction of the biliary duct.

15. **A.** Tetany may occur after thyroidectomy if the parathyroid glands are accidentally injured or removed.

16. **D.** Typical signs of hypothyroidism includes weight gain, fatigue, decreased energy, apathy, brittle nails, dry skin, cold intolerance, constipation and numbness.

17. **B.** After a pelvic surgery, there is an increased chance of thrombophlebitis owing to the pelvic manipulation that can interfere with circulation and promote venous stasis.

18. **D.** For the safety of all personnel, if the defibrillator paddles are being discharged, all personnel must stand back and be clear of all the contact with the client or the client’s bed.

19. **D.** Hard candy will relieve thirst and increase carbohydrates but does not supply extra fluid.

20. **C.** Infection is responsible for one third of the traumatic or surgically induced death of clients with renal failure as well as medical induced acute renal failure (ARF)
21. **C.** There is no respiratory movement in stage 4 of anesthesia, prior to this stage, respiration is depressed but present.

22. **B.** Compression of the lung by fluid that accumulates at the base of the lungs reduces expansion and air exchange.

23. **C.** Assessment of a client with Hodgkin’s disease most often reveals enlarged, painless lymph node, fever, malaise and night sweats.

24. **A.** Fractured pain is generally described as sharp, continuous, and increasing in frequency.

25. **D.** Signs and symptoms of infection under a casted area include odor or purulent drainage and the presence of “hot spot” which are areas on the cast that are warmer than the others.

26. **B.** Otoscopic examination in a client with mastoiditis reveals a dull, red, thick and immobile tympanic membrane with or without perforation.

27. **D.** Loss of gastric fluid via nasogastric suction or vomiting causes metabolic alkalosis because of the loss of hydrochloric acid which is a potent acid in the body.

28. **A.** The adult with normal cerebrospinal fluid has no red blood cells.

29. **D.** Measuring the urine output to detect excess amount and checking the specific gravity of urine samples to determine urine concentration are appropriate measures to determine the onset of diabetes insipidus.

30. **B.** The nurse should focus more on developing less stressful ways of accomplishing routine task.

31. **C.** Autotransfusion is acceptable for the client who is in danger of cardiac arrest.

32. **D.** The client with thromboembolism does not have coolness.

33. **A.** Positioning the client on one side with head flexed forward allows the tongue to fall forward and facilitates drainage secretions therefore prevents aspiration.

34. **C.** Nursing care after bone biopsy includes close monitoring of the punctured site for bleeding, swelling and hematoma formation.

35. **D.** Walking and swimming are very helpful in strengthening back muscles for the client suffering from lower back pain.

36. **C.** Sudden, severe abdominal pain is the most indicative sign of perforation. When perforation of an ulcer occurs, the nurse maybe unable to hear bowel sounds at all.
37. A. After surgery to correct a detached retina, prevention of increased intraocular pressure is the priority goal.

38. A. Miotic agent constricts the pupil and contracts ciliary muscle. These effects widen the filtration angle and permit increased out flow of aqueous humor.

39. D. It is a priority to hyperoxygenate the client before and after suctioning to prevent hypoxia and to maintain cerebral perfusion.

40. D. Abdominal breathing improves lungs expansion

41. C. A Client with burns is very sensitive to temperature changes because heat is loss in the burn areas.

42. A. The graft covers the nerve endings, which reduces pain and provides framework for granulation

43. B. Meat provides proteins and the fruit proteins vitamin C that both promote wound healing.

44. C. This is primarily caused by the trauma of intestinal manipulation and the depressive effects anesthetics and analgesics.

45. D. Constipation, diarrhea, and/or constipation alternating with diarrhea are the most common symptoms of colorectal cancer.

46. B. With increased intraabdominal pressure, the abdominal wall will become tender and rigid.

47. A. Pressure applied in the puncture site indicates that a biliary vessel was puncture which is a common complication after liver biopsy.

48. B. Hepatitis A is primarily spread via fecal-oral route. Sewage polluted water may harbor the virus.

49. B. Amylase concentration is high in the pancreas and is elevated in the serum when the pancreas becomes acutely inflamed and also it distinguishes pancreatitis from other acute abdominal problems.

50. A. Sodium, which is concerned with the regulation of extracellular fluid volume, it is lost with vomiting. Chloride, which balances cations in the extracellular compartments, is also lost with vomiting, because sodium and chloride are parallel electrolytes, hyponatremia will accompany.
Psychiatric Nursing Practice Test Part 1

1. Marco approached Nurse Trish asking for advice on how to deal with his alcohol addiction. Nurse Trish should tell the client that the only effective treatment for alcoholism is:
   a. Psychotherapy  
   b. Alcoholics anonymous (A.A.)  
   c. Total abstinence  
   d. Aversion Therapy

2. Nurse Hazel is caring for a male client who experience false sensory perceptions with no basis in reality. This perception is known as:
   a. Hallucinations  
   b. Delusions  
   c. Loose associations  
   d. Neologisms

3. Nurse Monet is caring for a female client who has suicidal tendency. When accompanying the client to the restroom, Nurse Monet should…
   a. Give her privacy  
   b. Allow her to urinate  
   c. Open the window and allow her to get some fresh air  
   d. Observe her

4. Nurse Maureen is developing a plan of care for a female client with anorexia nervosa. Which action should the nurse include in the plan?
   a. Provide privacy during meals  
   b. Set-up a strict eating plan for the client  
   c. Encourage client to exercise to reduce anxiety  
   d. Restrict visits with the family

5. A client is experiencing anxiety attack. The most appropriate nursing intervention should include?
   a. Turning on the television  
   b. Leaving the client alone  
   c. Staying with the client and speaking in short sentences
d. Ask the client to play with other clients

6. A female client is admitted with a diagnosis of delusions of GRANDEUR. This diagnosis reflects a belief that one is:
   a. Being Killed
   b. Highly famous and important
   c. Responsible for evil world
   d. Connected to client unrelated to oneself

7. A 20 year old client was diagnosed with dependent personality disorder. Which behavior is most likely to be evidence of ineffective individual coping?
   a. Recurrent self-destructive behavior
   b. Avoiding relationship
   c. Showing interest in solitary activities
   d. Inability to make choices and decision without advise

8. A male client is diagnosed with schizotypal personality disorder. Which signs would this client exhibit during social situation?
   a. Paranoid thoughts
   b. Emotional affect
   c. Independence need
   d. Aggressive behavior

9. Nurse Claire is caring for a client diagnosed with bulimia. The most appropriate initial goal for a client diagnosed with bulimia is?
   a. Encourage to avoid foods
   b. Identify anxiety causing situations
   c. Eat only three meals a day
   d. Avoid shopping plenty of groceries

10. Nurse Tony was caring for a 41 year old female client. Which behavior by the client indicates adult cognitive development?
    a. Generates new levels of awareness
    b. Assumes responsibility for her actions
    c. Has maximum ability to solve problems and learn new skills
    d. Her perception are based on reality

11. A neuromuscular blocking agent is administered to a client before ECT therapy. The Nurse should carefully observe the client for?
    a. Respiratory difficulties
    b. Nausea and vomiting
    c. Dizziness
    d. Seizures

12. A 75 year old client is admitted to the hospital with the diagnosis of dementia of the Alzheimer’s type and depression. The symptom that is unrelated to depression would be?
    a. Apathetic response to the environment
    b. “I don’t know” answer to questions
    c. Shallow of labile effect
    d. Neglect of personal hygiene

13. Nurse Trish is working in a mental health facility; the nurse priority nursing intervention for a newly admitted client with bulimia nervosa would be to?
a. Teach client to measure I & O  
b. Involve client in planning daily meal  
c. Observe client during meals  
d. Monitor client continuously

14. Nurse Patricia is aware that the major health complication associated with intractable anorexia nervosa would be?  
   a. Cardiac dysrhythmias resulting to cardiac arrest  
   b. Glucose intolerance resulting in protracted hypoglycemia  
   c. Endocrine imbalance causing cold amenorrhea  
   d. Decreased metabolism causing cold intolerance

15. Nurse Anna can minimize agitation in a disturbed client by?  
   a. Increasing stimulation  
   b. Limiting unnecessary interaction  
   c. Increasing appropriate sensory perception  
   d. Ensuring constant client and staff contact

16. A 39 year old mother with obsessive-compulsive disorder has become immobilized by her elaborate hand washing and walking rituals. Nurse Trish recognizes that the basis of O.C. disorder is often:  
   a. Problems with being too conscientious  
   b. Problems with anger and remorse  
   c. Feelings of guilt and inadequacy  
   d. Feeling of unworthiness and hopelessness

17. Mario is complaining to other clients about not being allowed by staff to keep food in his room. Which of the following interventions would be most appropriate?  
   a. Allowing a snack to be kept in his room  
   b. Reprimanding the client  
   c. Ignoring the clients behavior  
   d. Setting limits on the behavior

18. Conney with borderline personality disorder who is to be discharge soon threatens to “do something” to herself if discharged. Which of the following actions by the nurse would be most important?  
   a. Ask a family member to stay with the client at home temporarily  
   b. Discuss the meaning of the client’s statement with her  
   c. Request an immediate extension for the client  
   d. Ignore the clients statement because it’s a sign of manipulation

19. Joey a client with antisocial personality disorder belches loudly. A staff member asks Joey, “Do you know why people find you repulsive?” this statement most likely would elicit which of the following client reaction?  
   a. Depensiveness  
   b. Embarrassment  
   c. Shame  
   d. Remorsefulness

20. Which of the following approaches would be most appropriate to use with a client suffering from narcissistic personality disorder when discrepancies exist between what the client states and what actually exist?
a. Rationalization
b. Supportive confrontation
c. Limit setting
d. Consistency

21. Cely is experiencing alcohol withdrawal exhibits tremors, diaphoresis and hyperactivity. Blood pressure is 190/87 mmhg and pulse is 92 bpm. Which of the medications would the nurse expect to administer?
   a. Naloxone (Narcan)
   b. Benzlropine (Cogentin)
   c. Lorazepam (Ativan)
   d. Haloperidol (Haldol)

22. Which of the following foods would the nurse Trish eliminate from the diet of a client in alcohol withdrawal?
   a. Milk
   b. Orange Juice
   c. Soda
   d. Regular Coffee

23. Which of the following would Nurse Hazel expect to assess for a client who is exhibiting late signs of heroin withdrawal?
   a. Yawning & diaphoresis
   b. Restlessness & Irritability
   c. Constipation & steatorrhea
   d. Vomiting and Diarrhea

24. To establish open and trusting relationship with a female client who has been hospitalized with severe anxiety, the nurse in charge should?
   a. Encourage the staff to have frequent interaction with the client
   b. Share an activity with the client
   c. Give client feedback about behavior
   d. Respect client’s need for personal space

25. Nurse Monette recognizes that the focus of environmental (MILIEU) therapy is to:
   a. Manipulate the environment to bring about positive changes in behavior
   b. Allow the client’s freedom to determine whether or not they will be involved in activities
   c. Role play life events to meet individual needs
   d. Use natural remedies rather than drugs to control behavior

26. Nurse Trish would expect a child with a diagnosis of reactive attachment disorder to:
   a. Have more positive relation with the father than the mother
   b. Cling to mother & cry on separation
   c. Be able to develop only superficial relation with the others
   d. Have been physically abuse

27. When teaching parents about childhood depression Nurse Trina should say?
   a. It may appear acting out behavior
   b. Does not respond to conventional treatment
   c. Is short in duration & resolves easily
d. Looks almost identical to adult depression

28. Nurse Perry is aware that language development in autistic child resembles:  
   a. Scanning speech  
   b. Speech lag  
   c. Shuttering  
   d. Echolalia

29. A 60 year old female client who lives alone tells the nurse at the community health center “I really don’t need anyone to talk to”. The TV is my best friend. The nurse recognizes that the client is using the defense mechanism known as?  
   a. Displacement  
   b. Projection  
   c. Sublimation  
   d. Denial

30. When working with a male client suffering phobia about black cats, Nurse Trish should anticipate that a problem for this client would be?  
   a. Anxiety when discussing phobia  
   b. Anger toward the feared object  
   c. Denying that the phobia exist  
   d. Distortion of reality when completing daily routines

31. Linda is pacing the floor and appears extremely anxious. The duty nurse approaches in an attempt to alleviate Linda’s anxiety. The most therapeutic question by the nurse would be?  
   a. Would you like to watch TV?  
   b. Would you like me to talk with you?  
   c. Are you feeling upset now?  
   d. Ignore the client

32. Nurse Penny is aware that the symptoms that distinguish post traumatic stress disorder from other anxiety disorder would be:  
   a. Avoidance of situation & certain activities that resemble the stress  
   b. Depression and a blunted affect when discussing the traumatic situation  
   c. Lack of interest in family & others  
   d. Re-experiencing the trauma in dreams or flashback

33. Nurse Benjie is communicating with a male client with substance-induced persisting dementia; the client cannot remember facts and fills in the gaps with imaginary information. Nurse Benjie is aware that this is typical of?  
   a. Flight of ideas  
   b. Associative looseness  
   c. Confabulation  
   d. Concretism

34. Nurse Joey is aware that the signs & symptoms that would be most specific for diagnosis anorexia are?  
   a. Excessive weight loss, amenorrhea & abdominal distension  
   b. Slow pulse, 10% weight loss & alopecia  
   c. Compulsive behavior, excessive fears & nausea  
   d. Excessive activity, memory lapses & an increased pulse
35. A characteristic that would suggest to Nurse Anne that an adolescent may have bulimia would be:
   a. Frequent regurgitation & re-swallowing of food
   b. Previous history of gastritis
   c. Badly stained teeth
   d. Positive body image

36. Nurse Monette is aware that extremely depressed clients seem to do best in settings where they have:
   a. Multiple stimuli
   b. Routine Activities
   c. Minimal decision making
   d. Varied Activities

37. To further assess a client’s suicidal potential. Nurse Katrina should be especially alert to the client expression of:
   a. Frustration & fear of death
   b. Anger & resentment
   c. Anxiety & loneliness
   d. Helplessness & hopelessness

38. A nursing care plan for a male client with bipolar I disorder should include:
   a. Providing a structured environment
   b. Designing activities that will require the client to maintain contact with reality
   c. Engaging the client in conversing about current affairs
   d. Touching the client provide assurance

39. When planning care for a female client using ritualistic behavior, Nurse Gina must recognize that the ritual:
   a. Helps the client focus on the inability to deal with reality
   b. Helps the client control the anxiety
   c. Is under the client’s conscious control
   d. Is used by the client primarily for secondary gains

40. A 32 year old male graduate student, who has become increasingly withdrawn and neglectful of his work and personal hygiene, is brought to the psychiatric hospital by his parents. After detailed assessment, a diagnosis of schizophrenia is made. It is unlikely that the client will demonstrate:
   a. Low self esteem
   b. Concrete thinking
   c. Effective self boundaries
   d. Weak ego

41. A 23 year old client has been admitted with a diagnosis of schizophrenia says to the nurse “Yes, its march, March is little woman”. That’s literal you know”. These statement illustrate:
   a. Neologisms
   b. Echolalia
   c. Flight of ideas
   d. Loosening of association
42. A long term goal for a paranoid male client who has unjustifiably accused his wife of having many extramarital affairs would be to help the client develop:
   a. Insight into his behavior
   b. Better self control
   c. Feeling of self worth
   d. Faith in his wife

43. A male client who is experiencing disordered thinking about food being poisoned is admitted to the mental health unit. The nurse uses which communication technique to encourage the client to eat dinner?
   a. Focusing on self-disclosure of own food preference
   b. Using open ended question and silence
   c. Offering opinion about the need to eat
   d. Verbalizing reasons that the client may not choose to eat

44. Nurse Nina is assigned to care for a client diagnosed with Catatonic Stupor. When Nurse Nina enters the client’s room, the client is found lying on the bed with a body pulled into a fetal position. Nurse Nina should?
   a. Ask the client direct questions to encourage talking
   b. Rake the client into the dayroom to be with other clients
   c. Sit beside the client in silence and occasionally ask open-ended question
   d. Leave the client alone and continue with providing care to the other clients

45. Nurse Tina is caring for a client with delirium and states that “look at the spiders on the wall”. What should the nurse respond to the client?
   a. “You’re having hallucination, there are no spiders in this room at all”
   b. “I can see the spiders on the wall, but they are not going to hurt you”
   c. “Would you like me to kill the spiders”
   d. “I know you are frightened, but I do not see spiders on the wall”

46. Nurse Jonel is providing information to a community group about violence in the family. Which statement by a group member would indicate a need to provide additional information?
   a. “Abuse occurs more in low-income families”
   b. “Abuser Are often jealous or self-centered”
   c. “Abuser use fear and intimidation”
   d. “Abuser usually have poor self-esteem”

47. During electroconvulsive therapy (ECT) the client receives oxygen by mask via positive pressure ventilation. The nurse assisting with this procedure knows that positive pressure ventilation is necessary because?
   a. Anesthesia is administered during the procedure
   b. Decrease oxygen to the brain increases confusion and disorientation
   c. Grand mal seizure activity depresses respirations
   d. Muscle relaxations given to prevent injury during seizure activity depress respirations.

48. When planning the discharge of a client with chronic anxiety, Nurse Chris evaluates achievement of the discharge maintenance goals. Which goal would be most appropriately having been included in the plan of care requiring evaluation?
   a. The client eliminates all anxiety from daily situations
   b. The client ignores feelings of anxiety
c. The client identifies anxiety producing situations
d. The client maintains contact with a crisis counselor

49. Nurse Tina is caring for a client with depression who has not responded to antidepressant medication. The nurse anticipates that what treatment procedure may be prescribed?
   a. Neuroleptic medication
   b. Short term seclusion
   c. Psychosurgery
   d. Electroconvulsive therapy

50. Mario is admitted to the emergency room with drug-induced anxiety related to over ingestion of prescribed antipsychotic medication. The most important piece of information the nurse in charge should obtain initially is the:
   a. Length of time on the med.
   b. Name of the ingested medication & the amount ingested
   c. Reason for the suicide attempt
   d. Name of the nearest relative & their phone number

Answers and Rationale Psychiatric Nursing Practice Test Part 1

1. C. Total abstinence is the only effective treatment for alcoholism.

2. A. Hallucinations are visual, auditory, gustatory, tactile or olfactory perceptions that have no basis in reality.

3. D. The Nurse has a responsibility to observe continuously the acutely suicidal client. The Nurse should watch for clues, such as communicating suicidal thoughts, and messages; hoarding medications and talking about death.

4. B. Establishing a consistent eating plan and monitoring client’s weight are important to this disorder.

5. C. Appropriate nursing interventions for an anxiety attack include using short sentences, staying with the client, decreasing stimuli, remaining calm and medicating as needed.

6. B. Delusion of grandeur is a false belief that one is highly famous and important.

7. D. Individual with dependent personality disorder typically shows indecisiveness submissiveness and clinging behavior so that others will make decisions with them.

8. A. Clients with schizotypal personality disorder experience excessive social anxiety that can lead to paranoid thoughts.
9. **B.** Bulimia disorder generally is a maladaptive coping response to stress and underlying issues. The client should identify anxiety causing situation that stimulate the bulimic behavior and then learn new ways of coping with the anxiety.

10. **A.** An adult age 31 to 45 generates new level of awareness.

11. **A.** Neuromuscular Blocker, such as SUCCINYLCHOLINE (Anectine) produces respiratory depression because it inhibits contractions of respiratory muscles.

12. **C.** With depression, there is little or no emotional involvement therefore little alteration in affect.

13. **D.** These clients often hide food or force vomiting; therefore they must be carefully monitored.

14. **A.** These clients have severely depleted levels of sodium and potassium because of their starvation diet and energy expenditure, these electrolytes are necessary for cardiac functioning.

15. **B.** Limiting unnecessary interaction will decrease stimulation and agitation.

16. **C.** Ritualistic behavior seen in this disorder is aimed at controlling guilt and inadequacy by maintaining an absolute set pattern of behavior.

17. **D.** The nurse needs to set limits in the client’s manipulative behavior to help the client control dysfunctional behavior. A consistent approach by the staff is necessary to decrease manipulation.

18. **B.** Any suicidal statement must be assessed by the nurse. The nurse should discuss the client’s statement with her to determine its meaning in terms of suicide.

19. **A.** When the staff member ask the client if he wonders why others find him repulsive, the client is likely to feel defensive because the question is belittling. The natural tendency is to counterattack the threat to self image.

20. **B.** The nurse would specifically use supportive confrontation with the client to point out discrepancies between what the client states and what actually exists to increase responsibility for self.

21. **C.** The nurse would most likely administer benzodiazepine, such as lorazepan (ativan) to the client who is experiencing symptom: The client’s experiences symptoms of withdrawal because of the rebound phenomenon when the sedation of the CNS from alcohol begins to decrease.
22. D. Regular coffee contains caffeine which acts as psychomotor stimulants and leads to feelings of anxiety and agitation. Serving coffee top the client may add to tremors or wakefulness.

23. D. Vomiting and diarrhea are usually the late signs of heroin withdrawal, along with muscle spasm, fever, nausea, repetitive, abdominal cramps and backache.

24. D. Moving to a client’s personal space increases the feeling of threat, which increases anxiety.

25. A. Environmental (MILIEU) therapy aims at having everything in the client’s surrounding area toward helping the client.

26. C. Children who have experienced attachment difficulties with primary caregiver are not able to trust others and therefore relate superficially.

27. A. Children have difficulty verbally expressing their feelings, acting out behavior, such as temper tantrums, may indicate underlying depression.

28. D. The autistic child repeat sounds or words spoken by others.

29. D. The client statement is an example of the use of denial, a defense that blocks problem by unconscious refusing to admit they exist.

30. A. Discussion of the feared object triggers an emotional response to the object.

31. B. The nurse presence may provide the client with support & feeling of control.

32. D. Experiencing the actual trauma in dreams or flashback is the major symptom that distinguishes post traumatic stress disorder from other anxiety disorder.

33. C. Confabulation or the filling in of memory gaps with imaginary facts is a defense mechanism used by people experiencing memory deficits.

34. A. These are the major signs of anorexia nervosa. Weight loss is excessive (15% of expected weight).

35. C. Dental enamel erosion occurs from repeated self-induced vomiting.

36. B. Depression usually is both emotional & physical. A simple daily routine is the best, least stressful and least anxiety producing.

37. D. The expression of these feeling may indicate that this client is unable to continue the struggle of life.
38. A. Structure tends to decrease agitation and anxiety and to increase the client’s feeling of security.

39. B. The rituals used by a client with obsessive compulsive disorder help control the anxiety level by maintaining a set pattern of action.

40. C. A person with this disorder would not have adequate self-boundaries.

41. D. Loose associations are thoughts that are presented without the logical connections usually necessary for the listening to interpret the message.

42. C. Helping the client to develop feeling of self worth would reduce the client’s need to use pathologic defenses.

43. B. Open ended questions and silence are strategies used to encourage clients to discuss their problem in descriptive manner.

44. C. Clients who are withdrawn may be immobile and mute, and require consistent, repeated interventions. Communication with withdrawn clients requires much patience from the nurse. The nurse facilitates communication with the client by sitting in silence, asking open-ended question and pausing to provide opportunities for the client to respond.

45. D. When hallucination is present, the nurse should reinforce reality with the client.

46. A. Personal characteristics of abuser include low self-esteem, immaturity, dependence, insecurity and jealousy.

47. D. A short acting skeletal muscle relaxant such as succinylcholine (Anectine) is administered during this procedure to prevent injuries during seizure.

48. C. Recognizing situations that produce anxiety allows the client to prepare to cope with anxiety or avoid specific stimulus.

49. D. Electroconvulsive therapy is an effective treatment for depression that has not responded to medication.

50. B. In an emergency, lives saving facts are obtained first. The name and the amount of medication ingested are of outmost important in treating this potentially life threatening situation.

**Psychiatric Nursing Practice Test Part 2**

1. Nurse Tony should first discuss terminating the nurse-client relationship with a client during the:
a. Termination phase when discharge plans are being made.
b. Working phase when the client shows some progress.
c. Orientation phase when a contract is established.
d. Working phase when the client brings it up.

2. Malou is diagnosed with major depression spends majority of the day lying in bed with the sheet pulled over his head. Which of the following approaches by the nurse would be the most therapeutic?

a. Question the client until he responds
b. Initiate contact with the client frequently
c. Sit outside the clients room
d. Wait for the client to begin the conversation

3. Joe who is very depressed exhibits psychomotor retardation, a flat affect and apathy. The nurse in charge observes Joe to be in need of grooming and hygiene. Which of the following nursing actions would be most appropriate?

a. Waiting until the client’s family can participate in the client’s care
b. Asking the client if he is ready to take shower
c. Explaining the importance of hygiene to the client
d. Stating to the client that it’s time for him to take a shower

4. When teaching Mario with a typical depression about foods to avoid while taking phenelzine(Nardil), which of the following would the nurse in charge include?

a. Roasted chicken
b. Fresh fish
c. Salami
d. Hamburger

5. When assessing a female client who is receiving tricyclic antidepressant therapy, which of the following would alert the nurse to the possibility that the client is experiencing anticholinergic effects?

a. Urine retention and blurred vision
b. Respiratory depression and convulsion
c. Delirium and Sedation
d. Tremors and cardiac arrhythmias

6. For a male client with dysthymic disorder, which of the following approaches would the nurse expect to implement?

a. ECT
b. Psychotherapeutic approach
c. Psychoanalysis
d. Antidepressant therapy

7. Danny who is diagnosed with bipolar disorder and acute mania, states the nurse, “Where is my daughter? I love Louis. Rain, rain go away. Dogs eat dirt.” The nurse interprets these statements as indicating which of the following?

a. Echolalia
b. Neologism
c. Clang associations
d. Flight of ideas

8. Terry with mania is skipping up and down the hallway practically running into other clients. Which of the following activities would the nurse in charge expect to include in Terry’s plan of care?

a. Watching TV
b. Cleaning dayroom tables
c. Leading group activity
d. Reading a book

9. When assessing a male client for suicidal risk, which of the following methods of suicide would the nurse identify as most lethal?

a. Wrist cutting
b. Head banging
c. Use of gun
d. Aspirin overdose

10. Jun has been hospitalized for major depression and suicidal ideation. Which of the following statements indicates to the nurse that the client is improving?

a. “I’m of no use to anyone anymore.”
b. “I know my kids don’t need me anymore since they’re grown.”
c. “I couldn’t kill myself because I don’t want to go to hell.”
d. “I don’t think about killing myself as much as I used to.”

11. Which of the following activities would Nurse Trish recommend to the client who becomes very anxious when thoughts of suicide occur?

a. Using exercise bicycle
b. Meditating
c. Watching TV
d. Reading comics
12. When developing the plan of care for a client receiving haloperidol, which of the following medications would nurse Monet anticipate administering if the client developed extra pyramidal side effects?

a. Olanzapine (Zyprexa)
b. Paroxetine (Paxil)
c. Benztropine mesylate (Cogentin)
d. Lorazepam (Ativan)

13. Jon a suspicious client states that “I know you nurses are spraying my food with poison as you take it out of the cart.” Which of the following would be the best response of the nurse?

a. Giving the client canned supplements until the delusion subsides
b. Asking what kind of poison the client suspects is being used
c. Serving foods that come in sealed packages
d. Allowing the client to be the first to open the cart and get a tray

14. A client is suffering from catatonic behaviors. Which of the following would the nurse use to determine that the medication administered PRN have been most effective?

a. The client responds to verbal directions to eat
b. The client initiates simple activities without direction
c. The client walks with the nurse to her room
d. The client is able to move all extremities occasionally

15. Nurse Hazel invites new client’s parents to attend the psycho educational program for families of the chronically mentally ill. The program would be most likely to help the family with which of the following issues?

a. Developing a support network with other families
b. Feeling more guilty about the client’s illness
c. Recognizing the client’s weakness
d. Managing their financial concern and problems

16. When planning care for Dory with schizotypal personality disorder, which of the following would help the client become involved with others?

a. Attending an activity with the nurse
b. Leading a sing a long in the afternoon
c. Participating solely in group activities
d. Being involved with primarily one to one activities

17. Which statement about an individual with a personality disorder is true?
a. Psychotic behavior is common during acute episodes
b. Prognosis for recovery is good with therapeutic intervention
c. The individual typically remains in the mainstream of society, although he has problems in social and occupational roles
d. The individual usually seeks treatment willingly for symptoms that are personally distressful.

18. Nurse John is talking with a client who has been diagnosed with antisocial personality about how to socialize during activities without being seductive. Nurse John would focus the discussion on which of the following areas?

a. Discussing his relationship with his mother  
b. Asking him to explain reasons for his seductive behavior  
c. Suggesting to apologize to others for his behavior  
d. Explaining the negative reactions of others toward his behavior

19. Tina with a histrionic personality disorder is melodramatic and responds to others and situations in an exaggerated manner. Nurse Trish would recommend which of the following activities for Tina?

a. Baking class  
b. Role playing  
c. Scrap book making  
d. Music group

20. Joy has entered the chemical dependency unit for treatment of alcohol dependency. Which of the following client’s possession will the nurse most likely place in a locked area?

a. Toothpaste  
b. Shampoo  
c. Antiseptic wash  
d. Moisturizer

21. Which of the following assessment would provide the best information about the client’s physiologic response and the effectiveness of the medication prescribed specifically for alcohol withdrawal?

a. Sleeping pattern  
b. Mental alertness  
c. Nutritional status  
d. Vital signs

22. After administering naloxone (Narcan), an opioid antagonist, Nurse Ronald should monitor the female client carefully for which of the following?
a. Respiratory depression
b. Epilepsy
c. Kidney failure
d. Cerebral edema

23. Which of the following would nurse Ronald use as the best measure to determine a client’s progress in rehabilitation?

a. The way he gets along with his parents
b. The number of drug-free days he has
c. The kinds of friends he makes
d. The amount of responsibility his job entails

24. A female client is brought by ambulance to the hospital emergency room after taking an overdose of barbiturates is comatose. Nurse Trish would be especially alert for which of the following?

a. Epilepsy
b. Myocardial Infarction
c. Renal failure
d. Respiratory failure

25. Joey who has a chronic user of cocaine reports that he feels like he has cockroaches crawling under his skin. His arms are red because of scratching. The nurse in charge interprets these findings as possibly indicating which of the following?

a. Delusion
b. Formication
c. Flash back
d. Confusion

26. Jose is diagnosed with amphetamine psychosis and was admitted in the emergency room. Nurse Ronald would most likely prepare to administer which of the following medication?

a. Librium
b. Valium
c. Ativan
d. Haldol

27. Which of the following liquids would nurse Leng administer to a female client who is intoxicated with phencyclidine (PCP) to hasten excretion of the chemical?

a. Shake
b. Tea
c. Cranberry Juice
d. Grape juice

28. When developing a plan of care for a female client with acute stress disorder who lost her sister in a car accident. Which of the following would the nurse expect to initiate?

a. Facilitating progressive review of the accident and its consequences  
b. Postponing discussion of the accident until the client brings it up  
c. Telling the client to avoid details of the accident  
d. Helping the client to evaluate her sister’s behavior

29. The nursing assistant tells nurse Ronald that the client is not in the dining room for lunch. Nurse Ronald would direct the nursing assistant to do which of the following?

a. Tell the client he’ll need to wait until supper to eat if he misses lunch  
b. Invite the client to lunch and accompany him to the dining room  
c. Inform the client that he has 10 minutes to get to the dining room for lunch  
d. Take the client a lunch tray and let the client eat in his room

30. The initial nursing intervention for the significant-others during shock phase of a grief reaction should be focused on:

a. Presenting full reality of the loss of the individuals  
b. Directing the individual’s activities at this time  
c. Staying with the individuals involved  
d. Mobilizing the individual’s support system

31. Joy’s stream of consciousness is occupied exclusively with thoughts of her father’s death. Nurse Ronald should plan to help Joy through this stage of grieving, which is known as:

a. Shock and disbelief  
b. Developing awareness  
c. Resolving the loss  
d. Restitution

32. When taking a health history from a female client who has a moderate level of cognitive impairment due to dementia, the nurse would expect to note the presence of:

a. Accentuated premorbid traits  
b. Enhance intelligence  
c. Increased inhibitions  
d. Hyper vigilance

33. What is the priority care for a client with a dementia resulting from AIDS?
a. Planning for remotivational therapy  
b. Arranging for long term custodial care  
c. Providing basic intellectual stimulation  
d. Assessing pain frequently  

34. Jerome who has eating disorder often exhibits similar symptoms. Nurse Lhey would expect an adolescent client with anorexia to exhibit:

a. Affective instability  
b. Dishered, unkempt physical appearance  
c. Depersonalization and derealization  
d. Repetitive motor mechanisms  

35. The primary nursing diagnosis for a female client with a medical diagnosis of major depression would be:

a. Situational low self-esteem related to altered role  
b. Powerlessness related to the loss of idealized self  
c. Spiritual distress related to depression  
d. Impaired verbal communication related to depression  

36. When developing an initial nursing care plan for a male client with a Bipolar I disorder (manic episode) nurse Ron should plan to?

a. Isolate his gym time  
b. Encourage his active participation in unit programs  
c. Provide foods, fluids and rest  
d. Encourage his participation in programs  

37. Grace is exhibiting withdrawn patterns of behavior. Nurse Johnny is aware that this type of behavior eventually produces feeling of:

a. Repression  
b. Loneliness  
c. Anger  
d. Paranoia  

38. One morning a female client on the inpatient psychiatric service complains to nurse Hazel that she has been waiting for over an hour for someone to accompany her to activities. Nurse Hazel replies to the client “We’re doing the best we can. There are a lot of other people on the unit who needs attention too.” This statement shows that the nurse’s use of:

a. Defensive behavior  
b. Reality reinforcement  
c. Limit-setting behavior
d. Impulse control

39. A nursing diagnosis for a male client with a diagnosed multiple personality disorder is chronic low self-esteem probably related to childhood abuse. The most appropriate short term client outcome would be:

a. Verbalizing the need for anxiety medications  
b. Recognizing each existing personality  
c. Engaging in object-oriented activities  
d. Eliminating defense mechanisms and phobia

40. A 25 year old male is admitted to a mental health facility because of inappropriate behavior. The client has been hearing voices, responding to imaginary companions and withdrawing to his room for several days at a time. Nurse Monette understands that the withdrawal is a defense against the client’s fear of:

a. Phobia  
b. Powerlessness  
c. Punishment  
d. Rejection

41. When asking the parents about the onset of problems in young client with the diagnosis of schizophrenia, Nurse Linda would expect that they would relate the client’s difficulties began in:

a. Early childhood  
b. Late childhood  
c. Adolescence  
d. Puberty

42. Jose who has been hospitalized with schizophrenia tells Nurse Ron, “My heart has stopped and my veins have turned to glass!” Nurse Ron is aware that this is an example of:

a. Somatic delusions  
b. Depersonalization  
c. Hypochondriasis  
d. Echolalia

43. In recognizing common behaviors exhibited by male client who has a diagnosis of schizophrenia, nurse Josie can anticipate:

a. Slumped posture, pessimistic outlook and flight of ideas  
b. Grandiosity, arrogance and distractibility  
c. Withdrawal, regressed behavior and lack of social skills  
d. Disorientation, forgetfulness and anxiety
44. One morning, nurse Diane finds a disturbed client curled up in the fetal position in the corner of the dayroom. The most accurate initial evaluation of the behavior would be that the client is:

a. Physically ill and experiencing abdominal discomfort  
b. Tired and probably did not sleep well last night  
c. Attempting to hide from the nurse  
d. Feeling more anxious today

45. Nurse Bea notices a female client sitting alone in the corner smiling and talking to herself. Realizing that the client is hallucinating. Nurse Bea should:

a. Invite the client to help decorate the dayroom  
b. Leave the client alone until he stops talking  
c. Ask the client why he is smiling and talking  
d. Tell the client it is not good for him to talk to himself

46. When being admitted to a mental health facility, a young female adult tells Nurse Mylene that the voices she hears frighten her. Nurse Mylene understands that the client tends to hallucinate more vividly:

a. While watching TV  
b. During meal time  
c. During group activities  
d. After going to bed

47. Nurse John recognizes that paranoid delusions usually are related to the defense mechanism of:

a. Projection  
b. Identification  
c. Repression  
d. Regression

48. When planning care for a male client using paranoid ideation, nurse Jasmin should realize the importance of:

a. Giving the client difficult tasks to provide stimulation  
b. Providing the client with activities in which success can be achieved  
c. Removing stress so that the client can relax  
d. Not placing any demands on the client

49. Nurse Gerry is aware that the defense mechanism commonly used by clients who are alcoholics is:

a. Displacement
b. Denial  
c. Projection  
d. Compensation

50. Within a few hours of alcohol withdrawal, nurse John should assess the male client for the presence of:

a. Disorientation, paranoia, tachycardia  
b. Tremors, fever, profuse diaphoresis  
c. Irritability, heightened alertness, jerky movements  
d. Yawning, anxiety, convulsions

**Answers and Rationale Psychiatric Nursing Practice Test Part 2**

1. C. When the nurse and client agree to work together, a contract should be established, the length of the relationship should be discussed in terms of its ultimate termination.

2. B. The nurse should initiate brief, frequent contacts throughout the day to let the client know that he is important to the nurse. This will positively affect the client’s self-esteem.

3. D. The client with depression is preoccupied, has decreased energy, and is unable to make decisions. The nurse presents the situation, “It’s time for a shower”, and assists the client with personal hygiene to preserve his dignity and self-esteem.

4. C. Foods high in tyramine, those that are fermented, pickled, aged, or smoked must be avoided because when they are ingested in combination with MAOIs a hypertensive crisis will occur.

5. A. Anticholinergic effects, which result from blockage of the parasympathetic (craniosacral) nervous system including urine retention, blurred vision, dry mouth & constipation.

6. B. Dysthymia is a less severe, chronic depression diagnosed when a client has had a depressed mood for more days than not over a period of at least 2 years. Client with dysthymic disorder benefit from psychotherapeutic approaches that assist the client in reversing the negative self image, negative feelings about the future.

7. D. Flight of ideas is speech pattern of rapid transition from topic to topic, often without finishing one idea. It is common in mania.

8. B. The client with mania is very active & needs to have this energy channeled in a constructive task such as cleaning or tidying the room.

9. C. A crucial factor is determining the lethality of a method is the amount of time that occurs between initiating the method & the delivery of the lethal impact of the method.

10. D. The statement “I don’t think about killing myself as much as I used to.” Indicates a lessening of suicidal ideation and improvement in the client’s condition.

11. A. Using exercise bicycle is appropriate for the client who becomes very anxious when thoughts of suicidal occur.
12. C. The drug of choice for a client experiencing extra pyramidal side effects from haloperidol (Haldol) is benztropine mesylate (cogentin) because of its anti cholinergic properties.

13. D. Allowing the client to be the first to open the cart & take a tray presents the client with the reality that the nurses are not touching the food & tray, thereby dispelling the delusion.

14. B. Although all the actions indicate improvement, the ability to initiate simple activities without directions indicates the most improvement in the catatonic behaviors.

15. A. Psychoeducational groups for families develop a support network. They provide education about the biochemical etiology of psychiatric disease to reduce, not increase family guilt.

16. C. Attending activity with the nurse assists the client to become involved with others slowly. The client with schizotypal personality disorder needs support, kindness & gentle suggestion to improve social skills & interpersonal relationship.

17. C. An individual with personality disorder usually is not hospitalized unless a coexisting Axis I psychiatric disorder is present. Generally, these individuals make marginal adjustments and remain in society, although they typically experience relationship and occupational problems related to their inflexible behaviors. Personality disorders are chronic lifelong patterns of behavior; acute episodes do not occur. Psychotic behavior is usually not common, although it can occur in either schizotypal personality disorder or borderline personality disorder. Because these disorders are enduring and evasive and the individual is inflexible, prognosis for recovery is unfavorable. Generally, the individual does not seek treatment because he does not perceive problems with his own behavior. Distress can occur based on other people’s reaction to the individual’s behavior.

18. D. The nurse would explain the negative reactions of others towards the client’s behaviors to make the clients aware of the impact of his seductive behaviors on others.

19. B. The nurse would use role-playing to teach the client appropriate responses to others and in various situations. This client dramatizes events, drawn attention to self, and is unaware of and does not deal with feelings. The nurse works to help the client clarify true feelings & learn to express them appropriately.

20. C. Antiseptic mouthwash often contains alcohol & should be kept in locked area, unless labeling clearly indicates that the product does not contain alcohol.

21. D. Monitoring of vital signs provides the best information about the client’s overall physiologic status during alcohol withdrawal & the physiologic response to the medication used.

22. A. After administering naloxone (Narcan) the nurse should monitor the client’s respiratory status carefully, because the drug is short acting & respiratory depression may recur after its effects wear off.

23. B. The best measure to determine a client’s progress in rehabilitation is the number of drug- free days he has. The longer the client is free of drugs, the better the prognosis is.
24. D. Barbiturates are CNS depressants; the nurse would be especially alert for the possibility of respiratory failure. Respiratory failure is the most likely cause of death from barbiturate overdose.

25. B. The feeling of bugs crawling under the skin is termed as formication, and is associated with cocaine use.

26. D. The nurse would prepare to administer an antipsychotic medication such as Haldol to a client experiencing amphetamine psychosis to decrease agitation & psychotic symptoms, including delusions, hallucinations & cognitive impairment.

27. C. An acid environment aids in the excretion of PCP. The nurse will definitely give the client with PCP intoxication cranberry juice to acidify the urine to a pH of 5.5 & accelerate excretion.

28. A. The nurse would facilitate progressive review of the accident and its consequence to help the client integrate feelings & memories and to begin the grieving process.

29. B. The nurse instructs the nursing assistant to invite the client to lunch & accompany him to the dining room to decrease manipulation, secondary gain, dependency and reinforcement of negative behavior while maintaining the client’s worth.

30. C. This provides support until the individual’s coping mechanisms and personal support systems can be immobilized.

31. C. Resolving a loss is a slow, painful, continuous process until a mental image of the dead person, almost devoid of negative or undesirable features emerges.

32. A. A moderate level of cognitive impairment due to dementia is characterized by increasing dependence on environment & social structure and by increasing psychologic rigidity with accentuated previous traits & behaviors.

33. C. This action maintains for as long as possible, the client's intellectual functions by providing an opportunity to use them.

34. A. Individuals with anorexia often display irritability, hospitality, and a depressed mood.

35. D. Depressed clients demonstrate decreased communication because of lack of psychic or physical energy.

36. C. The client in a manic episode of the illness often neglects basic needs, these needs are a priority to ensure adequate nutrition, fluid, and rest.

37. B. The withdrawn pattern of behavior presents the individual from reaching out to others for sharing the isolation produces feeling of loneliness.

38. A. The nurse’s response is not therapeutic because it does not recognize the client’s needs but tries to make the client feel guilty for being demanding.

39. B. The client must recognize the existence of the sub personalities so that interpretation can occur.

40. D. An aloof, detached, withdrawn posture is a means of protecting the self by withdrawing and maintaining a safe, emotional distance.

41. C. The usual age of onset of schizophrenia is adolescence or early childhood.

42. A. Somatic delusion is a fixed false belief about one’s body.

43. C. These are the classic behaviors exhibited by clients with a diagnosis of schizophrenia.
44. D. The fetal position represents regressed behavior. Regression is a way of responding to overwhelming anxiety.
45. B. This provides a stimulus that competes with and reduces hallucination.
46. D. Auditory hallucinations are most troublesome when environmental stimuli are diminished and there are few competing distractions.
47. A. Projection is a mechanism in which inner thoughts and feelings are projected onto the environment, seeming to come from outside the self rather than from within.
48. B. This will help the client develop self-esteem and reduce the use of paranoid ideation.
49. B. Denial is a method of resolving conflict or escaping unpleasant realities by ignoring their existence.
50. C. Alcohol is a central nervous system depressant. These symptoms are the body’s neurologic adaptation to the withdrawal of alcohol.

Psychiatric Nursing Practice Test Part 3

1. Francis who is addicted to cocaine withdraws from the drug. Nurse Ron should expect to observe:
   a. Hyperactivity
   b. Depression
   c. Suspicion
   d. Delirium

2. Nurse John is aware that a serious effect of inhaling cocaine is?
   a. Deterioration of nasal septum
   b. Acute fluid and electrolyte imbalances
   c. Extra pyramidal tract symptoms
   d. Esophageal varices

3. A tentative diagnosis of opiate addiction, Nurse Candy should assess a recently hospitalized client for signs of opiate withdrawal. These signs would include:
   a. Rhinorrhea, convulsions, subnormal temperature
   b. Nausea, dilated pupils, constipation
   c. Lacrimation, vomiting, drowsiness
   d. Muscle aches, papillary constriction, yawning

4. A 48 year old male client is brought to the psychiatric emergency room after attempting to jump off a bridge. The client’s wife states that he lost his job several months ago and has been unable to find another job. The primary nursing intervention at this time would be to assess for:
   a. A past history of depression
b. Current plans to commit suicide  
c. The presence of marital difficulties  
d. Feelings of excessive failure  

5. Before helping a male client who has been sexually assaulted, nurse Maureen should recognize that the rapist is motivated by feelings of:

a. Hostility  
b. Inadequacy  
c. Incompetence  
d. Passion  

6. When working with children who have been sexually abused by a family member it is important for the nurse to understand that these victims usually are overwhelmed with feelings of:

a. Humiliation  
b. Confusion  
c. Self blame  
d. Hatred  

7. Joy who has just experienced her second spontaneous abortion expresses anger towards her physician, the hospital and the “rotten nursing care”. When assessing the situation, the nurse recognizes that the client may be using the coping mechanism of:

a. Projection  
b. Displacement  
c. Denial  
d. Reaction formation  

8. The most critical factor for nurse Linda to determine during crisis intervention would be the client’s:

a. Available situational supports  
b. Willingness to restructure the personality  
c. Developmental theory  
d. Underlying unconscious conflict  

9. Nurse Trish suggests a crisis intervention group to a client experiencing a developmental crisis. These groups are successful because the:

a. Crisis intervention worker is a psychologist and understands behavior patterns  
b. Crisis group supplies a workable solution to the client’s problem  
c. Client is encouraged to talk about personal problems  
d. Client is assisted to investigate alternative approaches to solving the identified problem
10. Nurse Ronald could evaluate that the staff’s approach to setting limits for a demanding, angry client was effective if the client:

   a. Apologizes for disrupting the unit’s routine when something is needed
   b. Understands the reason why frequent calls to the staff were made
   c. Discuss concerns regarding the emotional condition that required hospitalizations
   d. No longer calls the nursing staff for assistance

11. Nurse John is aware that the therapy that has the highest success rate for people with phobias would be:

   a. Psychotherapy aimed at rearranging maladaptive thought process
   b. Psychoanalytical exploration of repressed conflicts of an earlier development phase
   c. Systematic desensitization using relaxation technique
   d. Insight therapy to determine the origin of the anxiety and fear

12. When nurse Hazel considers a client’s placement on the continuum of anxiety, a key in determining the degree of anxiety being experienced is the client’s:

   a. Perceptual field
   b. Delusional system
   c. Memory state
   d. Creativity level

13. In the diagnosis of a possible pervasive developmental autistic disorder. The nurse would find it most unusual for a 3 year old child to demonstrate:

   a. An interest in music
   b. An attachment to odd objects
   c. Ritualistic behavior
   d. Responsiveness to the parents

14. Malou with schizophrenia tells Nurse Melinda, “My intestines are rotted from worms chewing on them.” This statement indicates a:

   a. Jealous delusion
   b. Somatic delusion
   c. Delusion of grandeur
   d. Delusion of persecution

15. Andy is admitted to the psychiatric unit with a diagnosis of borderline personality disorder. Nurse Hilary should expects the assessment to reveal:

   a. Coldness, detachment and lack of tender feelings
   b. Somatic symptoms
   c. Inability to function as responsible parent
d. Unpredictable behavior and intense interpersonal relationships

16. PROPRANOLOL (Inderal) is used in the mental health setting to manage which of the following conditions?

a. Antipsychotic - induced akathisia and anxiety
b. Obsessive - compulsive disorder (OCD) to reduce ritualistic behavior
c. Delusions for clients suffering from schizophrenia
d. The manic phase of bipolar illness as a mood stabilizer

17. Which medication can control the extra pyramidal effects associated with antipsychotic agents?

a. Clorazepate (Tranxene)
b. Amantadine (Symmetrel)
c. Doxepin (Sinequan)
d. Perphenazine (Trilafon)

18. Which of the following statements should be included when teaching clients about monoamine oxidase inhibitor (MAOI) antidepressants?

a. Don’t take aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs)
b. Have blood levels screened weekly for leucopenia
c. Avoid strenuous activity because of the cardiac effects of the drug
d. Don’t take prescribed or over the counter medications without consulting the physician

19. Kris periodically has acute panic attacks. These attacks are unpredictable and have no apparent association with a specific object or situation. During an acute panic attack, Kris may experience:

a. Heightened concentration
b. Decreased perceptual field
c. Decreased cardiac rate
d. Decreased respiratory rate

20. Initial interventions for Marco with acute anxiety include all except which of the following?

a. Touching the client in an attempt to comfort him
b. Approaching the client in calm, confident manner
c. Encouraging the client to verbalize feelings and concerns
d. Providing the client with a safe, quiet and private place

21. Nurse Jessie is assessing a client suffering from stress and anxiety. A common physiological response to stress and anxiety is:
22. When performing a physical examination on a female anxious client, nurse Nelli would expect to find which of the following effects produced by the parasympathetic system?

a. Muscle tension
b. Hyperactive bowel sounds
c. Decreased urine output
d. Constipation

23. Which of the following drugs have been known to be effective in treating obsessive-compulsive disorder (OCD)?

a. Divalproex (depakote) and Lithium (lithobid)
b. Chlordiazepoxide (Librium) and diazepam (valium)
c. Fluvoxamine (Luvox) and clomipramine (anafranil)
d. Benztropine (Cogentin) and diphenhydramine (benadryl)

24. Tony with agoraphobia has been symptom-free for 4 months. Classic signs and symptoms of phobia include:

a. Severe anxiety and fear
b. Withdrawal and failure to distinguish reality from fantasy
c. Depression and weight loss
d. Insomnia and inability to concentrate

25. Which nursing action is most appropriate when trying to diffuse a client’s impending violent behavior?

a. Place the client in seclusion
b. Leaving the client alone until he can talk about his feelings
c. Involving the client in a quiet activity to divert attention
d. Helping the client identify and express feelings of anxiety and anger

26. Rosana is in the second stage of Alzheimer’s disease who appears to be in pain. Which question by Nurse Jenny would best elicit information about the pain?

a. “Where is your pain located?”
b. “Do you hurt? (pause) “Do you hurt?”
c. “Can you describe your pain?”
d. “Where do you hurt?”
27. Nursing preparation for a client undergoing electroconvulsive therapy (ECT) resemble those used for:

a. General anesthesia
b. Cardiac stress testing
c. Neurologic examination
d. Physical therapy

28. Jose who is receiving monoamine oxidase inhibitor antidepressant should avoid tyramine, a compound found in which of the following foods?

a. Figs and cream cheese
b. Fruits and yellow vegetables
c. Aged cheese and Chianti wine
d. Green leafy vegetables

29. Erlinda, age 85, with major depression undergoes a sixth electroconvulsive therapy (ECT) treatment. When assessing the client immediately after ECT, the nurse expects to find:

a. Permanent short-term memory loss and hypertension
b. Permanent long-term memory loss and hypomania
c. Transitory short-term memory loss and permanent long-term memory loss
d. Transitory short and long term memory loss and confusion

30. Barbara with bipolar disorder is being treated with lithium for the first time. Nurse Clint should observe the client for which common adverse effect of lithium?

a. Polyuria
b. Seizures
c. Constipation
d. Sexual dysfunction

31. Nurse Fred is assessing a client who has just been admitted to the ER department. Which signs would suggest an overdose of an antianxiety agent?

a. Suspiciousness, dilated pupils and incomplete BP
b. Agitation, hyperactivity and grandiose ideation
c. Combativeness, sweating and confusion
d. Emotional lability, euphoria and impaired memory

32. Discharge instructions for a male client receiving tricyclic antidepressants include which of the following information?

a. Restrict fluids and sodium intake
b. Don’t consume alcohol
c. Discontinue if dry mouth and blurred vision occur
d. Restrict fluid and sodium intake

33. Important teaching for women in their childbearing years who are receiving antipsychotic medications includes which of the following?

a.Increased incidence of dysmenorrhea while taking the drug
b. Occurrence of incomplete libido due to medication adverse effects
c. Continuing previous use of contraception during periods of amenorrhea
d. Instruction that amenorrhea is irreversible

34. A client refuses to remain on psychotropic medications after discharge from an inpatient psychiatric unit. Which information should the community health nurse assess first during the initial follow-up with this client?

a. Income level and living arrangements
b. Involvement of family and support systems
c. Reason for inpatient admission
d. Reason for refusal to take medications

35. The nurse understands that the therapeutic effects of typical antipsychotic medications are associated with which neurotransmitter change?

a. Decreased dopamine level
b. Increased acetylcholine level
c. Stabilization of serotonin
d. Stimulation of GABA

36. Which of the following best explains why tricyclic antidepressants are used with caution in elderly patients?

a. Central Nervous System effects
b. Cardiovascular system effects
c. Gastrointestinal system effects
d. Serotonin syndrome effects

37. A client with depressive symptoms is given prescribed medications and talks with his therapist about his belief that he is worthless and unable to cope with life. Psychiatric care in this treatment plan is based on which framework?

a. Behavioral framework
b. Cognitive framework
c. Interpersonal framework
d. Psychodynamic framework
38. A nurse who explains that a client’s psychotic behavior is unconsciously motivated understands that the client’s disordered behavior arises from which of the following?

a. Abnormal thinking  
b. Altered neurotransmitters  
c. Internal needs  
d. Response to stimuli

39. A client with depression has been hospitalized for treatment after taking a leave of absence from work. The client’s employer expects the client to return to work following inpatient treatment. The client tells the nurse, “I’m no good. I’m a failure”. According to cognitive theory, these statements reflect:

a. Learned behavior  
b. Punitive superego and decreased self-esteem  
c. Faulty thought processes that govern behavior  
d. Evidence of difficult relationships in the work environment

40. The nurse describes a client as anxious. Which of the following statement about anxiety is true?

a. Anxiety is usually pathological  
b. Anxiety is directly observable  
c. Anxiety is usually harmful  
d. Anxiety is a response to a threat

41. A client with a phobic disorder is treated by systematic desensitization. The nurse understands that this approach will do which of the following?

a. Help the client execute actions that are feared  
b. Help the client develop insight into irrational fears  
c. Help the client substitutes one fear for another  
d. Help the client decrease anxiety

42. Which client outcome would best indicate successful treatment for a client with an antisocial personality disorder?

a. The client exhibits charming behavior when around authority figures  
b. The client has decreased episodes of impulsive behaviors  
c. The client makes statements of self-satisfaction  
d. The client’s statements indicate no remorse for behaviors

43. The nurse is caring for a client with an autoimmune disorder at a medical clinic, where alternative medicine is used as an adjunct to traditional therapies. Which information should the nurse teach the client to help foster a sense of control over his symptoms?
44. Which of the following is the most distinguishing feature of a client with an antisocial personality disorder?

a. Attention to detail and order
b. Bizarre mannerisms and thoughts
c. Submissive and dependent behavior
d. Disregard for social and legal norms

45. Which nursing diagnosis is most appropriate for a client with anorexia nervosa who expresses feelings of guilt about not meeting family expectations?

a. Anxiety
b. Disturbed body image
c. Defensive coping
d. Powerlessness

46. A nurse is evaluating therapy with the family of a client with anorexia nervosa. Which of the following would indicate that the therapy was successful?

a. The parents reinforced increased decision making by the client
b. The parents clearly verbalize their expectations for the client
c. The client verbalizes that family meals are now enjoyable
d. The client tells her parents about feelings of low-self esteem

47. A client with dysthymic disorder reports to a nurse that his life is hopeless and will never improve in the future. How can the nurse best respond using a cognitive approach?

a. Agree with the client’s painful feelings
b. Challenge the accuracy of the client’s belief
c. Deny that the situation is hopeless
d. Present a cheerful attitude

48. A client with major depression has not verbalized problem areas to staff or peers since admission to a psychiatric unit. Which activity should the nurse recommend to help this client express himself?

a. Art therapy in a small group
b. Basketball game with peers on the unit
c. Reading a self-help book on depression
d. Watching movie with the peer group
49. The home health psychiatric nurse visits a client with chronic schizophrenia who was recently discharged after a prolonged stay in a state hospital. The client lives in a boarding home, reports no family involvement, and has little social interaction. The nurse plans to refer the client to a day treatment program in order to help him with:

a. Managing his hallucinations  
b. Medication teaching  
c. Social skills training  
d. Vocational training

50. Which activity would be most appropriate for a severely withdrawn client?

a. Art activity with a staff member  
b. Board game with a small group of clients  
c. Team sport in the gym  
d. Watching TV in the dayroom

1. **B.** There is no set of symptoms associated with cocaine withdrawal, only the depression that follows the high caused by the drug.

2. **A.** Cocaine is a chemical that when inhaled, causes destruction of the mucous membranes of the nose.

3. **D.** These adaptations are associated with opiate withdrawal which occurs after cessation or reduction of prolonged moderate or heavy use of opiates.

4. **B.** Whether there is a suicide plan is a criterion when assessing the client’s determination to make another attempt.

5. **A.** Rapists are believed to harbor and act out hostile feelings toward all women through the act of rape.

6. **C.** These children often have nonsexual needs met by individual and are powerless to refuse. Ambivalence results in self-blame and also guilt.

7. **B.** The client’s anger over the abortion is shifted to the staff and the hospital because she is unable to deal with the abortion at this time.

8. **A.** Personal internal strength and supportive individuals are critical factors that can be employed to assist the individual to cope with a crisis.

9. **D.** Crisis intervention group helps client reestablish psychologic equilibrium by assisting them to explore new alternatives for coping. It considers realistic situations using rational and flexible problem solving methods.

10. **C.** This would document that the client feels comfortable enough to discuss the problems that have motivated the behavior.

11. **C.** The most successful therapy for people with phobias involves behavior modification techniques using desensitization.

12. **A.** Perceptual field is a key indicator of anxiety level because the perceptual fields narrow as anxiety increases.

13. **D.** One of the symptoms of autistic child displays a lack of responsiveness to others. There is little or no extension to the external environment.
14. **B.** Somatic delusions focus on bodily functions or systems and commonly include delusion about foul odor emissions, insect manifestations, internal parasites and misshapen parts.

15. **D.** A client with borderline personality displays a pervasive pattern of unpredictable behavior, mood and self image. Interpersonal relationships may be intense and unstable and behavior may be inappropriate and impulsive.

16. **A.** Propranolol is a potent beta adrenergic blocker and producing a sedating effect, therefore it is used to treat antipsychotic induced akathisia and anxiety.

17. **B.** Amantadine is an anticholinergic drug used to relieve drug-induced extra pyramidal adverse effects such as muscle weakness, involuntary muscle movements, pseudoparkinsonism and tar dive dyskinesia.

18. **C.** MAOI antidepressants when combined with a number of drugs can cause life-threatening hypertensive crisis. It’s imperative that a client checks with his physician and pharmacist before taking any other medications.

19. **B.** Panic is the most severe level of anxiety. During panic attack, the client experiences a decrease in the perceptual field, becoming more focused on self, less aware of surroundings and unable to process information from the environment. The decreased perceptual field contributes to impaired attention and inability to concentrate.

20. **A.** The emergency nurse must establish rapport and trust with the anxious client before using therapeutic touch. Touching an anxious client may actually increase anxiety.

21. **D.** Diarrhea is a common physiological response to stress and anxiety.

22. **B.** The parasympathetic nervous system would produce incomplete G.I. motility resulting in hyperactive bowel sounds, possibly leading to diarrhea.

23. **C.** The antidepressants fluvoxamine and clomipramine have been effective in the treatment of OCD.

24. **A.** Phobias cause severe anxiety (such as panic attack) that is out of proportion to the threat of the feared object or situation. Physical signs and symptoms of phobias include profuse sweating, poor motor control, tachycardia and elevated B.P.

25. **D.** In many instances, the nurse can diffuse impending violence by helping the client identify and express feelings of anger and anxiety. Such statement as “What happened to get you this angry?” may help the client verbalizes feelings rather than act on them.

26. **B.** When speaking to a client with Alzheimer’s disease, the nurse should use close-ended questions. Those that the client can answer with “yes” or “no” whenever possible and avoid questions that require the client to make choices. Repeating the question aids comprehension.

27. **A.** The nurse should prepare a client for ECT in a manner similar to that for general anesthesia.

28. **C.** Aged cheese and Chianti wine contain high concentrations of tyramine.

29. **D.** ECT commonly causes transitory short and long term memory loss and confusion, especially in geriatric clients. It rarely results in permanent short and long term memory loss.
30. A. Polyuria commonly occurs early in the treatment with lithium and could result in fluid volume deficit.
31. D. Signs of anxiety agent overdose include emotional lability, euphoria and impaired memory.
32. B. Drinking alcohol can potentiate the sedating action of tricyclic antidepressants. Dry mouth and blurred vision are normal adverse effects of tricyclic antidepressants.
33. C. Women may experience amenorrhea, which is reversible, while taking antipsychotics. Amenorrhea doesn’t indicate cessation of ovulation thus, the client can still be pregnant.
34. D. The first are for assessment would be the client’s reason for refusing medication. The client may not understand the purpose for the medication, may be experiencing distressing side effects, or may be concerned about the cost of medicine. In any case, the nurse cannot provide appropriate intervention before assessing the client’s problem with the medication. The patient’s income level, living arrangements, and involvement of family and support systems are relevant issues following determination of the client’s reason for refusing medication. The nurse providing follow-up care would have access to the client’s medical record and should already know the reason for inpatient admission.
35. A. Excess dopamine is thought to be the chemical cause for psychotic thinking. The typical antipsychotics act to block dopamine receptors and therefore decrease the amount of neurotransmitter at the synapses. The typical antipsychotics do not increase acetylcholine, stabilize serotonin, stimulate GABA.
36. B. The TCAs affect norepinephrine as well as other neurotransmitters, and thus have significant cardiovascular side effects. Therefore, they are used with caution in elderly clients who may have increased risk factors for cardiac problems because of their age and other medical conditions. The remaining side effects would apply to any client taking a TCA and are not particular to an elderly person.
37. B. Cognitive thinking therapy focuses on the client’s misperceptions about self, others and the world that impact functioning and contribute to symptoms. Using medications to alter neurotransmitter activity is a psychobiologic approach to treatment. The other answer choices are frameworks for care, but hey are not applicable to this situation.
38. C. The concept that behavior is motivated and has meaning comes from the psychodynamic framework. According to this perspective, behavior arises from internal wishes or needs. Much of what motivates behavior comes from the unconscious. The remaining responses do not address the internal forces thought to motivate behavior.
39. C. The client is demonstrating faulty thought processes that are negative and that govern his behavior in his work situation – issues that are typically examined using a cognitive theory approach. Issues involving learned behavior are best explored through behavior theory, not cognitive theory. Issues involving ego development are the focus of psychoanalytic theory. Option 4 is incorrect because there is no evidence in this situation that the client has conflictual relationships in the work environment.
40. D. Anxiety is a response to a threat arising from internal or external stimuli.
41. A. Systematic desensitization is a behavioral therapy technique that helps clients with irrational fears and avoidance behavior to face the thing they fear, without experiencing anxiety. There is no attempt to promote insight with this procedure, and the client will not be taught to substitute one fear for another. Although the client’s anxiety may decrease with successful confrontation of irrational fears, the purpose of the procedure is specifically related to performing activities that typically are avoided as part of the phobic response.
42. B. A client with antisocial personality disorder typically has frequent episodes of acting impulsively with poor ability to delay self-gratification. Therefore, decreased frequency of impulsive behaviors would be evidence of improvement. Charming behavior when around authority figures and statements indicating no remorse are examples of symptoms typical of someone with this disorder and would not indicate successful treatment. Self-satisfaction would be viewed as a positive change if the client expresses low self-esteem; however this is not a characteristic of a client with antisocial personality disorder.
43. D. In autoimmune disorders, stress and the response to stress can exacerbate symptoms. Stress management techniques can help the client reduce the psychological response to stress, which in turn will help reduce the physiologic stress response. This will afford the client an increased sense of control over his symptoms. The nurse can address the remaining answer choices in her teaching about the client’s disease and treatment; however, knowledge alone will not help the client to manage his stress effectively enough to control symptoms.
44. D. Disregard for established rules of society is the most common characteristic of a client with antisocial personality disorder. Attention to detail and order is characteristic of someone with obsessive compulsive disorder. Bizarre mannerisms and thoughts are characteristics of a client with schizoid or schizotypal disorder. Submissive and dependent behaviors are characteristic of someone with a dependent personality.
45. D. The client with anorexia typically feels powerless, with a sense of having little control over any aspect of life besides eating behavior. Often, parental expectations and standards are quite high and lead to the clients’ sense of guilt over not measuring up.
46. A. One of the core issues concerning the family of a client with anorexia is control. The family’s acceptance of the client’s ability to make independent decisions is key to successful family intervention. Although the remaining options may occur during the process of therapy, they would not necessarily indicate a successful outcome; the central family issues of dependence and independence are not addresses on these responses.
47. B. Use of cognitive techniques allows the nurse to help the client recognize that this negative beliefs may be distortions and that, by changing his thinking, he can adopt more positive beliefs that are realistic and hopeful. Agreeing with the client’s feelings and presenting a cheerful attitude are not consistent with a cognitive approach and would not be helpful in this situation. Denying the client’s feelings is belittling and may convey that the nurse does not understand the depth of the client’s distress.
48. A. Art therapy provides a nonthreatening vehicle for the expression of feelings, and use of a small group will help the client become comfortable with peers in a group setting. Basketball is a competitive game that requires energy; the client with major depression is not likely to participate in this activity. Recommending that the client read a self-help book may increase, not decrease his isolation. Watching movie with a peer group does not guarantee that interaction will occur; therefore, the client may remain isolated.

49. C. Day treatment programs provide clients with chronic, persistent mental illness training in social skills, such as meeting and greeting people, asking questions or directions, placing an order in a restaurant, taking turns in a group setting activity. Although management of hallucinations and medication teaching may also be part of the program offered in a day treatment, the nurse is referring the client in this situation because of his need for socialization skills. Vocational training generally takes place in a rehabilitation facility; the client described in this situation would not be a candidate for this service.

50. A. The best approach with a withdrawn client is to initiate brief, nondemanding activities on a one-to-one basis. This approach gives the nurse an opportunity to establish a trusting relationship with the client. A board game with a group clients or playing a team sport in the gym may overwhelm a severely withdrawn client. Watching TV is a solitary activity that will reinforce the client’s withdrawal from others.

Pre-board Examination

1. A woman in a child bearing age receives a rubella vaccination. Nurse Joy would give her which of the following instructions?

a. Refrain from eating eggs or egg products for 24 hours
b. Avoid having sexual intercourse
c. Don’t get pregnant at least 3 months
d. Avoid exposure to sun

2. Jonas who is diagnosed with encephalitis is under the treatment of Mannitol. Which of the following patient outcomes indicate to Nurse Ronald that the treatment of Mannitol has been effective for a patient that has increased intracranial pressure?

a. Increased urinary output
b. Decreased RR
c. Slowed papillary response
d. Decreased level of consciousness

3. Mary asked Nurse Maureen about the incubation period of rabies. Which statement by the Nurse Maureen is appropriate?

   a. Incubation period is 6 months
   b. Incubation period is 1 week
   c. Incubation period is 1 month
   d. Incubation period varies depending on the site of the bite

4. Which of the following should Nurse Cherry do first in taking care of a male client with rabies?

   a. Encourage the patient to take a bath
   b. Cover IV bottle with brown paper bag
   c. Place the patient near the comfort room
   d. Place the patient near the door

5. Which of the following is the screening test for dengue hemorrhagic fever?

   a. Complete blood count
   b. ELISA
   c. Rumpel-leede test
   d. Sedimentation rate

6. Mr. Dela Rosa is suspected to have malaria after a business trip in Palawan. The most important diagnostic test in malaria is:

   a. WBC count
   b. Urinalysis
   c. ELISA
   d. Peripheral blood smear

7. The Nurse supervisor is planning for patient’s assignment for the AM shift. The nurse supervisor avoids assigning which of the following staff members to a client with herpes zoster?

   a. Nurse who never had chicken pox
   b. Nurse who never had roseola
   c. Nurse who never had german measles
   d. Nurse who never had mumps

8. Clarissa is 7 weeks pregnant. Further examination revealed that she is susceptible to rubella. When would be the most appropriate for her to receive rubella immunization?

   a. At once
b. During 2nd trimester  
c. During 3rd trimester  
d. After the delivery of the baby

9. A female child with rubella should be isolated from a:

a. 21 year old male cousin living in the same house  
b. 18 year old sister who recently got married  
c. 11 year old sister who had rubeola during childhood  
d. 4 year old girl who lives next door

10. What is the primary prevention of leprosy?

a. Nutrition  
b. Vitamins  
c. BCG vaccination  
d. DPT vaccination

11. A bacteria which causes diphtheria is also known as?

a. Amoeba  
b. Cholera  
c. Klebs-loeffler bacillus  
d. Spirochete

12. Nurse Ron performed mantoux skin test today (Monday) to a male adult client. Which statement by the client indicates that he understood the instruction well?

a. I will come back later  
b. I will come back next month  
c. I will come back on Friday  
d. I will come back on Wednesday, same time, to read the result

13. A male client had undergone Mantoux skin test. Nurse Ronald notes an 8mm area of indurations at the site of the skin test. The nurse interprets the result as:

a. Negative  
b. Uncertain and needs to be repeated  
c. Positive  
d. Inconclusive

14. Tony will start a 6 month therapy with Isoniazid (INH). Nurse Trish plans to teach the client to:

a. Use alcohol moderately  
b. Avoid vitamin supplements while o therapy
c. Incomplete intake of dairy products
d. May be discontinued if symptoms subsides

15. Which is the primary characteristic lesion of syphilis?
   a. Sore eyes
   b. Sore throat
   c. Chancroid
   d. Chancre

16. What is the fast breathing of Jana who is 3 weeks old?
   a. 60 breaths per minute
   b. 40 breaths per minute
   c. 10 breaths per minute
   d. 20 breaths per minute

17. Which of the following signs and symptoms indicate some dehydration?
   a. Drinks eagerly
   b. Restless and irritable
   c. Unconscious
   d. A and B

18. What is the first line for dysentery?
   a. Amoxicillin
   b. Tetracycline
   c. Cefalexin
   d. Cotrimoxazole

19. In home made oresol, what is the ratio of salt and sugar if you want to prepare with 1 liter of water?
   a. 1 tbsp. salt and 8 tbsp. sugar
   b. 1 tbsp. salt and 8 tsp. sugar
   c. 1 tsp. salt and 8 tsp. sugar
   d. 8 tsp. salt and 8 tsp. sugar

20. Gentian Violet is used for:
   a. Wound
   b. Umbilical infections
   c. Ear infections
   d. Burn

21. Which of the following is a live attenuated bacterial vaccine?
   a. BCG
   b. OPV
   c. Measles
   d. None of the above
22. EPI is based on?
   a. Basic health services
   b. Scope of community affected
   c. Epidemiological situation
   d. Research studies

23. TT? provides how many percentage of protection against tetanus?
   a. 100
   b. 99
   c. 80
   d. 90

24. Temperature of refrigerator to maintain potency of measles and OPV vaccine is:
   a. -3c to -8c
   b. -15c to -25c
   c. +15c to +25c
   d. +3c to +8c

25. Diptheria is a:
   a. Bacterial toxin
   b. Killed bacteria
   c. Live attenuated
   d. Plasma derivatives

26. Budgeting is under in which part of management process?
   a. Directing
   b. Controlling
   c. Organizing
   d. Planning

27. Time table showing planned work days and shifts of nursing personnel is:
   a. Staffing
   b. Schedule
   c. Scheduling
   d. Planning

28. A force within an individual that influences the strength of behavior?
   a. Motivation
   b. Envy
   c. Reward
   d. Self-esteem
29. “To be the leading hospital in the Philippines” is best illustrate in:

a. Mission  
b. Philosophy  
c. Vision  
d. Objective

30. It is the professionally desired norms against which a staff performance will be compared?

a. Job descriptions  
b. Survey  
c. Flow chart  
d. Standards

31. Reprimanding a staff nurse for work that is done incorrectly is an example of what type of reinforcement?

a. Feedback  
b. Positive reinforcement  
c. Performance appraisal  
d. Negative reinforcement

32. Questions that are answerable only by choosing an option from a set of given alternatives are known as?

a. Survey  
b. Close ended  
c. Questionnaire  
d. Demographic

33. A researcher that makes a generalization based on observations of an individual's behavior is said to be which type of reasoning:

a. Inductive  
b. Logical  
c. Illogical  
d. Deductive

34. The balance of a research's benefit vs. its risks to the subject is:

a. Analysis  
b. Risk-benefit ratio  
c. Percentile  
d. Maximum risk

35. An individual/object that belongs to a general population is a/an:
a. Element  
b. Subject  
c. Respondent  
d. Author

36. An illustration that shows how the members of an organization are connected:

a. Flowchart  
b. Bar graph  
c. Organizational chart  
d. Line graph

37. The first college of nursing that was established in the Philippines is:

a. Fatima University  
b. Far Eastern University  
c. University of the East  
d. University of Sto. Tomas

38. Florence Nightingale is born on:

a. France  
b. Britain  
c. U.S  
d. Italy

39. Objective data is also called:

a. Covert  
b. Overt  
c. Inference  
d. Evaluation

40. An example of subjective data is:

a. Size of wounds  
b. VS  
c. Lethargy  
d. The statement of patient “My hand is painful”

41. What is the best position in palpating the breast?

a. Trendelenburg  
b. Side lying  
c. Supine  
d. Lithotomy

42. When is the best time in performing breast self examination?

a. 7 days after menstrual period
b. 7 days before menstrual period
c. 5 days after menstrual period
d. 5 days before menstrual period

43. Which of the following should be given the highest priority before performing physical examination to a patient?
   a. Preparation of the room
   b. Preparation of the patient
   c. Preparation of the nurse
   d. Preparation of environment

44. It is a flip over card usually kept in portable file at nursing station.
   a. Nursing care plan
   b. Medicine and treatment record
   c. Kardex
   d. TPR sheet

45. Jose has undergone thoracentesis. The nurse in charge is aware that the best position for Jose is:
   a. Semi fowlers
   b. Low fowlers
   c. Side lying, unaffected side
   d. Side lying, affected side

46. The degree of patients abdominal distension may be determined by:
   a. Auscultation
   b. Palpation
   c. Inspection
   d. Percussion

47. A male client is addicted with hallucinogen. Which physiologic effect should the nurse expect?
   a. Bradyprea
   b. Bradycardia
   c. Constricted pupils
   d. Dilated pupils

48. Tristan a 4 year old boy has suffered from full thickness burns of the face, chest and neck. What will be the priority nursing diagnosis?
   a. Ineffective airway clearance related to edema
   b. Impaired mobility related to pain
   c. Impaired urinary elimination related to fluid loss
   d. Risk for infection related to epidermal disruption
49. In assessing a client’s incision 1 day after the surgery, Nurse Betty expect to see which of the following as signs of a local inflammatory response?

a. Greenish discharge  
b. Brown exudates at incision edges  
c. Pallor around sutures  
d. Redness and warmth

50. Nurse Ronald is aware that the amiotic fluid in the third trimester weighs approximately:

a. 2 kilograms  
b. 1 kilograms  
c. 100 grams  
d. 1.5 kilograms

51. After delivery of a baby girl, Nurse Gina examines the umbilical cord and expects to find a cord to:

a. Two arteries and two veins  
b. One artery and one vein  
c. Two arteries and one vein  
d. One artery and two veins

52. Myrna a pregnant client reports that her last menstrual cycle is July 11, her expected date of birth is

a. November 4  
b. November 11  
c. April 4  
d. April 18

53. Which of the following is not a good source of iron?

a. Butter  
b. Pechay  
c. Grains  
d. Beef

54. Maureen is admitted with a diagnosis of ectopic pregnancy. Which of the following would you anticipate?

a. NPO  
b. Bed rest  
c. Immediate surgery
55. Gina a postpartum client is diagnosed with endometritis. Which position would you expect to place her based on this diagnosis?

a. Supine
b. Left side lying
c. Trendelenburg
d. Semi-fowlers

56. Nurse Hazel knows that Myrna understands her condition well when she remarks that urinary frequency is caused by:

a. Pressure caused by the ascending uterus
b. Water intake of 3L a day
c. Effect of cold weather
d. Increase intake of fruits and vegetables

57. How many ml of blood is loss during the first 24 hours post delivery of Myrna?

a. 100
b. 500
c. 200
d. 400

58. Which of the following hormones stimulates the secretion of milk?

a. Progesterone
b. Prolactin
c. Oxytocin
d. Estrogen

59. Nurse Carla is aware that Myla’s second stage of labor is beginning when the following assessment is noted:

a. Bay of water is broken
b. Contractions are regular
c. Cervix is completely dilated
d. Presence of bloody show

60. The leaking fluid is tested with nitrazine paper. Nurse Kelly confirms that the client’s membrane have ruptures when the paper turns into a:

a. Pink
b. Violet
c. Green
d. Blue

61. After amniotomy, the priority nursing action is:
   a. Document the color and consistency of amniotic fluid
   b. Listen the fetal heart tone
   c. Position the mother in her left side
   d. Let the mother rest

62. Which is the most frequent reason for postpartum hemorrhage?
   a. Perineal lacerations
   b. Frequent internal examination (IE)
   c. CS
   d. Uterine atony

63. On 2nd postpartum day, which height would you expect to find the fundus in a woman who has had a caesarian birth?
   a. 1 finger above umbilicus
   b. 2 fingers above umbilicus
   c. 2 fingers below umbilicus
   d. 1 finger below umbilicus

64. Which of the following criteria allows Nurse Kris to perform home deliveries?
   a. Normal findings during assessment
   b. Previous CS
   c. Diabetes history
   d. Hypertensive history

65. Nurse Carla is aware that one of the following vaccines is done by intramuscular (IM) injection?
   a. Measles
   b. OPV
   c. BCG
   d. Tetanus toxoid

66. Asin law is on which legal basis:
   a. RA 8860
   b. RA 2777
   c. RI 8172
   d. RR 6610
67. Nurse John is aware that the herbal medicine appropriate for urolithiasis is:

a. Akapulco  
b. Sambong  
c. Tsaang gubat  
d. Bayabas

68. Community/Public health bag is defined as:

a. An essential and indispensable equipment of the community health nurse during home visit  
b. It contains drugs and equipment used by the community health nurse  
c. Is a requirement in the health center and for home visit  
d. It is a tool used by the community health nurse in rendering effective procedures during home visit

69. TT4 provides how many percentage of protection against tetanus?

a. 70  
b. 80  
c. 90  
d. 99

70. Third postpartum visit must be done by public health nurse:

a. Within 24 hours after delivery  
b. After 2-4 weeks  
c. Within 1 week  
d. After 2 months

71. Nurse Candy is aware that the family planning method that may give 98% protection to another pregnancy to women

a. Pills  
b. Tubal ligation  
c. Lactational Amenorrhea method (LAM)  
d. IUD

72. Which of the following is not a part of IMCI case management process

a. Counsel the mother  
b. Identify the illness  
c. Assess the child  
d. Treat the child
73. If a young child has pneumonia when should the mother bring him back for follow up?

a. After 2 days  
b. In the afternoon  
c. After 4 days  
d. After 5 days

74. It is the certification recognition program that develop and promotes standard for health facilities:

a. Formula  
b. Tutok gamutan  
c. Sentrong program movement  
d. Sentrong sigla movement

75. Baby Marie was born May 23, 1984. Nurse John will expect finger thumb opposition on:

a. April 1985  
b. February 1985  
c. March 1985  
d. June 1985

76. Baby Reese is a 12 month old child. Nurse Oliver would anticipate how many teeth?

a. 9  
b. 7  
c. 8  
d. 6

77. Which of the following is the primary antidote for Tylenol poisoning?

a. Narcan  
b. Digoxin  
c. Acetylcysteine  
d. Flumazenil

78. A male child has an intelligence quotient of approximately 40. Which kind of environment and interdisciplinary program most likely to benefit this child would be best described as:

a. Habit training  
b. Sheltered workshop  
c. Custodial  
d. Educational
79. Nurse Judy is aware that following condition would reflect presence of congenital G.I anomaly?

a. Cord prolapse  
b. Polyhydramios  
c. Placenta previa  
d. Oligohydramios

80. Nurse Christine provides health teaching for the parents of a child diagnosed with celiac disease. Nurse Christine teaches the parents to include which of the following food items in the child’s diet:

a. Rye toast  
b. Oatmeal  
c. White bread  
d. Rice

81. Nurse Randy is planning to administer oral medication to a 3 year old child. Nurse Randy is aware that the best way to proceed is by:

a. “Would you like to drink your medicine?”  
b. “If you take your medicine now, I’ll give you lollipop”  
c. “See the other boy took his medicine? Now it’s your turn.”  
d. “Here’s your medicine. Would you like a mango or orange juice?”

82. At what age a child can brush her teeth without help?

a. 6 years  
b. 7 years  
c. 5 years  
d. 8 years

83. Ribivarin (Virazole) is prescribed for a female hospitalized child with RSV. Nurse Judy prepare this medication via which route?

a. Intra venous  
b. Oral  
c. Oxygen tent  
d. Subcutaneous

84. The present chairman of the Board of Nursing in the Philippines is:

a. Maria Joanna Cervantes  
b. Carmencita Abaquin  
c. Leonor Rosero  
d. Primitiva Paquic
85. The obligation to maintain efficient ethical standards in the practice of nursing belong to this body:

a. BON  
b. ANSAP  
c. PNA  
d. RN

86. A male nurse was found guilty of negligence. His license was revoked. Re-issuance of revoked certificates is after how many years?

a. 1 year  
b. 2 years  
c. 3 years  
d. 4 years

87. Which of the following information cannot be seen in the PRC identification card?

a. Registration Date  
b. License Number  
c. Date of Application  
d. Signature of PRC chairperson

88. Breastfeeding is being enforced by milk code or:

a. EO 51  
b. R.A. 7600  
c. R.A. 6700  
d. P.D. 996

89. Self governance, ability to choose or carry out decision without undue pressure or coercion from anyone:

a. Veracity  
b. Autonomy  
c. Fidelity  
d. Beneficence

90. A male patient complained because his scheduled surgery was cancelled because of earthquake. The hospital personnel may be excused because of:

a. Governance  
b. Respondent superior  
c. Force majeure  
d. Res ipsa loquitur
91. Being on time, meeting deadlines and completing all scheduled duties is what virtue?

a. Fidelity  
b. Autonomy  
c. Veracity  
d. Confidentiality

92. This quality is being demonstrated by Nurse Ron who raises the side rails of a confused and disoriented patient?

a. Responsibility  
b. Resourcefulness  
c. Autonomy  
d. Prudence  

93. Which of the following is formal continuing education?

a. Conference  
b. Enrollment in graduate school  
c. Refresher course  
d. Seminar

94. The BSN curriculum prepares the graduates to become?

a. Nurse generalist  
b. Nurse specialist  
c. Primary health nurse  
d. Clinical instructor

95. Disposal of medical records in government hospital/institutions must be done in close coordination with what agency?

a. Department of Health  
b. Records Management Archives Office  
c. Metro Manila Development Authority  
d. Bureau of Internal Revenue

96. Nurse Jolina must see to it that the written consent of mentally ill patients must be taken from:

a. Nurse  
b. Priest  
c. Family lawyer  
d. Parents/legal guardians

97. When Nurse Clarence respects the client’s self-disclosure, this is a gauge for the nurses’
a. Respectfulness  
b. Loyalty  
c. Trustworthiness  
d. Professionalism  

98. The Nurse is aware that the following tasks can be safely delegated by the nurse to a non-nurse health worker except:

a. Taking vital signs  
b. Change IV infusions  
c. Transferring the client from bed to chair  
d. Irrigation of NGT  

99. During the evening round Nurse Tina saw Mr. Toralba meditating and afterwards started singing prayerful hymns. What would be the best response of Nurse Tina?

a. Call the attention of the client and encourage to sleep  
b. Report the incidence to head nurse  
c. Respect the client’s action  
d. Document the situation  

100. In caring for a dying client, you should perform which of the following activities

a. Do not resuscitate  
b. Assist client to perform ADL  
c. Encourage to exercise  
d. Assist client towards a peaceful death  

101. The Nurse is aware that the ability to enter into the life of another person and perceive his current feelings and their meaning is known:

a. Belongingness  
b. Genuineness  
c. Empathy  
d. Respect  

102. The termination phase of the NPR is best described one of the following:

a. Review progress of therapy and attainment of goals  
b. Exploring the client’s thoughts, feelings and concerns  
c. Identifying and solving patients problem  
d. Establishing rapport  

103. During the process of cocaine withdrawal, the physician orders which of the following:
a. Haloperidol (Haldol)
b. Imipramine (Tofranil)
c. Benztropine (Cogentin)
d. Diazepam (Valium)

104. The nurse is aware that cocaine is classified as:

a. Hallucinogen
b. Psycho stimulant
c. Anxiolytic
d. Narcotic

105. In community health nursing, it is the most important risk factor in the development of mental illness?

a. Separation of parents
b. Political problems
c. Poverty
d. Sexual abuse

106. All of the following are characteristics of crisis except

a. The client may become resistive and active in stopping the crisis
b. It is self-limiting for 4-6 weeks
c. It is unique in every individual
d. It may also affect the family of the client

107. Freud states that temper tantrums is observed in which of the following:

a. Oral
b. Anal
c. Phallic
d. Latency

108. The nurse is aware that ego development begins during:

a. Toddler period
b. Preschool age
c. School age
d. Infancy

109. Situation: A 19 year old nursing student has lost 36 lbs for 4 weeks. Her parents brought her to the hospital for medical evaluation. The diagnosis was ANOREXIA NERVOSA. The Primary gain of a client with anorexia nervosa is:

a. Weight loss
b. Weight gain
   c. Reduce anxiety
   d. Attractive appearance

110. The nurse is aware that the primary nursing diagnosis for the client is:

   a. Altered nutrition : less than body requirement
   b. Altered nutrition : more than body requirement
   c. Impaired tissue integrity
   d. Risk for malnutrition

111. After 14 days in the hospital, which finding indicates that her condition is improving?

   a. She tells the nurse that she had no idea that she is thin
   b. She arrives earlier than scheduled time of group therapy
   c. She tells the nurse that she eats 3 times or more in a day
   d. She gained 4 lbs in two weeks

112. The nurse is aware that ataractics or psychic energizers are also known as:

   a. Anti manic
   b. Anti depressants
   c. Antipsychotics
   d. Anti anxiety

113. Known as mood elevators:

   a. Anti depressants
   b. Antipsychotics
   c. Anti manic
   d. Anti anxiety

114. The priority of care for a client with Alzheimer’s disease is

   a. Help client develop coping mechanism
   b. Encourage to learn new hobbies and interest
   c. Provide him stimulating environment
   d. Simplify the environment to eliminate the need to make chores

115. Autism is diagnosed at:

   a. Infancy
   b. 3 years old
   c. 5 years old
   d. School age
116. The common characteristic of autism child is:
   a. Impulsitity
   b. Self destructiveness
   c. Hostility
   d. Withdrawal

117. The nurse is aware that the most common indication in using ECT is:
   a. Schizophrenia
   b. Bipolar
   c. Anorexia Nervosa
   d. Depression

118. A therapy that focuses on here and now principle to promote self-acceptance?
   a. Gestalt therapy
   b. Cognitive therapy
   c. Behavior therapy
   d. Personality therapy

119. A client has many irrational thoughts. The goal of therapy is to change her:
   a. Personality
   b. Communication
   c. Behavior
   d. Cognition

120. The appropriate nutrition for Bipolar I disorder, in manic phase is:
   a. Low fat, low sodium
   b. Low calorie, high fat
   c. Finger foods, high in calorie
   d. Small frequent feedings

121. Which of the following activity would be best for a depressed client?
   a. Chess
   b. Basketball
   c. Swimming
   d. Finger painting

122. The nurse is aware that clients with severe depression, possess which defense mechanism:
   a. Introjection
   b. Suppression
   c. Repression
   d. Projection
123. Nurse John is aware that self mutilation among Bipolar disorder patients is a means of:
   a. Overcoming fear of failure
   b. Overcoming feeling of insecurity
   c. Relieving depression
   d. Relieving anxiety

124. Which of the following may cause an increase in the cystitis symptoms?
   a. Water
   b. Orange juice
   c. Coffee
   d. Mango juice

125. In caring for clients with renal calculi, which is the priority nursing intervention?
   a. Record vital signs
   b. Strain urine
   c. Limit fluids
   d. Administer analgesics as prescribed

126. In patient with renal failure, the diet should be:
   a. Low protein, low sodium, low potassium
   b. Low protein, high potassium
   c. High carbohydrate, low protein
   d. High calcium, high protein

127. Which of the following cannot be corrected by dialysis?
   a. Hypernatremia
   b. Hyperkalemia
   c. Elevated creatinine
   d. Decreased hemoglobin

128. Tony with infection is receiving antibiotic therapy. Later the client complaints of ringing in the ears. This ototoxicity is damage to:
   a. 4th CN
   b. 8th CN
   c. 7th CN
   d. 9th CN

129. Nurse Emma provides teaching to a patient with recurrent urinary tract infection includes the following:
   a. Increase intake of tea, coffee and colas
   b. Void every 6 hours per day
   c. Void immediately after intercourse
   d. Take tub bath everyday
130. Which assessment finding indicates circulatory constriction in a male client with a newly applied long leg cast?
   a. Blanching or cyanosis of legs
   b. Complaints of pressure or tightness
   c. Inability to move toes
   d. Numbness of toes

131. During acute gout attack, the nurse administer which of the following drug:
   a. Prednisone (Deltasone)
   b. Colchicines
   c. Aspirin
   d. Allopurinol (Zyloprim)

132. Information in the patients chart is inadmissible in court as evidence when:
   a. The client objects to its use
   b. Handwriting is not legible
   c. It has too many unofficial abbreviations
   d. The clients parents refuses to use it

133. Nurse Karen is revising a client plan of care. During which step of the nursing process does such revision take place?
   a. Planning
   b. Implementation
   c. Diagnosing
   d. Evaluation

134. When examining a client with abdominal pain, Nurse Hazel should assess:
   a. Symptomatic quadrant either second or first
   b. The symptomatic quadrant last
   c. The symptomatic quadrant first
   d. Any quadrant

135. How long will nurse John obtain an accurate reading of temperature via oral route?
   a. 3 minutes
   b. 1 minute
   c. 8 minutes
   d. 15 minutes

136. The one filing the criminal care against an accused party is said to be the?
   a. Guilty
   b. Accused
   c. Plaintiff
   d. Witness

137. A male client has a standing DNR order. He then suddenly stopped breathing and you are at his bedside. You would:
   a. Call the physician
b. Stay with the client and do nothing  
c. Call another nurse  
d. Call the family

138. The ANA recognized nursing informatics heralding its establishment as a new field in nursing during what year?
   a. 1994  
   b. 1992  
   c. 2000  
   d. 2001

139. When is the first certification of nursing informatics given?
   a. 1990-1993  
   b. 2001-2002  
   c. 1994-1996  
   d. 2005-2008

140. The nurse is assessing a female client with possible diagnosis of osteoarthritis. The most significant risk factor for osteoarthritis is:
   a. Obesity  
   b. Race  
   c. Job  
   d. Age

141. A male client complains of vertigo. Nurse Bea anticipates that the client may have a problem with which portion of the ear?
   a. Tympanic membranes  
   b. Inner ear  
   c. Auricle  
   d. External ear

142. When performing Weber’s test, Nurse Rosean expects that this client will hear
   a. On unaffected side  
   b. Longer through bone than air conduction  
   c. On affected side by bone conduction  
   d. By neither bone or air conduction

143. Toy with a tentative diagnosis of myasthenia gravis is admitted for diagnostic make up. Myasthenia gravis can confirmed by:
   a. Kernigs sign  
   b. Brudzinski’s sign  
   c. A positive sweat chloride test  
   d. A positive edrophonium (Tensilon) test

144. A male client is hospitalized with Guillain-Barre Syndrome. Which assessment finding is the most significant?
a. Even, unlabored respirations  
b. Soft, non distended abdomen  
c. Urine output of 50 ml/hr  
d. Warm skin  

145. For a female client with suspected intracranial pressure (ICP), a most appropriate respiratory goal is:

a. Maintain partial pressure of arterial oxygen (Pa O2) above 80mmHg  
b. Promote elimination of carbon dioxide  
c. Lower the PH  
d. Prevent respiratory alkalosis  

146. Which nursing assessment would identify the earliest sign of ICP?  
a. Change in level of consciousness  
b. Temperature of over 103°F  
c. Widening pulse pressure  
d. Unequal pupils  

147. The greatest danger of an uncorrected atrial fibrillation for a male patient will be which of the following:  
a. Pulmonary embolism  
b. Cardiac arrest  
c. Thrombus formation  
d. Myocardial infarction  

148. Linda, A 30 year old post hysterectomy client has visited the health center. She inquired about BSE and asked the nurse when BSE should be performed. You answered that the BSE is best performed:

a. 7 days after menstruation  
b. At the same day each month  
c. During menstruation  
d. Before menstruation  

149. An infant is ordered to receive 500 ml of D5NSS for 24 hours. The Intravenous drip is running at 60 gtts/min. How many drops per minute should the flow rate be?

a. 60 gtts/min.  
b. 21 gtts/min  
c. 30 gtts/min  
d. 15 gtts/min  

150. Mr. Gutierrez is to receive 1 liter of D5RL to run for 12 hours. The drop factor

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of the IV infusion set is 10 drops per minute. Approximately how many drops per minutes should the IV be regulated?

a. 13-14 drops  
b. 17-18 drops  
c. 10-12 drops  
d. 15-16 drops

Maternal and Child Health Practice Test Part 1

1. When assessing the adequacy of sperm for conception to occur, which of the following is the most useful criterion?
   a. Sperm count  
   b. Sperm motility  
   c. Sperm maturity  
   d. Semen volume

2. A couple who wants to conceive but has been unsuccessful during the last 2 years has undergone many diagnostic procedures. When discussing the situation with the nurse, one partner states, “We know several friends in our age group and all of them have their own child already, Why can’t we have one?” Which of the following would be the most pertinent nursing diagnosis for this couple?
   a. Fear related to the unknown  
   b. Pain related to numerous procedures.  
   c. Ineffective family coping related to infertility.  
   d. Self-esteem disturbance related to infertility.

3. Which of the following urinary symptoms does the pregnant woman most frequently experience during the first trimester?
   a. Dysuria  
   b. Frequency  
   c. Incontinence  
   d. Burning

4. Heartburn and flatulence, common in the second trimester, are most likely the result of which of the following?
   a. Increased plasma HCG levels  
   b. Decreased intestinal motility  
   c. Decreased gastric acidity  
   d. Elevated estrogen levels

5. On which of the following areas would the nurse expect to observe chloasma?
   a. Breast, areola, and nipples  
   b. Chest, neck, arms, and legs  
   c. Abdomen, breast, and thighs
6. A pregnant client states that she “waddles” when she walks. The nurse’s explanation is based on which of the following as the cause?
   a. The large size of the newborn
   b. Pressure on the pelvic muscles
   c. Relaxation of the pelvic joints
   d. Excessive weight gain

7. Which of the following represents the average amount of weight gained during pregnancy?
   a. 12 to 22 lb
   b. 15 to 25 lb
   c. 24 to 30 lb
   d. 25 to 40 lb

8. When talking with a pregnant client who is experiencing aching swollen, leg veins, the nurse would explain that this is most probably the result of which of the following?
   a. Thrombophlebitis
   b. Pregnancy-induced hypertension
   c. Pressure on blood vessels from the enlarging uterus
   d. The force of gravity pulling down on the uterus

9. Cervical softening and uterine souffle are classified as which of the following?
   a. Diagnostic signs
   b. Presumptive signs
   c. Probable signs
   d. Positive signs

10. Which of the following would the nurse identify as a presumptive sign of pregnancy?
    a. Hegar sign
    b. Nausea and vomiting
    c. Skin pigmentation changes
    d. Positive serum pregnancy test

11. Which of the following common emotional reactions to pregnancy would the nurse expect to occur during the first trimester?
    a. Introversion, egocentrism, narcissism
    b. Awkwardness, clumsiness, and unattractiveness
    c. Anxiety, passivity, extroversion
    d. Ambivalence, fear, fantasies

12. During which of the following would the focus of classes be mainly on physiologic changes, fetal development, sexuality, during pregnancy, and nutrition?
    a. Prepregnant period
    b. First trimester
    c. Second trimester
    d. Third trimester

13. Which of the following would be disadvantage of breast feeding?
    a. Involution occurs more rapidly
b. The incidence of allergies increases due to maternal antibodies
c. The father may resent the infant’s demands on the mother’s body
d. There is a greater chance for error during preparation

14. Which of the following would cause a false-positive result on a pregnancy test?
   a. The test was performed less than 10 days after an abortion
   b. The test was performed too early or too late in the pregnancy
   c. The urine sample was stored too long at room temperature
   d. A spontaneous abortion or a missed abortion is impending

15. FHR can be auscultated with a fetoscope as early as which of the following?
   a. 5 weeks gestation
   b. 10 weeks gestation
   c. 15 weeks gestation
   d. 20 weeks gestation

16. A client LMP began July 5. Her EDD should be which of the following?
   a. January 2
   b. March 28
   c. April 12
   d. October 12

17. Which of the following fundal heights indicates less than 12 weeks’ gestation when the date of the LMP is unknown?
   a. Uterus in the pelvis
   b. Uterus at the xiphoid
   c. Uterus in the abdomen
   d. Uterus at the umbilicus

18. Which of the following danger signs should be reported promptly during the antepartum period?
   a. Constipation
   b. Breast tenderness
   c. Nasal stuffiness
   d. Leaking amniotic fluid

19. Which of the following prenatal laboratory test values would the nurse consider as significant?
   a. Hematocrit 33.5%
   b. Rubella titer less than 1:8
   c. White blood cells 8,000/mm3
   d. One hour glucose challenge test 110 g/dL

20. Which of the following characteristics of contractions would the nurse expect to find in a client experiencing true labor?
   a. Occurring at irregular intervals
   b. Starting mainly in the abdomen
   c. Gradually increasing intervals
   d. Increasing intensity with walking

21. During which of the following stages of labor would the nurse assess “crowning”?
   a. First stage
   b. Second stage
   c. Third stage
22. Barbiturates are usually not given for pain relief during active labor for which of the following reasons?
   a. The neonatal effects include hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days.
   b. These drugs readily cross the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection.
   c. They rapidly transfer across the placenta, and lack of an antagonist make them generally inappropriate during labor.
   d. Adverse reactions may include maternal hypotension, allergic or toxic reaction or partial or total respiratory failure.
23. Which of the following nursing interventions would the nurse perform during the third stage of labor?
   a. Obtain a urine specimen and other laboratory tests.
   b. Assess uterine contractions every 30 minutes.
   c. Coach for effective client pushing.
   d. Promote parent-newborn interaction.
24. Which of the following actions demonstrates the nurse’s understanding about the newborn’s thermoregulatory ability?
   a. Placing the newborn under a radiant warmer.
   b. Suctioning with a bulb syringe.
   c. Obtaining an Apgar score.
   d. Inspecting the newborn’s umbilical cord.
25. Immediately before expulsion, which of the following cardinal movements occur?
   a. Descent.
   b. Flexion.
   c. Extension.
   d. External rotation.
26. Before birth, which of the following structures connects the right and left auricles of the heart?
   a. Umbilical vein.
   b. Foramen ovale.
   c. Ductus arteriosus.
   d. Ductus venosus.
27. Which of the following when present in the urine may cause a reddish stain on the diaper of a newborn?
   a. Mucus.
   b. Uric acid crystals.
   c. Bilirubin.
   d. Excess iron.
28. When assessing the newborn’s heart rate, which of the following ranges would be considered normal if the newborn were sleeping?
   a. 80 beats per minute.
   b. 100 beats per minute.
   c. 120 beats per minute.
   d. 140 beats per minute.
29. Which of the following is true regarding the fontanels of the newborn?
   a. The anterior is triangular shaped; the posterior is diamond shaped.
   b. The posterior closes at 18 months; the anterior closes at 8 to 12 weeks.
   c. The anterior is large in size when compared to the posterior fontanel.
   d. The anterior is bulging; the posterior appears sunken.

30. Which of the following groups of newborn reflexes below are present at birth and remain unchanged through adulthood?
   a. Blink, cough, rooting, and gag
   b. Blink, cough, sneeze, gag
   c. Rooting, sneeze, swallowing, and cough
   d. Stepping, blink, cough, and sneeze

31. Which of the following describes the Babinski reflex?
   a. The newborn’s toes will hyperextend and fan apart from dorsiflexion of the big toe when one side of foot is stroked upward from the ball of the heel and across the ball of the foot.
   b. The newborn abducts and flexes all extremities and may begin to cry when exposed to sudden movement or loud noise.
   c. The newborn turns the head in the direction of stimulus, opens the mouth, and begins to suck when cheek, lip, or corner of mouth is touched.
   d. The newborn will attempt to crawl forward with both arms and legs when he is placed on his abdomen on a flat surface

32. Which of the following statements best describes hyperemesis gravidarum?
   a. Severe anemia leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems.
   b. Severe nausea and vomiting leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems.
   c. Loss of appetite and continuous vomiting that commonly results in dehydration and ultimately decreasing maternal nutrients
   d. Severe nausea and diarrhea that can cause gastrointestinal irritation and possibly internal bleeding

33. Which of the following would the nurse identify as a classic sign of PIH?
   a. Edema of the feet and ankles
   b. Edema of the hands and face
   c. Weight gain of 1 lb/week
   d. Early morning headache

34. In which of the following types of spontaneous abortions would the nurse assess dark brown vaginal discharge and a negative pregnancy tests?
   a. Threatened
   b. Imminent
   c. Missed
   d. Incomplete

35. Which of the following factors would the nurse suspect as predisposing a client to placenta previa?
   a. Multiple gestation
   b. Uterine anomalies
   c. Abdominal trauma
d. Renal or vascular disease

36. Which of the following would the nurse assess in a client experiencing abruptio placenta?
   a. Bright red, painless vaginal bleeding
   b. Concealed or external dark red bleeding
   c. Palpable fetal outline
   d. Soft and nontender abdomen

37. Which of the following is described as premature separation of a normally implanted placenta during the second half of pregnancy, usually with severe hemorrhage?
   a. Placenta previa
   b. Ectopic pregnancy
   c. Incompetent cervix
   d. Abruptio placentae

38. Which of the following may happen if the uterus becomes overstimulated by oxytocin during the induction of labor?
   a. Weak contraction prolonged to more than 70 seconds
   b. Tetanic contractions prolonged to more than 90 seconds
   c. Increased pain with bright red vaginal bleeding
   d. Increased restlessness and anxiety

39. When preparing a client for cesarean delivery, which of the following key concepts should be considered when implementing nursing care?
   a. Instruct the mother’s support person to remain in the family lounge until after the delivery
   b. Arrange for a staff member of the anesthesia department to explain what to expect postoperatively
   c. Modify preoperative teaching to meet the needs of either a planned or emergency cesarean birth
   d. Explain the surgery, expected outcome, and kind of anesthetics

40. Which of the following best describes preterm labor?
   a. Labor that begins after 20 weeks gestation and before 37 weeks gestation
   b. Labor that begins after 15 weeks gestation and before 37 weeks gestation
   c. Labor that begins after 24 weeks gestation and before 28 weeks gestation
   d. Labor that begins after 28 weeks gestation and before 40 weeks gestation

41. When PROM occurs, which of the following provides evidence of the nurse’s understanding of the client’s immediate needs?
   a. The chorion and amnion rupture 4 hours before the onset of labor.
   b. PROM removes the fetus most effective defense against infection
   c. Nursing care is based on fetal viability and gestational age.
   d. PROM is associated with malpresentation and possibly incompetent cervix

42. Which of the following factors is the underlying cause of dystocia?
   a. Nutritional
   b. Mechanical
   c. Environmental
   d. Medical

43. When uterine rupture occurs, which of the following would be the priority?
a. Limiting hypovolemic shock  
b. Obtaining blood specimens  
c. Instituting complete bed rest  
d. Inserting a urinary catheter

44. Which of the following is the nurse’s initial action when umbilical cord prolapse occurs?
   a. Begin monitoring maternal vital signs and FHR  
   b. Place the client in a knee-chest position in bed  
   c. Notify the physician and prepare the client for delivery  
   d. Apply a sterile warm saline dressing to the exposed cord

45. Which of the following amounts of blood loss following birth marks the criterion for describing postpartum hemorrhage?
   a. More than 200 ml  
   b. More than 300 ml  
   c. More than 400 ml  
   d. More than 500 ml

46. Which of the following is the primary predisposing factor related to mastitis?
   a. Epidemic infection from nosocomial sources localizing in the lactiferous glands and ducts  
   b. Endemic infection occurring randomly and localizing in the periglandular connective tissue  
   c. Temporary urinary retention due to decreased perception of the urge to avoid  
   d. Breast injury caused by overdistention, stasis, and cracking of the nipples

47. Which of the following best describes thrombophlebitis?
   a. Inflammation and clot formation that result when blood components combine to form an aggregate body  
   b. Inflammation and blood clots that eventually become lodged within the pulmonary blood vessels  
   c. Inflammation and blood clots that eventually become lodged within the femoral vein  
   d. Inflammation of the vascular endothelium with clot formation on the vessel wall

48. Which of the following assessment findings would the nurse expect if the client develops DVT?
   a. Midcalf pain, tenderness and redness along the vein  
   b. Chills, fever, malaise, occurring 2 weeks after delivery  
   c. Muscle pain the presence of Homans sign, and swelling in the affected limb  
   d. Chills, fever, stiffness, and pain occurring 10 to 14 days after delivery

49. Which of the following are the most commonly assessed findings in cystitis?
   a. Frequency, urgency, dehydration, nausea, chills, and flank pain  
   b. Nocturia, frequency, urgency dysuria, hematuria, fever and suprapubic pain  
   c. Dehydration, hypertension, dysuria, suprapubic pain, chills, and fever  
   d. High fever, chills, flank pain nausea, vomiting, dysuria, and frequency
50. Which of the following best reflects the frequency of reported postpartum “blues”?
   a. Between 10% and 40% of all new mothers report some form of postpartum blues
   b. Between 30% and 50% of all new mothers report some form of postpartum blues
   c. Between 50% and 80% of all new mothers report some form of postpartum blues
   d. Between 25% and 70% of all new mothers report some form of postpartum blues

Answers and Rationale Maternal and Child Health Practice Test Part 1

1. B. Although all of the factors listed are important, sperm motility is the most significant criterion when assessing male infertility. Sperm count, sperm maturity, and semen volume are all significant, but they are not as significant sperm motility.

2. D. Based on the partner’s statement, the couple is verbalizing feelings of inadequacy and negative feelings about themselves and their capabilities. Thus, the nursing diagnosis of self-esteem disturbance is most appropriate. Fear, pain, and ineffective family coping also may be present but as secondary nursing diagnoses.

3. B. Pressure and irritation of the bladder by the growing uterus during the first trimester is responsible for causing urinary frequency. Dysuria, incontinence, and burning are symptoms associated with urinary tract infections.

4. C. During the second trimester, the reduction in gastric acidity in conjunction with pressure from the growing uterus and smooth muscle relaxation, can cause heartburn and flatulence. HCG levels increase in the first, not the second trimester. Decrease intestinal motility would most likely be the cause of constipation and bloating. Estrogen levels decrease in the second trimester.

5. D. Chloasma, also called the mask of pregnancy, is an irregular hyperpigmented area found on the face. It is not seen on the breasts, areola, nipples, chest, neck, arms, legs, abdomen, or thighs.

6. C. During pregnancy, hormonal changes cause relaxation of the pelvic joints, resulting in the typical “waddling” gait. Changes in posture are related to the growing fetus. Pressure on the surrounding muscles causing discomfort is due to the growing uterus. Weight gain has no effect on gait.

7. C. The average amount of weight gained during pregnancy is 24 to 30 lb. This weight gain consists of the following: fetus – 7.5 lb; placenta and membrane – 1.5 lb; amniotic fluid – 2 lb; uterus – 2.5 lb; breasts – 3 lb; and increased blood volume – 2 to 4 lb; extravascular fluid and fat – 4 to 9 lb. A gain of 12 to 22 lb is insufficient, whereas a weight gain of 15 to 25 lb is marginal. A weight gain of 25 to 40 lb is considered excessive.

8. C. Pressure of the growing uterus on blood vessels results in an increased risk for venous stasis in the lower extremities. Subsequently, edema and varicose vein formation may occur. Thrombophlebitis is an inflammation of the veins due to
thrombus formation. Pregnancy-induced hypertension is not associated with these symptoms. Gravity plays only a minor role with these symptoms.

9. **C.** Cervical softening (Goodell sign) and uterine soufflé are two probable signs of pregnancy. Probable signs are objective findings that strongly suggest pregnancy. Other probable signs include Hegar sign, which is softening of the lower uterine segment; Piskacek sign, which is enlargement and softening of the uterus; serum laboratory tests; changes in skin pigmentation; and ultrasonic evidence of a gestational sac. Presumptive signs are subjective signs and include amenorrhea; nausea and vomiting; urinary frequency; breast tenderness and changes; excessive fatigue; uterine enlargement; and quickening.

10. **B.** Presumptive signs of pregnancy are subjective signs. Of the signs listed, only nausea and vomiting are presumptive signs. Hegar sign, skin pigmentation changes, and a positive serum pregnancy test are considered probably signs, which are strongly suggestive of pregnancy.

11. **D.** During the first trimester, common emotional reactions include ambivalence, fear, fantasies, or anxiety. The second trimester is a period of well-being accompanied by the increased need to learn about fetal growth and development. Common emotional reactions during this trimester include narcissism, passivity, or introversion. At times the woman may seem egocentric and self-centered. During the third trimester, the woman typically feels awkward, clumsy, and unattractive, often becoming more introverted or reflective of her own childhood.

12. **B.** First-trimester classes commonly focus on such issues as early physiologic changes, fetal development, sexuality during pregnancy, and nutrition. Some early classes may include pregnant couples. Second and third trimester classes may focus on preparation for birth, parenting, and newborn care.

13. **C.** With breast feeding, the father’s body is not capable of providing the milk for the newborn, which may interfere with feeding the newborn, providing fewer chances for bonding, or he may be jealous of the infant’s demands on his wife’s time and body. Breast feeding is advantageous because uterine involution occurs more rapidly, thus minimizing blood loss. The presence of maternal antibodies in breast milk helps decrease the incidence of allergies in the newborn. A greater chance for error is associated with bottle feeding. No preparation is required for breast feeding.

14. **A.** A false-positive reaction can occur if the pregnancy test is performed less than 10 days after an abortion. Performing the tests too early or too late in the pregnancy, storing the urine sample too long at room temperature, or having a spontaneous or missed abortion impending can all produce false-negative results.

15. **D.** The FHR can be auscultated with a fetoscope at about 20 week’s gestation. FHR is usually auscultated at the midline suprapubic region with Doppler ultrasound transducer at 10 to 12 week’s gestation. FHR cannot be heard any earlier than 10 weeks’ gestation.

16. **C.** To determine the EDD when the date of the client’s LMP is known use Nagele rule. To the first day of the LMP, add 7 days, subtract 3 months, and add 1 year (if applicable) to arrive at the EDD as follows: \(5 + 7 = 12\) (July) minus \(3 = 4\) (April). Therefore, the client’s EDD is April 12.
17. **A.** When the LMP is unknown, the gestational age of the fetus is estimated by uterine size or position (fundal height). The presence of the uterus in the pelvis indicates less than 12 weeks’ gestation. At approximately 12 to 14 weeks, the fundus is out of the pelvis above the symphysis pubis. The fundus is at the level of the umbilicus at approximately 20 weeks’ gestation and reaches the xiphoid at term or 40 weeks.

18. **D.** Danger signs that require prompt reporting leaking of amniotic fluid, vaginal bleeding, blurred vision, rapid weight gain, and elevated blood pressure. Constipation, breast tenderness, and nasal stuffiness are common discomforts associated with pregnancy.

19. **B.** A rubella titer should be 1:8 or greater. Thurs, a finding of a titer less than 1:8 is significant, indicating that the client may not possess immunity to rubella. A hematocrit of 33.5% a white blood cell count of 8,000/mm3, and a 1 hour glucose challenge test of 110 g/dl are with normal parameters.

20. **D.** With true labor, contractions increase in intensity with walking. In addition, true labor contractions occur at regular intervals, usually starting in the back and sweeping around to the abdomen. The interval of true labor contractions gradually shortens.

21. **B.** Crowing, which occurs when the newborn’s head or presenting part appears at the vaginal opening, occurs during the second stage of labor. During the first stage of labor, cervical dilation and effacement occur. During the third stage of labor, the newborn and placenta are delivered. The fourth stage of labor lasts from 1 to 4 hours after birth, during which time the mother and newborn recover from the physical process of birth and the mother’s organs undergo the initial readjustment to the nonpregnant state.

22. **C.** Barbiturates are rapidly transferred across the placental barrier, and lack of an antagonist makes them generally inappropriate during active labor. Neonatal side effects of barbiturates include central nervous system depression, prolonged drowsiness, delayed establishment of feeding (e.g. due to poor sucking reflex or poor sucking pressure). Tranquilizers are associated with neonatal effects such as hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days. Narcotic analgesic readily cross the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection. Regional anesthesia is associated with adverse reactions such as maternal hypotension, allergic or toxic reaction, or partial or total respiratory failure.

23. **D.** During the third stage of labor, which begins with the delivery of the newborn, the nurse would promote parent-newborn interaction by placing the newborn on the mother’s abdomen and encouraging the parents to touch the newborn. Collecting a urine specimen and other laboratory tests is done on admission during the first stage of labor. Assessing uterine contractions every 30 minutes is performed during the latent phase of the first stage of labor. Coaching the client to push effectively is appropriate during the second stage of labor.

24. **A.** The newborn’s ability to regulate body temperature is poor. Therefore, placing the newborn under a radiant warmer aids in maintaining his or her body temperature. Suctioning with a bulb syringe helps maintain a patent airway.
Obtaining an Apgar score measures the newborn’s immediate adjustment to extrauterine life. Inspecting the umbilical cord aids in detecting cord anomalies.

25. D. Immediately before expulsion or birth of the rest of the body, the cardinal movement of external rotation occurs. Descent flexion, internal rotation, extension, and restitution (in this order) occur before external rotation.

26. B. The foramen ovale is an opening between the right and left auricles (atria) that should close shortly after birth so the newborn will not have a murmur or mixed blood traveling through the vascular system. The umbilical vein, ductus arteriosus, and ductus venosus are obliterated at birth.

27. B. Uric acid crystals in the urine may produce the reddish “brick dust” stain on the diaper. Mucus would not produce a stain. Bilirubin and iron are from hepatic adaptation.

28. B. The normal heart rate for a newborn that is sleeping is approximately 100 beats per minute. If the newborn was awake, the normal heart rate would range from 120 to 160 beats per minute.

29. C. The anterior fontanel is larger in size than the posterior fontanel. Additionally, the anterior fontanel, which is diamond shaped, closes at 18 months, whereas the posterior fontanel, which is triangular shaped, closes at 8 to 12 weeks. Neither fontanel should appear bulging, which may indicate increased intracranial pressure, or sunken, which may indicate dehydration.

30. B. Blink, cough, sneeze, swallowing and gag reflexes are all present at birth and remain unchanged through adulthood. Reflexes such as rooting and stepping subside within the first year.

31. A. With the babinski reflex, the newborn’s toes hyperextend and fan apart from dorsiflexion of the big toe when one side of foot is stroked upward form the heel and across the ball of the foot. With the startle reflex, the newborn abducts and flexes all extremities and may begin to cry when exposed to sudden movement of loud noise. With the rooting and sucking reflex, the newborn turns his head in the direction of stimulus, opens the mouth, and begins to suck when the cheeks, lip, or corner of mouth is touched. With the crawl reflex, the newborn will attempt to crawl forward with both arms and legs when he is placed on his abdomen on a flat surface.

32. B. The description of hyperemesis gravidarum includes severe nausea and vomiting, leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems. Hyperemesis is not a form of anemia. Loss of appetite may occur secondary to the nausea and vomiting of hyperemesis, which, if it continues, can deplete the nutrients transported to the fetus. Diarrhea does not occur with hyperemesis.

33. B. Edema of the hands and face is a classic sign of PIH. Many healthy pregnant woman experience foot and ankle edema. A weight gain of 2 lb or more per week indicates a problem. Early morning headache is not a classic sign of PIH.

34. C. In a missed abortion, there is early fetal intrauterine death, and products of conception are not expelled. The cervix remains closed; there may be a dark brown vaginal discharge, negative pregnancy test, and cessation of uterine growth and breast tenderness. A threatened abortion is evidenced with cramping and vaginal bleeding in early pregnancy, with no cervical dilation. An incomplete
abortion presents with bleeding, cramping, and cervical dilation. An incomplete abortion involves only expulsion of part of the products of conception and bleeding occurs with cervical dilation.

35. **A.** Multiple gestation is one of the predisposing factors that may cause placenta previa. Uterine anomalies abdominal trauma, and renal or vascular disease may predispose a client to abruptio placentae.

36. **B.** A client with abruptio placentae may exhibit concealed or dark red bleeding, possibly reporting sudden intense localized uterine pain. The uterus is typically firm to boardlike, and the fetal presenting part may be engaged. Bright red, painless vaginal bleeding, a palpable fetal outline and a soft nontender abdomen are manifestations of placenta previa.

37. **D.** Abruptio placentae is described as premature separation of a normally implanted placenta during the second half of pregnancy, usually with severe hemorrhage. Placenta previa refers to implantation of the placenta in the lower uterine segment, causing painless bleeding in the third trimester of pregnancy. Ectopic pregnancy refers to the implantation of the products of conception in a site other than the endometrium. Incompetent cervix is a condition characterized by painful dilation of the cervical os without uterine contractions.

38. **B.** Hyperstimulation of the uterus such as with oxytocin during the induction of labor may result in tetanic contractions prolonged to more than 90 seconds, which could lead to such complications as fetal distress, abruptio placenta, amniotic fluid embolism, laceration of the cervix, and uterine rupture. Weak contractions would not occur. Pain, bright red vaginal bleeding, and increased restlessness and anxiety are not associated with hyperstimulation.

39. **C.** A key point to consider when preparing the client for a cesarean delivery is to modify the preoperative teaching to meet the needs of either a planned or emergency cesarean birth, the depth and breadth of instruction will depend on circumstances and time available. Allowing the mother’s support person to remain with her as much as possible is an important concept, although doing so depends on many variables. Arranging for necessary explanations by various staff members to be involved with the client’s care is a nursing responsibility. The nurse is responsible for reinforcing the explanations about the surgery, expected outcome, and type of anesthetic to be used. The obstetrician is responsible for explaining about the surgery and outcome and the anesthesiology staff is responsible for explanations about the type of anesthesia to be used.

40. **A.** Preterm labor is best described as labor that begins after 20 weeks’ gestation and before 37 weeks’ gestation. The other time periods are inaccurate.

41. **B.** PROM can precipitate many potential and actual problems; one of the most serious is the fetus loss of an effective defense against infection. This is the client’s most immediate need at this time. Typically, PROM occurs about 1 hour, not 4 hours, before labor begins. Fetal viability and gestational age are less immediate considerations that affect the plan of care. Malpresentation and an incompetent cervix may be causes of PROM.

42. **B.** Dystocia is difficult, painful, prolonged labor due to mechanical factors involving the fetus (passenger), uterus (powers), pelvis (passage), or psyche.
Nutritional, environment, and medical factors may contribute to the mechanical factors that cause dystocia.

43. **A.** With uterine rupture, the client is at risk for hypovolemic shock. Therefore, the priority is to prevent and limit hypovolemic shock. Immediate steps should include giving oxygen, replacing lost fluids, providing drug therapy as needed, evaluating fetal responses and preparing for surgery. Obtaining blood specimens, instituting complete bed rest, and inserting a urinary catheter are necessary in preparation for surgery to remedy the rupture.

44. **B.** The immediate priority is to minimize pressure on the cord. Thus the nurse’s initial action involves placing the client on bed rest and then placing the client in a knee-chest position or lowering the head of the bed, and elevating the maternal hips on a pillow to minimize the pressure on the cord. Monitoring maternal vital signs and FHR, notifying the physician and preparing the client for delivery, and wrapping the cord with sterile saline soaked warm gauze are important. But these actions have no effect on minimizing the pressure on the cord.

45. **D.** Postpartum hemorrhage is defined as blood loss of more than 500 ml following birth. Any amount less than this not considered postpartum hemorrhage.

46. **D.** With mastitis, injury to the breast, such as overdistention, stasis, and cracking of the nipples, is the primary predisposing factor. Epidemic and endemic infections are probable sources of infection for mastitis. Temporary urinary retention due to decreased perception of the urge to void is a contributory factor to the development of urinary tract infection, not mastitis.

47. **D.** Thrombophlebitis refers to an inflammation of the vascular endothelium with clot formation on the wall of the vessel. Blood components combining to form an aggregate body describe a thrombus or thrombosis. Clots lodging in the pulmonary vasculature refers to pulmonary embolism; in the femoral vein, femoral thrombophlebitis.

48. **C.** Classic symptoms of DVT include muscle pain, the presence of Homans sign, and swelling of the affected limb. Midcalf pain, tenderness, and redness, along the vein reflect superficial thrombophlebitis. Chills, fever and malaise occurring 2 weeks after delivery reflect pelvic thrombophlebitis. Chills, fever, stiffness and pain occurring 10 to 14 days after delivery suggest femoral thrombophlebitis.

49. **B.** Manifestations of cystitis include, frequency, urgency, dysuria, hematuria, nocturia, fever, and suprapubic pain. Dehydration, hypertension, and chills are not typically associated with cystitis. High fever chills, flank pain, nausea, vomiting, dysuria, and frequency are associated with pvelonephritis.

50. **C.** According to statistical reports, between 50% and 80% of all new mothers report some form of postpartum blues. The ranges of 10% to 40%, 30% to 50%, and 25% to 70% are incorrect.
Maternal and Child Health Practice Test Part 2

1. For the client who is using oral contraceptives, the nurse informs the client about the need to take the pill at the same time each day to accomplish which of the following?
   a. Decrease the incidence of nausea
   b. Maintain hormonal levels
   c. Reduce side effects
   d. Prevent drug interactions

2. When teaching a client about contraception, which of the following would the nurse include as the most effective method for preventing sexually transmitted infections?
   a. Spermicides
   b. Diaphragm
   c. Condoms
   d. Vasectomy

3. When preparing a woman who is 2 days postpartum for discharge, recommendations for which of the following contraceptive methods would be avoided?
   a. Diaphragm
   b. Female condom
   c. Oral contraceptives
   d. Rhythm method

4. For which of the following clients would the nurse expect that an intrauterine device would not be recommended?
   a. Woman over age 35
   b. Nulliparous woman
   c. Promiscuous young adult
   d. Postpartum client

5. A client in her third trimester tells the nurse, “I’m constipated all the time!” Which of the following should the nurse recommend?
   a. Daily enemas
   b. Laxatives
   c. Increased fiber intake
   d. Decreased fluid intake

6. Which of the following would the nurse use as the basis for the teaching plan when caring for a pregnant teenager concerned about gaining too much weight during pregnancy?
   a. 10 pounds per trimester
   b. 1 pound per week for 40 weeks
   c. ½ pound per week for 40 weeks
   d. A total gain of 25 to 30 pounds

7. The client tells the nurse that her last menstrual period started on January 14 and ended on January 20. Using Nagele’s rule, the nurse determines her EDD to be which of the following?
   a. September 27
b. October 21
   c. November 7
   d. December 27

8. When taking an obstetrical history on a pregnant client who states, “I had a son born at 38 weeks gestation, a daughter born at 30 weeks gestation and I lost a baby at about 8 weeks,” the nurse should record her obstetrical history as which of the following?
   a. G2 T2 P0 A0 L2
   b. G3 T1 P1 A0 L2
   c. G3 T2 P0 A0 L2
   d. G4 T1 P1 A1 L2

9. When preparing to listen to the fetal heart rate at 12 weeks’ gestation, the nurse would use which of the following?
   a. Stethoscope placed midline at the umbilicus
   b. Doppler placed midline at the suprapubic region
   c. Fetoscope placed midway between the umbilicus and the xiphoid process
   d. External electronic fetal monitor placed at the umbilicus

10. When developing a plan of care for a client newly diagnosed with gestational diabetes, which of the following instructions would be the priority?
   a. Dietary intake
   b. Medication
   c. Exercise
   d. Glucose monitoring

11. A client at 24 weeks gestation has gained 6 pounds in 4 weeks. Which of the following would be the priority when assessing the client?
   a. Glucosuria
   b. Depression
   c. Hand/face edema
   d. Dietary intake

12. A client 12 weeks’ pregnant come to the emergency department with abdominal cramping and moderate vaginal bleeding. Speculum examination reveals 2 to 3 cms cervical dilation. The nurse would document these findings as which of the following?
   a. Threatened abortion
   b. Imminent abortion
   c. Complete abortion
   d. Missed abortion

13. Which of the following would be the priority nursing diagnosis for a client with an ectopic pregnancy?
   a. Risk for infection
   b. Pain
   c. Knowledge Deficit
   d. Anticipatory Grieving

14. Before assessing the postpartum client’s uterus for firmness and position in relation to the umbilicus and midline, which of the following should the nurse do first?
a. Assess the vital signs
b. Administer analgesia
c. Ambulate her in the hall
d. Assist her to urinate

15. Which of the following should the nurse do when a primipara who is lactating tells the nurse that she has sore nipples?
   a. Tell her to breast feed more frequently
   b. Administer a narcotic before breast feeding
   c. Encourage her to wear a nursing brassiere
   d. Use soap and water to clean the nipples

16. The nurse assesses the vital signs of a client, 4 hours’ postpartum that are as follows: BP 90/60; temperature 100.4°F; pulse 100 weak, thready; R 20 per minute. Which of the following should the nurse do first?
   a. Report the temperature to the physician
   b. Recheck the blood pressure with another cuff
   c. Assess the uterus for firmness and position
   d. Determine the amount of lochia

17. The nurse assesses the postpartum vaginal discharge (lochia) on four clients. Which of the following assessments would warrant notification of the physician?
   a. A dark red discharge on a 2-day postpartum client
   b. A pink to brownish discharge on a client who is 5 days postpartum
   c. Almost colorless to creamy discharge on a client 2 weeks after delivery
   d. A bright red discharge 5 days after delivery

18. A postpartum client has a temperature of 101.4°F, with a uterus that is tender when palpated, remains unusually large, and not descending as normally expected. Which of the following should the nurse assess next?
   a. Lochia
   b. Breasts
   c. Incision
   d. Urine

19. Which of the following is the priority focus of nursing practice with the current early postpartum discharge?
   a. Promoting comfort and restoration of health
   b. Exploring the emotional status of the family
   c. Facilitating safe and effective self-and newborn care
   d. Teaching about the importance of family planning

20. Which of the following actions would be least effective in maintaining a neutral thermal environment for the newborn?
   a. Placing infant under radiant warmer after bathing
   b. Covering the scale with a warmed blanket prior to weighing
   c. Placing crib close to nursery window for family viewing
   d. Covering the infant’s head with a knit stockinette

21. A newborn who has an asymmetrical Moro reflex response should be further assessed for which of the following?
   a. Talipes equinovarus
   b. Fractured clavicle
c. Congenital hypothyroidism
d. Increased intracranial pressure

22. During the first 4 hours after a male circumcision, assessing for which of the following is the priority?
   a. Infection
   b. Hemorrhage
   c. Discomfort
   d. Dehydration

23. The mother asks the nurse, “What’s wrong with my son’s breasts? Why are they so enlarged?” Which of the following would be the best response by the nurse?
   a. “The breast tissue is inflamed from the trauma experienced with birth”
   b. “A decrease in maternal hormones present before birth causes enlargement,”
   c. “You should discuss this with your doctor. It could be a malignancy”
   d. “The tissue has hypertrophied while the baby was in the uterus”

24. Immediately after birth the nurse notes the following on a male newborn:
   Respiration 78; apical heart rate 160 BPM, nostril flaring; mild intercostal retractions; and grunting at the end of expiration. Which of the following should the nurse do?
   a. Call the assessment data to the physician’s attention
   b. Start oxygen per nasal cannula at 2 L/min.
   c. Suction the infant’s mouth and nares
   d. Recognize this as normal first period of reactivity

25. The nurse hears a mother telling a friend on the telephone about umbilical cord care. Which of the following statements by the mother indicates effective teaching?
   a. “Daily soap and water cleansing is best”
   b. “Alcohol helps it dry and kills germs”
   c. “An antibiotic ointment applied daily prevents infection”
   d. “He can have a tub bath each day”

26. A newborn weighing 3000 grams and feeding every 4 hours needs 120 calories/kg of body weight every 24 hours for proper growth and development. How many ounces of 20 cal/oz formula should this newborn receive at each feeding to meet nutritional needs?
   a. 2 ounces
   b. 3 ounces
   c. 4 ounces
   d. 6 ounces

27. The postterm neonate with meconium-stained amniotic fluid needs care designed to especially monitor for which of the following?
   a. Respiratory problems
   b. Gastrointestinal problems
   c. Integumentary problems
   d. Elimination problems

28. When measuring a client’s fundal height, which of the following techniques denotes the correct method of measurement used by the nurse?
a. From the xiphoid process to the umbilicus
b. From the symphysis pubis to the xiphoid process
c. From the symphysis pubis to the fundus
d. From the fundus to the umbilicus

29. A client with severe preeclampsia is admitted with BP 160/110, proteinuria, and severe pitting edema. Which of the following would be most important to include in the client’s plan of care?
   a. Daily weights
   b. Seizure precautions
   c. Right lateral positioning
   d. Stress reduction

30. A postpartum primipara asks the nurse, “When can we have sexual intercourse again?” Which of the following would be the nurse’s best response?
   a. “Anytime you both want to.”
   b. “As soon as choose a contraceptive method.”
   c. “When the discharge has stopped and the incision is healed.”
   d. “After your 6 weeks examination.”

31. When preparing to administer the vitamin K injection to a neonate, the nurse would select which of the following sites as appropriate for the injection?
   a. Deltoid muscle
   b. Anterior femoris muscle
   c. Vastus lateralis muscle
   d. Gluteus maximus muscle

32. When performing a pelvic examination, the nurse observes a red swollen area on the right side of the vaginal orifice. The nurse would document this as enlargement of which of the following?
   a. Clitoris
   b. Parotid gland
   c. Skene’s gland
   d. Bartholin’s gland

33. To differentiate as a female, the hormonal stimulation of the embryo that must occur involves which of the following?
   a. Increase in maternal estrogen secretion
   b. Decrease in maternal androgen secretion
   c. Secretion of androgen by the fetal gonad
   d. Secretion of estrogen by the fetal gonad

34. A client at 8 weeks’ gestation calls complaining of slight nausea in the morning hours. Which of the following client interventions should the nurse question?
   a. Taking 1 teaspoon of bicarbonate of soda in an 8-ounce glass of water
   b. Eating a few low-sodium crackers before getting out of bed
   c. Avoiding the intake of liquids in the morning hours
   d. Eating six small meals a day instead of three large meals

35. The nurse documents positive ballottement in the client’s prenatal record. The nurse understands that this indicates which of the following?
   a. Palpable contractions on the abdomen
   b. Passive movement of the unengaged fetus
c. Fetal kicking felt by the client
d. Enlargement and softening of the uterus

36. During a pelvic exam the nurse notes a purple-blue tinge of the cervix. The nurse documents this as which of the following?
   a. Braxton-Hicks sign
   b. Chadwick’s sign
   c. Goodell’s sign
   d. McDonald’s sign

37. During a prenatal class, the nurse explains the rationale for breathing techniques during preparation for labor based on the understanding that breathing techniques are most important in achieving which of the following?
   a. Eliminate pain and give the expectant parents something to do
   b. Reduce the risk of fetal distress by increasing uteroplacental perfusion
   c. Facilitate relaxation, possibly reducing the perception of pain
   d. Eliminate pain so that less analgesia and anesthesia are needed

38. After 4 hours of active labor, the nurse notes that the contractions of a primigravida client are not strong enough to dilate the cervix. Which of the following would the nurse anticipate doing?
   a. Obtaining an order to begin IV oxytocin infusion
   b. Administering a light sedative to allow the patient to rest for several hour
   c. Preparing for a cesarean section for failure to progress
   d. Increasing the encouragement to the patient when pushing begins

39. A multigravida at 38 weeks’ gestation is admitted with painless, bright red bleeding and mild contractions every 7 to 10 minutes. Which of the following assessments should be avoided?
   a. Maternal vital sign
   b. Fetal heart rate
   c. Contraction monitoring
   d. Cervical dilation

40. Which of the following would be the nurse’s most appropriate response to a client who asks why she must have a cesarean delivery if she has a complete placenta previa?
   a. “You will have to ask your physician when he returns.”
   b. “You need a cesarean to prevent hemorrhage.”
   c. “The placenta is covering most of your cervix.”
   d. “The placenta is covering the opening of the uterus and blocking your baby.”

41. The nurse understands that the fetal head is in which of the following positions with a face presentation?
   a. Completely flexed
   b. Completely extended
   c. Partially extended
   d. Partially flexed

42. With a fetus in the left-anterior breech presentation, the nurse would expect the fetal heart rate would be most audible in which of the following areas?
   a. Above the maternal umbilicus and to the right of midline
b. In the lower-left maternal abdominal quadrant
c. In the lower-right maternal abdominal quadrant
d. Above the maternal umbilicus and to the left of midline

43. The amniotic fluid of a client has a greenish tint. The nurse interprets this to be the result of which of the following?
   a. Lanugo
   b. Hydramnio
   c. Meconium
   d. Vernix

44. A patient is in labor and has just been told she has a breech presentation. The nurse should be particularly alert for which of the following?
   a. Quickening
   b. Ophthalmia neonatorum
   c. Pica
   d. Prolapsed umbilical cord

45. When describing dizygotic twins to a couple, on which of the following would the nurse base the explanation?
   a. Two ova fertilized by separate sperm
   b. Sharing of a common placenta
   c. Each ova with the same genotype
   d. Sharing of a common chorion

46. Which of the following refers to the single cell that reproduces itself after conception?
   a. Chromosome
   b. Blastocyst
   c. Zygote
   d. Trophoblast

47. In the late 1950s, consumers and health care professionals began challenging the routine use of analgesics and anesthetics during childbirth. Which of the following was an outgrowth of this concept?
   a. Labor, delivery, recovery, postpartum (LDRP)
   b. Nurse-midwifery
   c. Clinical nurse specialist
   d. Prepared childbirth

48. A client has a midpelvic contracture from a previous pelvic injury due to a motor vehicle accident as a teenager. The nurse is aware that this could prevent a fetus from passing through or around which structure during childbirth?
   a. Symphysis pubis
   b. Sacral promontory
   c. Ischial spines
   d. Pubic arch

49. When teaching a group of adolescents about variations in the length of the menstrual cycle, the nurse understands that the underlying mechanism is due to variations in which of the following phases?
   a. Menstrual phase
   b. Proliferative phase
c. Secretory phase  
d. Ischemic phase  

50. When teaching a group of adolescents about male hormone production, which of the following would the nurse include as being produced by the Leydig cells?  
a. Follicle-stimulating hormone  
b. Testosterone  
c. Leuteinizing hormone  
d. Gonadotropin releasing hormone

Answers and Rationale Maternal and Child Health Practice Test Part 2

2. C. Condoms, when used correctly and consistently, are the most effective contraceptive method or barrier against bacterial and viral sexually transmitted infections. Although spermicides kill sperm, they do not provide reliable protection against the spread of sexually transmitted infections, especially intracellular organisms such as HIV. Insertion and removal of the diaphragm along with the use of the spermicides may cause vaginal irritations, which could place the client at risk for infection transmission. Male sterilization eliminates spermatozoa from the ejaculate, but it does not eliminate bacterial and/or viral microorganisms that can cause sexually transmitted infections.

3. A. The diaphragm must be fitted individually to ensure effectiveness. Because of the changes to the reproductive structures during pregnancy and following delivery, the diaphragm must be refitted, usually at the 6 weeks’ examination following childbirth or after a weight loss of 15 lbs or more. In addition, for maximum effectiveness, spermicidal jelly should be placed in the dome and around the rim. However, spermicidal jelly should not be inserted into the vagina until involution is completed at approximately 6 weeks. Use of a female condom protects the reproductive system from the introduction of semen or spermicides into the vagina and may be used after childbirth. Oral contraceptives may be started within the first postpartum week to ensure suppression of ovulation. For the couple who has determined the female’s fertile period, using the rhythm method, avoidance of intercourse during this period, is safe and effective.

4. C. An IUD may increase the risk of pelvic inflammatory disease, especially in women with more than one sexual partner, because of the increased risk of sexually transmitted infections. An UID should not be used if the woman has an active or chronic pelvic infection, postpartum infection, endometrial hyperplasia or carcinoma, or uterine abnormalities. Age is not a factor in determining the risks associated with IUD use. Most IUD users are over the age of 30. Although there is a slightly higher risk for infertility in women who have never been pregnant, the IUD is an acceptable option as long as the risk-benefit ratio is discussed. IUDs may be inserted immediately after delivery, but this is not recommended because of the increased risk and rate of expulsion at this time.

5. C. During the third trimester, the enlarging uterus places pressure on the intestines. This coupled with the effect of hormones on smooth muscle relaxation
causes decreased intestinal motility (peristalsis). Increasing fiber in the diet will help fecal matter pass more quickly through the intestinal tract, thus decreasing the amount of water that is absorbed. As a result, stool is softer and easier to pass. Enemas could precipitate preterm labor and/or electrolyte loss and should be avoided. Laxatives may cause preterm labor by stimulating peristalsis and may interfere with the absorption of nutrients. Use for more than 1 week can also lead to laxative dependency. Liquid in the diet helps provide a semisolid, soft consistency to the stool. Eight to ten glasses of fluid per day are essential to maintain hydration and promote stool evacuation.

6. **D.** To ensure adequate fetal growth and development during the 40 weeks of a pregnancy, a total weight gain 25 to 30 pounds is recommended: 1.5 pounds in the first 10 weeks; 9 pounds by 30 weeks; and 27.5 pounds by 40 weeks. The pregnant woman should gain less weight in the first and second trimester than in the third. During the first trimester, the client should only gain 1.5 pounds in the first 10 weeks, not 1 pound per week. A weight gain of ½ pound per week would be 20 pounds for the total pregnancy, less than the recommended amount.

7. **B.** To calculate the EDD by Nagele’s rule, add 7 days to the first day of the last menstrual period and count back 3 months, changing the year appropriately. To obtain a date of September 27, 7 days have been added to the last day of the LMP (rather than the first day of the LMP), plus 4 months (instead of 3 months) were counted back. To obtain the date of November 7, 7 days have been subtracted (instead of added) from the first day of LMP plus November indicates counting back 2 months (instead of 3 months) from January. To obtain the date of December 27, 7 days were added to the last day of the LMP (rather than the first day of the LMP) and December indicates counting back only 1 month (instead of 3 months) from January.

8. **D.** The client has been pregnant four times, including current pregnancy (G). Birth at 38 weeks’ gestation is considered full term (T), while birth form 20 weeks to 38 weeks is considered preterm (P). A spontaneous abortion occurred at 8 weeks (A). She has two living children (L).

9. **B.** At 12 weeks gestation, the uterus rises out of the pelvis and is palpable above the symphysis pubis. The Doppler intensifies the sound of the fetal pulse rate so it is audible. The uterus has merely risen out of the pelvis into the abdominal cavity and is not at the level of the umbilicus. The fetal heart rate at this age is not audible with a stethoscope. The uterus at 12 weeks is just above the symphysis pubis in the abdominal cavity, not midway between the umbilicus and the xiphoid process. At 12 weeks the FHR would be difficult to auscultate with a fetoscope. Although the external electronic fetal monitor would project the FHR, the uterus has not risen to the umbilicus at 12 weeks.

10. **A.** Although all of the choices are important in the management of diabetes, diet therapy is the mainstay of the treatment plan and should always be the priority. Women diagnosed with gestational diabetes generally need only diet therapy without medication to control their blood sugar levels. Exercise, is important for all pregnant women and especially for diabetic women, because it burns up glucose, thus decreasing blood sugar. However, dietary intake, not exercise, is the priority. All pregnant women with diabetes should have periodic monitoring of
serum glucose. However, those with gestational diabetes generally do not need daily glucose monitoring. The standard of care recommends a fasting and 2-hour postprandial blood sugar level every 2 weeks.

11. **C.** After 20 weeks’ gestation, when there is a rapid weight gain, preeclampsia should be suspected, which may be caused by fluid retention manifested by edema, especially of the hands and face. The three classic signs of preeclampsia are hypertension, edema, and proteinuria. Although urine is checked for glucose at each clinic visit, this is not the priority. Depression may cause either anorexia or excessive food intake, leading to excessive weight gain or loss. This is not, however, the priority consideration at this time. Weight gain thought to be caused by excessive food intake would require a 24-hour diet recall. However, excessive intake would not be the primary consideration for this client at this time.

12. **B.** Cramping and vaginal bleeding coupled with cervical dilation signifies that termination of the pregnancy is inevitable and cannot be prevented. Thus, the nurse would document an imminent abortion. In a threatened abortion, cramping and vaginal bleeding are present, but there is no cervical dilation. The symptoms may subside or progress to abortion. In a complete abortion all the products of conception are expelled. A missed abortion is early fetal intrauterine death without expulsion of the products of conception.

13. **B.** For the client with an ectopic pregnancy, lower abdominal pain, usually unilateral, is the primary symptom. Thus, pain is the priority. Although the potential for infection is always present, the risk is low in ectopic pregnancy because pathogenic microorganisms have not been introduced from external sources. The client may have a limited knowledge of the pathology and treatment of the condition and will most likely experience grieving, but this is not the priority at this time.

14. **D.** Before uterine assessment is performed, it is essential that the woman empty her bladder. A full bladder will interfere with the accuracy of the assessment by elevating the uterus and displacing to the side of the midline. Vital sign assessment is not necessary unless an abnormality in uterine assessment is identified. Uterine assessment should not cause acute pain that requires administration of analgesia. Ambulating the client is an essential component of postpartum care, but is not necessary prior to assessment of the uterus.

15. **A.** Feeding more frequently, about every 2 hours, will decrease the infant’s frantic, vigorous sucking from hunger and will decrease breast engorgement, soften the breast, and promote ease of correct latching-on for feeding. Narcotics administered prior to breast feeding are passed through the breast milk to the infant, causing excessive sleepiness. Nipple soreness is not severe enough to warrant narcotic analgesia. All postpartum clients, especially lactating mothers, should wear a supportive brassiere with wide cotton straps. This does not, however, prevent or reduce nipple soreness. Soaps are drying to the skin of the nipples and should not be used on the breasts of lactating mothers. Dry nipple skin predisposes to cracks and fissures, which can become sore and painful.

16. **D.** A weak, thready pulse elevated to 100 BPM may indicate impending hemorrhagic shock. An increased pulse is a compensatory mechanism of the body in response to decreased fluid volume. Thus, the nurse should check the amount
of lochia present. Temperatures up to 100.48°F in the first 24 hours after birth are related to the dehydrating effects of labor and are considered normal. Although rechecking the blood pressure may be a correct choice of action, it is not the first action that should be implemented in light of the other data. The data indicate a potential impending hemorrhage. Assessing the uterus for firmness and position in relation to the umbilicus and midline is important, but the nurse should check the extent of vaginal bleeding first. Then it would be appropriate to check the uterus, which may be a possible cause of the hemorrhage.

17. D. Any bright red vaginal discharge would be considered abnormal, but especially 5 days after delivery, when the lochia is typically pink to brownish. Lochia rubra, a dark red discharge, is present for 2 to 3 days after delivery. Bright red vaginal bleeding at this time suggests late postpartum hemorrhage, which occurs after the first 24 hours following delivery and is generally caused by retained placental fragments or bleeding disorders. Lochia rubra is the normal dark red discharge occurring in the first 2 to 3 days after delivery, containing epithelial cells, erythrocytes, leukocytes and decidua. Lochia serosa is a pink to brownish serosanguineous discharge occurring from 3 to 10 days after delivery that contains decidua, erythrocytes, leukocytes, cervical mucus, and microorganisms. Lochia alba is an almost colorless to yellowish discharge occurring from 10 days to 3 weeks after delivery and containing leukocytes, decidua, epithelial cells, fat, cervical mucus, cholesterol crystals, and bacteria.

18. A. The data suggests an infection of the endometrial lining of the uterus. The lochia may be decreased or copious, dark brown in appearance, and foul smelling, providing further evidence of a possible infection. All the client’s data indicate a uterine problem, not a breast problem. Typically, transient fever, usually 101°F, may be present with breast engorgement. Symptoms of mastitis include influenza-like manifestations. Localized infection of an episiotomy or C-section incision rarely causes systemic symptoms, and uterine involution would not be affected. The client data do not include dysuria, frequency, or urgency, symptoms of urinary tract infections, which would necessitate assessing the client’s urine.

19. C. Because of early postpartum discharge and limited time for teaching, the nurse’s priority is to facilitate the safe and effective care of the client and newborn. Although promoting comfort and restoration of health, exploring the family’s emotional status, and teaching about family planning are important in postpartum/newborn nursing care, they are not the priority focus in the limited time presented by early post-partum discharge.

20. C. Heat loss by radiation occurs when the infant’s crib is placed too near cold walls or windows. Thus placing the newborn’s crib close to the viewing window would be least effective. Body heat is lost through evaporation during bathing. Placing the infant under the radiant warmer after bathing will assist the infant to be rewarmed. Covering the scale with a warmed blanket prior to weighing prevents heat loss through conduction. A knit cap prevents heat loss from the head a large head, a large body surface area of the newborn’s body.

21. B. A fractured clavicle would prevent the normal Moro response of symmetrical sequential extension and abduction of the arms followed by flexion and adduction. In talipes equinovarus (clubfoot) the foot is turned medially, and in
plantar flexion, with the heel elevated. The feet are not involved with the Moro reflex. Hypothyroidism has no effect on the primitive reflexes. Absence of the Moro reflex is the most significant single indicator of central nervous system status, but it is not a sign of increased intracranial pressure.

22. **B.** Hemorrhage is a potential risk following any surgical procedure. Although the infant has been given vitamin K to facilitate clotting, the prophylactic dose is often not sufficient to prevent bleeding. Although infection is a possibility, signs will not appear within 4 hours after the surgical procedure. The primary discomfort of circumcision occurs during the surgical procedure, not afterward. Although feedings are withheld prior to the circumcision, the chances of dehydration are minimal.

23. **B.** The presence of excessive estrogen and progesterone in the maternal-fetal blood followed by prompt withdrawal at birth precipitates breast engorgement, which will spontaneously resolve in 4 to 5 days after birth. The trauma of the birth process does not cause inflammation of the newborn’s breast tissue. Newborns do not have breast malignancy. This reply by the nurse would cause the mother to have undue anxiety. Breast tissue does not hypertrophy in the fetus or newborns.

24. **D.** The first 15 minutes to 1 hour after birth is the first period of reactivity involving respiratory and circulatory adaptation to extrauterine life. The data given reflect the normal changes during this time period. The infant’s assessment data reflect normal adaptation. Thus, the physician does not need to be notified and oxygen is not needed. The data do not indicate the presence of choking, gagging or coughing, which are signs of excessive secretions. Suctioning is not necessary.

25. **B.** Application of 70% isopropyl alcohol to the cord minimizes microorganisms (germicidal) and promotes drying. The cord should be kept dry until it falls off and the stump has healed. Antibiotic ointment should only be used to treat an infection, not as a prophylaxis. Infants should not be submerged in a tub of water until the cord falls off and the stump has completely healed.

26. **B.** To determine the amount of formula needed, do the following mathematical calculation. 3 kg x 120 cal/kg per day = 360 calories/day feeding q 4 hours = 6 feedings per day = 60 calories per feeding: 60 calories per feeding with formula 20 cal/oz = 3 ounces per feeding. Based on the calculation. 2, 4 or 6 ounces are incorrect.

27. **A.** Intrauterine anoxia may cause relaxation of the anal sphincter and emptying of meconium into the amniotic fluid. At birth some of the meconium fluid may be aspirated, causing mechanical obstruction or chemical pneumonitis. The infant is not at increased risk for gastrointestinal problems. Even though the skin is stained with meconium, it is noninfectious (sterile) and nonirritating. The postterm meconium-stained infant is not at additional risk for bowel or urinary problems.

28. **C.** The nurse should use a nonelastic, flexible, paper measuring tape, placing the zero point on the superior border of the symphysis pubis and stretching the tape across the abdomen at the midline to the top of the fundus. The xiphoid and umbilicus are not appropriate landmarks to use when measuring the height of the fundus (McDonald’s measurement).
29. **B.** Women hospitalized with severe preeclampsia need decreased CNS stimulation to prevent a seizure. Seizure precautions provide environmental safety should a seizure occur. Because of edema, daily weight is important but not the priority. Preclampsia causes vasoconstriction and therefore can reduce utero-placental perfusion. The client should be placed on her left side to maximize blood flow, reduce blood pressure, and promote diuresis. Interventions to reduce stress and anxiety are very important to facilitate coping and a sense of control, but seizure precautions are the priority.

30. **C.** Cessation of the lochial discharge signifies healing of the endometrium. Risk of hemorrhage and infection are minimal 3 weeks after a normal vaginal delivery. Telling the client anytime is inappropriate because this response does not provide the client with the specific information she is requesting. Choice of a contraceptive method is important, but not the specific criteria for safe resumption of sexual activity. Culturally, the 6-weeks’ examination has been used as the time frame for resuming sexual activity, but it may be resumed earlier.

31. **C.** The middle third of the vastus lateralis is the preferred injection site for vitamin K administration because it is free of blood vessels and nerves and is large enough to absorb the medication. The deltoid muscle of a newborn is not large enough for a newborn IM injection. Injections into this muscle in a small child might cause damage to the radial nerve. The anterior femoris muscle is the next safest muscle to use in a newborn but is not the safest. Because of the proximity of the sciatic nerve, the gluteus maximus muscle should not be until the child has been walking 2 years.

32. **D.** Bartholin’s glands are the glands on either side of the vaginal orifice. The clitoris is female erectile tissue found in the perineal area above the urethra. The parotid glands are open into the mouth. Skene’s glands open into the posterior wall of the female urinary meatus.

33. **D.** The fetal gonad must secrete estrogen for the embryo to differentiate as a female. An increase in maternal estrogen secretion does not effect differentiation of the embryo, and maternal estrogen secretion occurs in every pregnancy. Maternal androgen secretion remains the same as before pregnancy and does not effect differentiation. Secretion of androgen by the fetal gonad would produce a male fetus.

34. **A.** Using bicarbonate would increase the amount of sodium ingested, which can cause complications. Eating low-sodium crackers would be appropriate. Since liquids can increase nausea avoiding them in the morning hours when nausea is usually the strongest is appropriate. Eating six small meals a day would keep the stomach full, which often decrease nausea.

35. **B.** Ballottement indicates passive movement of the unengaged fetus. Ballottement is not a contraction. Fetal kicking felt by the client represents quickening. Enlargement and softening of the uterus is known as Piskacek’s sign.

36. **B.** Chadwick’s sign refers to the purple-blue tinge of the cervix. Braxton Hicks contractions are painless contractions beginning around the 4th month. Goodell’s sign indicates softening of the cervix. Flexibility of the uterus against the cervix is known as McDonald’s sign.
37. C. Breathing techniques can raise the pain threshold and reduce the perception of pain. They also promote relaxation. Breathing techniques do not eliminate pain, but they can reduce it. Positioning, not breathing, increases uteroplacental perfusion.

38. A. The client’s labor is hypotonic. The nurse should call the physical and obtain an order for an infusion of oxytocin, which will assist the uterus to contact more forcefully in an attempt to dilate the cervix. Administering light sedative would be done for hypertonic uterine contractions. Preparing for cesarean section is unnecessary at this time. Oxytocin would increase the uterine contractions and hopefully progress labor before a cesarean would be necessary. It is too early to anticipate client pushing with contractions.

39. D. The signs indicate placenta previa and vaginal exam to determine cervical dilation would not be done because it could cause hemorrhage. Assessing maternal vital signs can help determine maternal physiologic status. Fetal heart rate is important to assess fetal well-being and should be done. Monitoring the contractions will help evaluate the progress of labor.

40. D. A complete placenta previa occurs when the placenta covers the opening of the uterus, thus blocking the passageway for the baby. This response explains what a complete previa is and the reason the baby cannot come out except by cesarean delivery. Telling the client to ask the physician is a poor response and would increase the patient’s anxiety. Although a cesarean would help to prevent hemorrhage, the statement does not explain why the hemorrhage could occur. With a complete previa, the placenta is covering all the cervix, not just most of it.

41. B. With a face presentation, the head is completely extended. With a vertex presentation, the head is completely or partially flexed. With a brow (forehead) presentation, the head would be partially extended.

42. D. With this presentation, the fetal upper torso and back face the left upper maternal abdominal wall. The fetal heart rate would be most audible above the maternal umbilicus and to the left of the middle. The other positions would be incorrect.

43. C. The greenish tint is due to the presence of meconium. Lanugo is the soft, downy hair on the shoulders and back of the fetus. Hydramnios represents excessive amniotic fluid. Vernix is the white, cheesy substance covering the fetus.

44. D. In a breech position, because of the space between the presenting part and the cervix, prolapse of the umbilical cord is common. Quickening is the woman’s first perception of fetal movement. Ophthalmia neonatorum usually results from maternal gonorrhea and is conjunctivitis. Pica refers to the oral intake of nonfood substances.

45. A. Dizygotic (fraternal) twins involve two ova fertilized by separate sperm. Monozygotic (identical) twins involve a common placenta, same genotype, and common chorion.

46. C. The zygote is the single cell that reproduces itself after conception. The chromosome is the material that makes up the cell and is gained from each parent. Blastocyst and trophoblast are later terms for the embryo after zygote.

47. D. Prepared childbirth was the direct result of the 1950’s challenging of the routine use of analgesic and anesthetics during childbirth. The LDRP was a much
later concept and was not a direct result of the challenging of routine use of analgesics and anesthetics during childbirth. Roles for nurse midwives and clinical nurse specialists did not develop from this challenge.

48. C. The ischial spines are located in the mid-pelvic region and could be narrowed due to the previous pelvic injury. The symphysis pubis, sacral promontory, and pubic arch are not part of the mid-pelvis.

49. B. Variations in the length of the menstrual cycle are due to variations in the proliferative phase. The menstrual, secretory and ischemic phases do not contribute to this variation.

50. B. Testosterone is produced by the Leyding cells in the seminiferous tubules. Follicle-stimulating hormone and leuteinizng hormone are released by the anterior pituitary gland. The hypothalamus is responsible for releasing gonadotropin-releasing hormone.

Maternal and Child Health Practice Test Part 3

1. While performing physical assessment of a 12 month-old, the nurse notes that the infant’s anterior fontanelle is still slightly open. Which of the following is the nurse’s most appropriate action?
   a. Notify the physician immediately because there is a problem.
   b. Perform an intensive neurologic examination.
   c. Perform an intensive developmental examination.
   d. Do nothing because this is a normal finding for the age.

2. When teaching a mother about introducing solid foods to her child, which of the following indicates the earliest age at which this should be done?
   a. 1 month
   b. 2 months
   c. 3 months
   d. 4 months

3. The infant of a substance-abusing mother is at risk for developing a sense of which of the following?
   a. Mistrust
   b. Shame
   c. Guilt
   d. Inferiority

4. Which of the following toys should the nurse recommend for a 5-month-old?
   a. A big red balloon
   b. A teddy bear with button eyes
   c. A push-pull wooden truck
   d. A colorful busy box
5. The mother of a 2-month-old is concerned that she may be spoiling her baby by picking her up when she cries. Which of the following would be the nurse’s best response?
   a. “Let her cry for a while before picking her up, so you don’t spoil her”
   b. “Babies need to be held and cuddled; you won’t spoil her this way”
   c. “Crying at this age means the baby is hungry; give her a bottle”
   d. “If you leave her alone she will learn how to cry herself to sleep”

6. When assessing an 18-month-old, the nurse notes a characteristic protruding abdomen. Which of the following would explain the rationale for this finding?
   a. Increased food intake owing to age
   b. Underdeveloped abdominal muscles
   c. Bowlegged posture
   d. Linear growth curve

7. If parents keep a toddler dependent in areas where he is capable of using skills, the toddler will develop a sense of which of the following?
   a. Mistrust
   b. Shame
   c. Guilt
   d. Inferiority

8. Which of the following is an appropriate toy for an 18-month-old?
   a. Multiple-piece puzzle
   b. Miniature cars
   c. Finger paints
   d. Comic book

9. When teaching parents about the child’s readiness for toilet training, which of the following signs should the nurse instruct them to watch for in the toddler?
   a. Demonstrates dryness for 4 hours
   b. Demonstrates ability to sit and walk
   c. Has a new sibling for stimulation
   d. Verbalizes desire to go to the bathroom

10. When teaching parents about typical toddler eating patterns, which of the following should be included?
    a. Food “jags”
    b. Preference to eat alone
    c. Consistent table manners
    d. Increase in appetite

11. Which of the following suggestions should the nurse offer the parents of a 4-year-old boy who resists going to bed at night?
    a. “Allow him to fall asleep in your room, then move him to his own bed.”
    b. “Tell him that you will lock him in his room if he gets out of bed one more time.”
    c. “Encourage active play at bedtime to tire him out so he will fall asleep faster.”
    d. “Read him a story and allow him to play quietly in his bed until he falls asleep.”
12. When providing therapeutic play, which of the following toys would best promote imaginative play in a 4-year-old?
   a. Large blocks
   b. Dress-up clothes
   c. Wooden puzzle
   d. Big wheels

13. Which of the following activities, when voiced by the parents following a teaching session about the characteristics of school-age cognitive development would indicate the need for additional teaching?
   a. Collecting baseball cards and marbles
   b. Ordering dolls according to size
   c. Considering simple problem-solving options
   d. Developing plans for the future

14. A hospitalized schoolager states: “I’m not afraid of this place, I’m not afraid of anything.” This statement is most likely an example of which of the following?
   a. Regression
   b. Repression
   c. Reaction formation
   d. Rationalization

15. After teaching a group of parents about accident prevention for schoolagers, which of the following statements by the group would indicate the need for more teaching?
   a. “Schoolagers are more active and adventurous than are younger children.”
   b. “Schoolagers are more susceptible to home hazards than are younger children.”
   c. “Schoolagers are unable to understand potential dangers around them.”
   d. “Schoolagers are less subject to parental control than are younger children.”

16. Which of the following skills is the most significant one learned during the schoolage period?
   a. Collecting
   b. Ordering
   c. Reading
   d. Sorting

17. A child age 7 was unable to receive the measles, mumps, and rubella (MMR) vaccine at the recommended scheduled time. When would the nurse expect to administer MMR vaccine?
   a. In a month from now
   b. In a year from now
   c. At age 10
   d. At age 13

18. The adolescent’s inability to develop a sense of who he is and what he can become results in a sense of which of the following?
   a. Shame
   b. Guilt
   c. Inferiority
19. Which of the following would be most appropriate for a nurse to use when describing menarche to a 13-year-old?
   a. A female’s first menstruation or menstrual “periods”
   b. The first year of menstruation or “period”
   c. The entire menstrual cycle or from one “period” to another
   d. The onset of uterine maturation or peak growth

20. A 14-year-old boy has acne and according to his parents, dominates the bathroom by using the mirror all the time. Which of the following remarks by the nurse would be least helpful in talking to the boy and his parents?
   a. “This is probably the only concern he has about his body. So don’t worry about it or the time he spends on it.”
   b. “Teenagers are anxious about how their peers perceive them. So they spend a lot of time grooming.”
   c. “A teen may develop a poor self-image when experiencing acne. Do you feel this way sometimes?”
   d. “You appear to be keeping your face well washed. Would you feel comfortable discussing your cleansing method?”

21. Which of the following should the nurse suspect when noting that a 3-year-old is engaging in explicit sexual behavior during doll play?
   a. The child is exhibiting normal pre-school curiosity
   b. The child is acting out personal experiences
   c. The child does not know how to play with dolls
   d. The child is probably developmentally delayed.

22. Which of the following statements by the parents of a child with school phobia would indicate the need for further teaching?
   a. “We’ll keep him at home until phobia subsides.”
   b. “We’ll work with his teachers and counselors at school.”
   c. “We’ll try to encourage him to talk about his problem.”
   d. “We’ll discuss possible solutions with him and his counselor.”

23. When developing a teaching plan for a group of high school students about teenage pregnancy, the nurse would keep in mind which of the following?
   a. The incidence of teenage pregnancies is increasing.
   b. Most teenage pregnancies are planned.
   c. Denial of the pregnancy is common early on.
   d. The risk for complications during pregnancy is rare.

24. When assessing a child with a cleft palate, the nurse is aware that the child is at risk for more frequent episodes of otitis media due to which of the following?
   a. Lowered resistance from malnutrition
   b. Ineffective functioning of the Eustachian tubes
   c. Plugging of the Eustachian tubes with food particles
   d. Associated congenital defects of the middle ear.

25. While performing a neurodevelopmental assessment on a 3-month-old infant, which of the following characteristics would be expected?
   a. A strong Moro reflex
   b. A strong parachute reflex
c. Rolling from front to back
d. Lifting of head and chest when prone

26. By the end of which of the following would the nurse most commonly expect a child’s birth weight to triple?
   a. 4 months
   b. 7 months
   c. 9 months
   d. 12 months

27. Which of the following best describes parallel play between two toddlers?
   a. Sharing crayons to color separate pictures
   b. Playing a board game with a nurse
   c. Sitting near each other while playing with separate dolls
   d. Sharing their dolls with two different nurses

28. Which of the following would the nurse identify as the initial priority for a child with acute lymphocytic leukemia?
   a. Instituting infection control precautions
   b. Encouraging adequate intake of iron-rich foods
   c. Assisting with coping with chronic illness
   d. Administering medications via IM injections

29. Which of the following information, when voiced by the mother, would indicate to the nurse that she understands home care instructions following the administration of a diphtheria, tetanus, and pertussis injection?
   a. Measures to reduce fever
   b. Need for dietary restrictions
   c. Reasons for subsequent rash
   d. Measures to control subsequent diarrhea

30. Which of the following actions by a community health nurse is most appropriate when noting multiple bruises and burns on the posterior trunk of an 18-month-old child during a home visit?
   a. Report the child’s condition to Protective Services immediately.
   b. Schedule a follow-up visit to check for more bruises.
   c. Notify the child’s physician immediately.
   d. Do nothing because this is a normal finding in a toddler.

31. Which of the following is being used when the mother of a hospitalized child calls the student nurse and states, “You idiot, you have no idea how to care for my sick child”?
   a. Displacement
   b. Projection
   c. Repression
   d. Psychosis

32. Which of the following should the nurse expect to note as a frequent complication for a child with congenital heart disease?
   a. Susceptibility to respiratory infection
   b. Bleeding tendencies
   c. Frequent vomiting and diarrhea
   d. Seizure disorder
33. Which of the following would the nurse do first for a 3-year-old boy who arrives in the emergency room with a temperature of 105 degrees, inspiratory stridor, and restlessness, who is learning forward and drooling?
   a. Auscultate his lungs and place him in a mist tent.
   b. Have him lie down and rest after encouraging fluids.
   c. Examine his throat and perform a throat culture
   d. Notify the physician immediately and prepare for intubation.

34. Which of the following would the nurse need to keep in mind as a predisposing factor when formulating a teaching plan for child with a urinary tract infection?
   a. A shorter urethra in females
   b. Frequent emptying of the bladder
   c. Increased fluid intake
   d. Ingestion of acidic juices

35. Which of the following should the nurse do first for a 15-year-old boy with a full leg cast who is screaming in unrelenting pain and exhibiting right foot pallor signifying compartment syndrome?
   a. Medicate him with acetaminophen.
   b. Notify the physician immediately
   c. Release the traction
   d. Monitor him every 5 minutes

36. At which of the following ages would the nurse expect to administer the varicella zoster vaccine to child?
   a. At birth
   b. 2 months
   c. 6 months
   d. 12 months

37. When discussing normal infant growth and development with parents, which of the following toys would the nurse suggest as most appropriate for an 8-month-old?
   a. Push-pull toys
   b. Rattle
   c. Large blocks
   d. Mobile

38. Which of the following aspects of psychosocial development is necessary for the nurse to keep in mind when providing care for the preschool child?
   a. The child can use complex reasoning to think out situations.
   b. Fear of body mutilation is a common preschool fear
   c. The child engages in competitive types of play
   d. Immediate gratification is necessary to develop initiative.

39. Which of the following is characteristic of a preschooler with mid mental retardation?
   a. Slow to feed self
   b. Lack of speech
   c. Marked motor delays
   d. Gait disability
40. Which of the following assessment findings would lead the nurse to suspect Down syndrome in an infant?
   a. Small tongue
   b. Transverse palmar crease
   c. Large nose
   d. Restricted joint movement

41. While assessing a newborn with cleft lip, the nurse would be alert that which of the following will most likely be compromised?
   a. Sucking ability
   b. Respiratory status
   c. Locomotion
   d. GI function

42. When providing postoperative care for the child with a cleft palate, the nurse should position the child in which of the following positions?
   a. Supine
   b. Prone
   c. In an infant seat
   d. On the side

43. While assessing a child with pyloric stenosis, the nurse is likely to note which of the following?
   a. Regurgitation
   b. Steatorrhea
   c. Projectile vomiting
   d. “Currant jelly” stools

44. Which of the following nursing diagnoses would be inappropriate for the infant with gastroesophageal reflux (GER)?
   a. Fluid volume deficit
   b. Risk for aspiration
   c. Altered nutrition: less than body requirements
   d. Altered oral mucous membranes

45. Which of the following parameters would the nurse monitor to evaluate the effectiveness of thickened feedings for an infant with gastroesophageal reflux (GER)?
   a. Vomiting
   b. Stools
   c. Uterine
   d. Weight

46. Discharge teaching for a child with celiac disease would include instructions about avoiding which of the following?
   a. Rice
   b. Milk
   c. Wheat
   d. Chicken

47. Which of the following would the nurse expect to assess in a child with celiac disease having a celiac crisis secondary to an upper respiratory infection?
   a. Respiratory distress
b. Lethargy  
c. Watery diarrhea  
d. Weight gain  
48. Which of the following should the nurse do first after noting that a child with Hirschsprung disease has a fever and watery explosive diarrhea?  
   a. Notify the physician immediately  
   b. Administer antidiarrheal medications  
   c. Monitor child ever 30 minutes  
   d. Nothing, this is characteristic of Hirschsprung disease  
49. A newborn’s failure to pass meconium within the first 24 hours after birth may indicate which of the following?  
   a. Hirschsprung disease  
   b. Celiac disease  
   c. Intussusception  
   d. Abdominal wall defect  
50. When assessing a child for possible intussusception, which of the following would be least likely to provide valuable information?  
   a. Stool inspection  
   b. Pain pattern  
   c. Family history  
   d. Abdominal palpation  

Answers and Rationale Maternal and Child Health Practice Test Part 3

1. D. The anterior fontanelle typically closes anywhere between 12 to 18 months of age. Thus, assessing the anterior fontanelle as still being slightly open is a normal finding requiring no further action. Because it is normal finding for this age, notifying the physician or performing additional examinations are inappropriate.

2. D. Solid foods are not recommended before age 4 to 6 months because of the sucking reflex and the immaturity of the gastrointestinal tract and immune system. Therefore, the earliest age at which to introduce foods is 4 months. Any time earlier would be inappropriate.

3. A. According to Erikson, infants need to have their needs met consistently and effectively to develop a sense of trust. An infant whose needs are consistently unmet or who experiences significant delays in having them met, such as in the case of the infant of a substance-abusing mother, will develop a sense of uncertainty, leading to mistrust of caregivers and the environment. Toddlers develop a sense of shame when their autonomy needs are not met consistently. Preschoolers develop a sense of guilt when their sense of initiative is thwarted. Schoolagers develop a sense of inferiority when they do not develop a sense of industry.
4. **D.** A busy box facilitates the fine motor development that occurs between 4 and 6 months. Balloons are contraindicated because small children may aspirate balloons. Because the button eyes of a teddy bear may detach and be aspirated, this toy is unsafe for children younger than 3 years. A 5-month-old is too young to use a push-pull toy.

5. **B.** Infants need to have their security needs met by being held and cuddled. At 2 months of age, they are unable to make the connection between crying and attention. This association does not occur until late infancy or early toddlerhood. Letting the infant cry for a time before picking up the infant or leaving the infant alone to cry herself to sleep interferes with meeting the infant’s need for security at this very young age. Infants cry for many reasons. Assuming that the child is hungry may cause overfeeding problems such as obesity.

6. **B.** Underdeveloped abdominal musculature gives the toddler a characteristically protruding abdomen. During toddlerhood, food intake decreases, not increases. Toddlers are characteristically bowlegged because the leg muscles must bear the weight of the relatively large trunk. Toddler growth patterns occur in a steplike, not linear pattern.

7. **B.** According to Erikson, toddlers experience a sense of shame when they are not allowed to develop appropriate independence and autonomy. Infants develop mistrust when their needs are not consistently gratified. Preschoolers develop guilt when their initiative needs are not met while schoolagers develop a sense of inferiority when their industry needs are not met.

8. **C.** Young toddlers are still sensorimotor learners and they enjoy the experience of feeling different textures. Thus, finger paints would be an appropriate toy choice. Multiple-piece toys, such as puzzle, are too difficult to manipulate and may be hazardous if the pieces are small enough to be aspirated. Miniature cars also have a high potential for aspiration. Comic books are on too high a level for toddlers. Although they may enjoy looking at some of the pictures, toddlers are more likely to rip a comic book apart.

9. **D.** The child must be able to sate the need to go to the bathroom to initiate toilet training. Usually, a child needs to be dry for only 2 hours, not 4 hours. The child also must be able to sit, walk, and squat. A new sibling would most likely hinder toilet training.

10. **A.** Toddlers become picky eaters, experiencing food jags and eating large amounts one day and very little the next. A toddler’s food gags express a preference for the ritualism of eating one type of food for several days at a time. Toddlers typically enjoy socialization and limiting others at meal time. Toddlers prefer to feed themselves and thus are too young to have table manners. A toddler’s appetite and need for calories, protein, and fluid decrease due to the dramatic slowing of growth rate.
11. **D.** Preschoolers commonly have fears of the dark, being left alone especially at bedtime, and ghosts, which may affect the child’s going to bed at night. Quiet play and time with parents is a positive bedtime routine that provides security and also readies the child for sleep. The child should sleep in his own bed. Telling the child about locking him in his room will viewed by the child as a threat. Additionally, a locked door is frightening and potentially hazardous. Vigorous activity at bedtime stirs up the child and makes more difficult to fall asleep.

12. **B.** Dress-up clothes enhance imaginative play and imagination, allowing preschoolers to engage in rich fantasy play. Building blocks and wooden puzzles are appropriate for encouraging fine motor development. Big wheels and tricycles encourage gross motor development.

13. **D.** The school-aged child is in the stage of concrete operations, marked by inductive reasoning, logical operations, and reversible concrete thought. The ability to consider the future requires formal thought operations, which are not developed until adolescence. Collecting baseball cards and marbles, ordering dolls by size, and simple problem-solving options are examples of the concrete operational thinking of the schoolager.

14. **C.** Reaction formation is the schoolager’s typical defensive response when hospitalized. In reaction formation, expression of unacceptable thoughts or behaviors is prevented (or overridden) by the exaggerated expression of opposite thoughts or types of behaviors. Regression is seen in toddlers and preschoolers when they retreat or return to an earlier level of development. Repression refers to the involuntary blocking of unpleasant feelings and experiences from one’s awareness. Rationalization is the attempt to make excuses to justify unacceptable feelings or behaviors.

15. **C.** The schoolager’s cognitive level is sufficiently developed to enable good understanding of and adherence to rules. Thus, schoolagers should be able to understand the potential dangers around them. With growth comes greater freedom and children become more adventurous and daring. The school-aged child is also still prone to accidents and home hazards, especially because of increased motor abilities and independence. Plus the home hazards differ from other age groups. These hazards, which are potentially lethal but tempting, may include firearms, alcohol, and medications. School-age children begin to internalize their own controls and need less outside direction. Plus the child is away from home more often. Some parental or caregiver assistance is still needed to answer questions and provide guidance for decisions and responsibilities.

16. **C.** The most significant skill learned during the school-age period is reading. During this time the child develops formal adult articulation patterns and learns that words can be arranged in structure. Collective, ordering, and sorting, although important, are not most significant skills learned.
17. **C.** Based on the recommendations of the American Academy of Family Physicians and the American Academy of Pediatrics, the MMR vaccine should be given at the age of 10 if the child did not receive it between the ages of 4 to 6 years as recommended. Immunization for diphtheria and tetanus is required at age 13.

18. **D.** According to Erikson, role diffusion develops when the adolescent does not develop a sense of identity and a sense of where he fits in. Toddlers develop a sense of shame when they do not achieve autonomy. Preschoolers develop a sense of guilt when they do not develop a sense of initiative. School-age children develop a sense of inferiority when they do not develop a sense of industry.

19. **A.** Menarche refers to the onset of the first menstruation or menstrual period and refers only to the first cycle. Uterine growth and broadening of the pelvic girdle occurs before menarche.

20. **A.** Stating that this is probably the only concern the adolescent has and telling the parents not to worry about it or the time her spends on it shuts off further investigation and is likely to make the adolescent and his parents feel defensive. The statement about peer acceptance and time spent in front of the mirror for the development of self image provides information about the adolescent’s needs to the parents and may help to gain trust with the adolescent. Asking the adolescent how he feels about the acne will encourage the adolescent to share his feelings. Discussing the cleansing method shows interest and concern for the adolescent and also can help to identify any patient-teaching needs for the adolescent regarding cleansing.

21. **B.** Preschoolers should be developmentally incapable of demonstrating explicit sexual behavior. If a child does so, the child has been exposed to such behavior, and sexual abuse should be suspected. Explicit sexual behavior during doll play is not a characteristic of preschool development nor symptomatic of developmental delay. Whether or nor the child knows how to play with dolls is irrelevant.

22. **A.** The parents need more teaching if they state that they will keep the child home until the phobia subsides. Doing so reinforces the child’s feelings of worthlessness and dependency. The child should attend school even during resolution of the problem. Allowing the child to verbalize helps the child to ventilate feelings and may help to uncover causes and solutions. Collaboration with the teachers and counselors at school may lead to uncovering the cause of the phobia and to the development of solutions. The child should participate and play an active role in developing possible solutions.

23. **C.** The adolescent who becomes pregnant typically denies the pregnancy early on. Early recognition by a parent or health care provider may be crucial to timely initiation of prenatal care. The incidence of adolescent pregnancy has declined since 1991, yet morbidity remains high. Most teenage pregnancies are unplanned and occur out of wedlock. The pregnant adolescent is at high risk for physical complications including premature labor and low-birth-weight infants, high neonatal mortality, iron
deficiency anemia, prolonged labor, and fetopelvic disproportion as well as numerous psychological crises.

24. **B.** Because of the structural defect, children with cleft palate may have ineffective functioning of their Eustachian tubes creating frequent bouts of otitis media. Most children with cleft palate remain well-nourished and maintain adequate nutrition through the use of proper feeding techniques. Food particles do not pass through the cleft and into the Eustachian tubes. There is no association between cleft palate and congenial ear deformities.

25. **D.** A 3-month-old infant should be able to lift the head and chest when prone. The Moro reflex typically diminishes or subsides by 3 months. The parachute reflex appears at 9 months. Rolling from front to back usually is accomplished at about 5 months.

26. **D.** A child’s birth weight usually triples by 12 months and doubles by 4 months. No specific birth weight parameters are established for 7 or 9 months.

27. **C.** Toddlers engaging in parallel play will play near each other, but not with each other. Thus, when two toddlers sit near each other but play with separate dolls, they are exhibiting parallel play. Sharing crayons, playing a board game with a nurse, or sharing dolls with two different nurses are all examples of cooperative play.

28. **A.** Acute lymphocytic leukemia (ALL) causes leukopenia, resulting in immunosuppression and increasing the risk of infection, a leading cause of death in children with ALL. Therefore, the initial priority nursing intervention would be to institute infection control precautions to decrease the risk of infection. Iron-rich foods help with anemia, but dietary iron is not an initial intervention. The prognosis of ALL usually is good. However, later on, the nurse may need to assist the child and family with coping since death and dying may still be an issue in need of discussion. Injections should be discouraged, owing to increased risk from bleeding due to thrombocytopenia.

29. **A.** The pertussis component may result in fever and the tetanus component may result in injection soreness. Therefore, the mother’s verbalization of information about measures to reduce fever indicates understanding. No dietary restrictions are necessary after this injection is given. A subsequent rash is more likely to be seen 5 to 10 days after receiving the MMR vaccine, not the diphtheria, pertussis, and tetanus vaccine. Diarrhea is not associated with this vaccine.

30. **A.** Multiple bruises and burns on a toddler are signs child abuse. Therefore, the nurse is responsible for reporting the case to Protective Services immediately to protect the child from further harm. Scheduling a follow-up visit is inappropriate because additional harm may come to the child if the nurse waits for further assessment data. Although the nurse should notify the physician, the goal is to initiate measures to protect the child’s safety. Notifying the physician immediately does not initiate the
removal of the child from harm nor does it absolve the nurse from responsibility. Multiple bruises and burns are not normal toddler injuries.

31. **B.** The mother is using projection, the defense mechanism used when a person attributes his or her own undesirable traits to another. Displacement is the transfer of emotion onto an unrelated object, such as when the mother would kick a chair or bang the door shut. Repression is the submerging of painful ideas into the unconscious. Psychosis is a state of being out of touch with reality.

32. **A.** Children with congenital heart disease are more prone to respiratory infections. Bleeding tendencies, frequent vomiting, and diarrhea and seizure disorders are not associated with congenital heart disease.

33. **D.** The child is exhibiting classic signs of epiglottitis, always a pediatric emergency. The physician must be notified immediately and the nurse must be prepared for an emergency intubation or tracheostomy. Further assessment with auscultating lungs and placing the child in a mist tent wastes valuable time. The situation is a possible life-threatening emergency. Having the child lie down would cause additional distress and may result in respiratory arrest. Throat examination may result in laryngospasm that could be fatal.

34. **A.** In females, the urethra is shorter than in males. This decreases the distance for organisms to travel, thereby increasing the chance of the child developing a urinary tract infection. Frequent emptying of the bladder would help to decrease urinary tract infections by avoiding sphincter stress. Increased fluid intake enables the bladder to be cleared more frequently, thus helping to prevent urinary tract infections. The intake of acidic juices helps to keep the urine pH acidic and thus decrease the chance of flora development.

35. **B.** Compartment syndrome is an emergent situation and the physician needs to be notified immediately so that interventions can be initiated to relieve the increasing pressure and restore circulation. Acetaminophen (Tylenol) will be ineffective since the pain is related to the increasing pressure and tissue ischemia. The cast, not traction, is being used in this situation for immobilization, so releasing the traction would be inappropriate. In this situation, specific action not continued monitoring is indicated.

36. **D.** The varicella zoster vaccine (VZV) is a live vaccine given after age 12 months. The first dose of hepatitis B vaccine is given at birth to 2 months, then at 1 to 4 months, and then again at 6 to 18 months. DtaP is routinely given at 2, 4, 6, and 15 to 18 months and a booster at 4 to 6 years.

37. **C.** Because the 8-month-old is refining his gross motor skills, being able to sit unsupported and also improving his fine motor skills, probably capable of making hand-to-hand transfers, large blocks would be the most appropriate toy selection. Push-pull toys would be more appropriate for the 10 to 12-month-old as he or she
begins to cruise the environment. Rattles and mobiles are more appropriate for infants in the 1 to 3 month age range. Mobiles pose a danger to older infants because of possible strangulation.

38. B. During the preschool period, the child has mastered a sense of autonomy and goes on to master a sense of initiative. During this period, the child commonly experiences more fears than at any other time. One common fear is fear of the body mutilation, especially associated with painful experiences. The preschool child uses simple, not complex, reasoning, engages in associative, not competitive, play (interactive and cooperative play with sharing), and is able to tolerate longer periods of delayed gratification.

39. A. Mild mental retardation refers to development disability involving an IQ 50 to 70. Typically, the child is not noted as being retarded, but exhibits slowness in performing tasks, such as self-feeding, walking, and taking. Little or no speech, marked motor delays, and gait disabilities would be seen in more severe forms mental retardation.

40. B. Down syndrome is characterized by the following a transverse palmar crease (simian crease), separated sagittal suture, oblique palpebral fissures, small nose, depressed nasal bridge, high-arched palate, excess and lax skin, wide spacing and plantar crease between the second and big toes, hyperextensible and lax joints, large protruding tongue, and muscle weakness.

41. A. Because of the defect, the child will be unable to from the mouth adequately around nipple, thereby requiring special devices to allow for feeding and sucking gratification. Respiratory status may be compromised if the child is fed improperly or during postoperative period, Locomotion would be a problem for the older infant because of the use of restraints. GI functioning is not compromised in the child with a cleft lip.

42. B. Postoperatively children with cleft palate should be placed on their abdomens to facilitate drainage. If the child is placed in the supine position, he or she may aspirate. Using an infant seat does not facilitate drainage. Side-lying does not facilitate drainage as well as the prone position.

43. C. Projectile vomiting is a key symptom of pyloric stenosis. Regurgitation is seen more commonly with GER. Steatorrhea occurs in malabsorption disorders such as celiac disease. “Currant jelly” stools are characteristic of intussusception.

44. D. GER is the backflow of gastric contents into the esophagus resulting from relaxation or incompetence of the lower esophageal (cardiac) sphincter. No alteration in the oral mucous membranes occurs with this disorder. Fluid volume deficit, risk for aspiration, and altered nutrition are appropriate nursing diagnoses.
45. A. Thickened feedings are used with GER to stop the vomiting. Therefore, the nurse would monitor the child’s vomiting to evaluate the effectiveness of using the thickened feedings. No relationship exists between feedings and characteristics of stools and uterine. If feedings are ineffective, this should be noted before there is any change in the child’s weight.

46. C. Children with celiac disease cannot tolerate or digest gluten. Therefore, because of its gluten content, wheat and wheat-containing products must be avoided. Rice, milk, and chicken do not contain gluten and need not be avoided.

47. C. Episodes of celiac crises are precipitated by infections, ingestion of gluten, prolonged fasting, or exposure to anticholinergic drugs. Celiac crisis is typically characterized by severe watery diarrhea. Respiratory distress is unlikely in a routine upper respiratory infection. Irritability, rather than lethargy, is more likely. Because of the fluid loss associated with the severe watery diarrhea, the child’s weight is more likely to be decreased.

48. A. For the child with Hirschsprung disease, fever and explosive diarrhea indicate enterocolitis, a life-threatening situation. Therefore, the physician should be notified immediately. Generally, because of the intestinal obstruction and inadequate propulsive intestinal movement, antidiarrheals are not used to treat Hirschsprung disease. The child is acutely ill and requires intervention, with monitoring more frequently than every 30 minutes. Hirschsprung disease typically presents with chronic constipation.

49. A. Failure to pass meconium within the first 24 hours after birth may be an indication of Hirschsprung disease, a congenital anomaly resulting in mechanical obstruction due to inadequate motility in an intestinal segment. Failure to pass meconium is not associated with celiac disease, intussusception, or abdominal wall defect.

50. C. Because intussusception is not believed to have a familial tendency, obtaining a family history would provide the least amount of information. Stool inspection, pain pattern, and abdominal palpation would reveal possible indicators of intussusception. Current, jelly-like stools containing blood and mucus are an indication of intussusception. Acute, episodic abdominal pain is characteristics of intussusception. A sausage-shaped mass may be palpated in the right upper quadrant.

**Foundation of Nursing - Comprehensive Test Part 1**

1. Using the principles of standard precautions, the nurse would wear gloves in what nursing interventions?
   a. Providing a back massage
b. Feeding a client

c. Providing hair care

d. Providing oral hygiene

2. The nurse is preparing to take vital sign in an alert client admitted to the hospital with dehydration secondary to vomiting and diarrhea. What is the best method used to assess the client’s temperature?

   a. Oral
   b. Axillary
   c. Radial
   d. Heat sensitive tape

3. A nurse obtained a client’s pulse and found the rate to be above normal. The nurse document this findings as:

   a. Tachypnea
   b. Hyper pyrexia
   c. Arrhythmia
   d. Tachycardia

4. Which of the following actions should the nurse take to use a wide base support when assisting a client to get up in a chair?

   a. Bend at the waist and place arms under the client’s arms and lift
   b. Face the client, bend knees and place hands on client’s forearm and lift
   c. Spread his or her feet apart
   d. Tighten his or her pelvic muscles

5. A client had oral surgery following a motor vehicle accident. The nurse assessing the client finds the skin flushed and warm. Which of the following would be the best method to take the client’s body temperature?

   a. Oral
   b. Axillary
   c. Arterial line
   d. Rectal

6. A client who is unconscious needs frequent mouth care. When performing a mouth care, the best position of a client is:

   a. Fowler’s position
   b. Side lying
   c. Supine
   d. Trendelenburg

7. A client is hospitalized for the first time, which of the following actions ensure the safety of the client?

   a. Keep unnecessary furniture out of the way
   b. Keep the lights on at all time
   c. Keep side rails up at all time
   d. Keep all equipment out of view

8. A walk-in client enters into the clinic with a chief complaint of abdominal pain and diarrhea. The nurse takes the client’s vital sign hereafter. What phrase of nursing process is being implemented here by the nurse?

   a. Assessment
   b. Diagnosis
9. It is best describe as a systematic, rational method of planning and providing nursing care for individual, families, group and community
   a. Assessment
   b. Nursing Process
   c. Diagnosis
   d. Implementation

10. Exchange of gases takes place in which of the following organ?
    a. Kidney
    b. Lungs
    c. Liver
    d. Heart

11. The Chamber of the heart that receives oxygenated blood from the lungs is the?
    a. Left atrium
    b. Right atrium
    c. Left ventricle
    d. Right ventricle

12. A muscular enlarge pouch or sac that lies slightly to the left which is used for temporary storage of food…
    a. Gallbladder
    b. Urinary bladder
    c. Stomach
    d. Lungs

13. The ability of the body to defend itself against scientific invading agent such as bacteria, toxin, viruses and foreign body
    a. Hormones
    b. Secretion
    c. Immunity
    d. Glands

14. Hormones secreted by Islets of Langerhans
    a. Progesterone
    b. Testosterone
    c. Insulin
    d. Hemoglobin

15. It is a transparent membrane that focuses the light that enters the eyes to the retina.
    a. Lens
    b. Sclera
    c. Cornea
    d. Pupils

16. Which of the following is included in Orem’s theory?
    a. Maintenance of a sufficient intake of air
    b. Self perception
    c. Love and belonging
    d. Physiologic needs
17. Which of the following cluster of data belong to Maslow’s hierarchy of needs
   a. Love and belonging
   b. Physiologic needs
   c. Self actualization
   d. All of the above

18. This is characterized by severe symptoms relatively of short duration.
   a. Chronic Illness
   b. Acute Illness
   c. Pain
   d. Syndrome

19. Which of the following is the nurse’s role in the health promotion
   a. Health risk appraisal
   b. Teach client to be effective health consumer
   c. Worksite wellness
   d. None of the above

20. It is describe as a collection of people who share some attributes of their lives.
   a. Family
   b. Illness
   c. Community
   d. Nursing

21. Five teaspoon is equivalent to how many milliliters (ml)?
   a. 30 ml
   b. 25 ml
   c. 12 ml
   d. 22 ml

22. 1800 ml is equal to how many liters?
   a. 1.8
   b. 18000
   c. 180
   d. 2800

23. Which of the following is the abbreviation of drops?
   a. Gtt.
   b. Gtts.
   c. Dp.
   d. Dr.

24. The abbreviation for micro drop is…
   a. µgtt
   b. gtt
   c. mdr
   d. mgtts

25. Which of the following is the meaning of PRN?
   a. When advice
   b. Immediately
   c. When necessary
   d. Now

26. Which of the following is the appropriate meaning of CBR?
a. Cardiac Board Room  
b. Complete Bathroom  
c. Complete Bed Rest  
d. Complete Board Room  

27. 1 tsp is equals to how many drops?
   a. 15  
   b. 60  
   c. 10  
   d. 30

28. 20 cc is equal to how many ml?
   a. 2  
   b. 20  
   c. 2000  
   d. 20000

29. 1 cup is equals to how many ounces?
   a. 8  
   b. 80  
   c. 800  
   d. 8000

30. The nurse must verify the client’s identity before administration of medication. Which of the following is the safest way to identify the client?
   a. Ask the client his name  
   b. Check the client’s identification band  
   c. State the client’s name aloud and have the client repeat it  
   d. Check the room number

31. The nurse prepares to administer buccal medication. The medicine should be placed…
   a. On the client’s skin  
   b. Between the client’s cheeks and gums  
   c. Under the client’s tongue  
   d. On the client’s conjuctiva

32. The nurse administers cleansing enema. The common position for this procedure is…
   a. Sims left lateral  
   b. Dorsal Recumbent  
   c. Supine  
   d. Prone

33. A client complains of difficulty of swallowing, when the nurse try to administer capsule medication. Which of the following measures the nurse should do?
   a. Dissolve the capsule in a glass of water  
   b. Break the capsule and give the content with an applesauce  
   c. Check the availability of a liquid preparation  
   d. Crash the capsule and place it under the tongue

34. Which of the following is the appropriate route of administration for insulin?
   a. Intramuscular  
   b. Intradermal
c. Subcutaneous
d. Intravenous

35. The nurse is ordered to administer ampicillin capsule TIP p.o. The nurse should give the medication…
   a. Three times a day orally
   b. Three times a day after meals
   c. Two times a day by mouth
   d. Two times a day before meals

36. Back Care is best described as:
   a. Caring for the back by means of massage
   b. Washing of the back
   c. Application of cold compress at the back
   d. Application of hot compress at the back

37. It refers to the preparation of the bed with a new set of linens
   a. Bed bath
   b. Bed making
   c. Bed shampoo
   d. Bed lining

38. Which of the following is the most important purpose of handwashing
   a. To promote hand circulation
   b. To prevent the transfer of microorganisms
   c. To avoid touching the client with a dirty hand
   d. To provide comfort

39. What should be done in order to prevent contaminating the environment in bed making?
   a. Avoid funning soiled linens
   b. Strip all linens at the same time
   c. Finished both sides at the time
   d. Embrace soiled linen

40. The most important purpose of cleansing bed bath is:
   a. To cleanse, refresh and give comfort to the client who must remain in bed
   b. To expose the necessary parts of the body
   c. To develop skills in bed bath
   d. To check the body temperature of the client in bed

41. Which of the following techniques involves the sense of sight?
   a. Inspection
   b. Palpation
   c. Percussion
   d. Auscultation

42. The first techniques used examining the abdomen of a client is:
   a. Palpation
   b. Auscultation
   c. Percussion
   d. Inspection

43. A technique in physical examination that is used to assess the movement of air through the tracheobronchial tree:
a. Palpation  
   b. Auscultation  
   c. Inspection  
   d. Percussion

44. An instrument used for auscultation is:  
   a. Percussion-hammer  
   b. Audiometer  
   c. Stethoscope  
   d. Sphygmomanometer

45. Resonance is best describe as:  
   a. Sounds created by air filled lungs  
   b. Short, high pitch and thudding  
   c. Moderately loud with musical quality  
   d. Drum-like

46. The best position for examining the rectum is:  
   a. Prone  
   b. Sim’s  
   c. Knee-chest  
   d. Lithotomy

47. It refers to the manner of walking  
   a. Gait  
   b. Range of motion  
   c. Flexion and extension  
   d. Hopping

48. The nurse asked the client to read the Snellen chart. Which of the following is tested:  
   a. Optic  
   b. Olfactory  
   c. Oculomotor  
   d. Troclear

49. Another name for knee-chest position is:  
   a. Genu-dorsal  
   b. Genu-pectoral  
   c. Lithotomy  
   d. Sim’s

50. The nurse prepare IM injection that is irritating to the subcutaneous tissue. Which of the following is the best action in order to prevent tracking of the medication  
   a. Use a small gauge needle  
   b. Apply ice on the injection site  
   c. Administer at a 45° angle  
   d. Use the Z-track technique

Part 1
## Foundation of Nursing - Comprehensive Test Part 2

1. The most appropriate nursing order for a patient who develops dyspnea and shortness of breath would be…
   - a. Maintain the patient on strict bed rest at all times
   - b. Maintain the patient in an orthopneic position as needed
   - c. Administer oxygen by Venturi mask at 24%, as needed
   - d. Allow a 1 hour rest period between activities

2. The nurse observes that Mr. Adams begins to have increased difficulty breathing. She elevates the head of the bed to the high Fowler position, which decreases his respiratory distress. The nurse documents this breathing as:
   - a. Tachypnea
   - b. Eupnea
   - c. Orthopnea
   - d. Hyperventilation

3. The physician orders a platelet count to be performed on Mrs. Smith after breakfast. The nurse is responsible for:
   - a. Instructing the patient about this diagnostic test
   - b. Writing the order for this test
   - c. Giving the patient breakfast
   - d. All of the above

4. Mrs. Mitchell has been given a copy of her diet. The nurse discusses the foods allowed on a 500-mg low sodium diet. These include:
   - a. A ham and Swiss cheese sandwich on whole wheat bread
   - b. Mashed potatoes and broiled chicken
   - c. A tossed salad with oil and vinegar and olives
d. Chicken bouillon

5. The physician orders a maintenance dose of 5,000 units of subcutaneous heparin (an anticoagulant) daily. Nursing responsibilities for Mrs. Mitchell now include:
   a. Reviewing daily activated partial thromboplastin time (APTT) and prothrombin time.
   b. Reporting an APTT above 45 seconds to the physician
   c. Assessing the patient for signs and symptoms of frank and occult bleeding
   d. All of the above

6. The four main concepts common to nursing that appear in each of the current conceptual models are:
   a. Person, nursing, environment, medicine
   b. Person, health, nursing, support systems
   c. Person, health, psychology, nursing
   d. Person, environment, health, nursing

7. In Maslow’s hierarchy of physiologic needs, the human need of greatest priority is:
   a. Love
   b. Elimination
   c. Nutrition
   d. Oxygen

8. The family of an accident victim who has been declared brain-dead seems amenable to organ donation. What should the nurse do?
   a. Discourage them from making a decision until their grief has eased
   b. Listen to their concerns and answer their questions honestly
   c. Encourage them to sign the consent form right away
   d. Tell them the body will not be available for a wake or funeral

9. A new head nurse on a unit is distressed about the poor staffing on the 11 p.m. to 7 a.m. shift. What should she do?
   a. Complain to her fellow nurses
   b. Wait until she knows more about the unit
   c. Discuss the problem with her supervisor
   d. Inform the staff that they must volunteer to rotate

10. Which of the following principles of primary nursing has proven the most satisfying to the patient and nurse?
    a. Continuity of patient care promotes efficient, cost-effective nursing care
    b. Autonomy and authority for planning are best delegated to a nurse who knows the patient well
    c. Accountability is clearest when one nurse is responsible for the overall plan and its implementation.
    d. The holistic approach provides for a therapeutic relationship, continuity, and efficient nursing care.

11. If nurse administers an injection to a patient who refuses that injection, she has committed:
    a. Assault and battery
    b. Negligence
    c. Malpractice
12. If patient asks the nurse her opinion about a particular physician and the nurse replies that the physician is incompetent, the nurse could be held liable for:
   a. Slander
   b. Libel
   c. Assault
   d. Respondent superior

13. A registered nurse reaches to answer the telephone on a busy pediatric unit, momentarily turning away from a 3 month-old infant she has been weighing. The infant falls off the scale, suffering a skull fracture. The nurse could be charged with:
   a. Defamation
   b. Assault
   c. Battery
   d. Malpractice

14. Which of the following is an example of nursing malpractice?
   a. The nurse administers penicillin to a patient with a documented history of allergy to the drug. The patient experiences an allergic reaction and has cerebral damage resulting from anoxia.
   b. The nurse applies a hot water bottle or a heating pad to the abdomen of a patient with abdominal cramping.
   c. The nurse assists a patient out of bed with the bed locked in position; the patient slips and fractures his right humerus.
   d. The nurse administers the wrong medication to a patient and the patient vomits. This information is documented and reported to the physician and the nursing supervisor.

15. Which of the following signs and symptoms would the nurse expect to find when assessing an Asian patient for postoperative pain following abdominal surgery?
   a. Decreased blood pressure and heart rate and shallow respirations
   b. Quiet crying
   c. Immobility, diaphoresis, and avoidance of deep breathing or coughing
   d. Changing position every 2 hours

16. A patient is admitted to the hospital with complaints of nausea, vomiting, diarrhea, and severe abdominal pain. Which of the following would immediately alert the nurse that the patient has bleeding from the GI tract?
   a. Complete blood count
   b. Guaiac test
   c. Vital signs
   d. Abdominal girth

17. The correct sequence for assessing the abdomen is:
   a. Tympanic percussion, measurement of abdominal girth, and inspection
   b. Assessment for distention, tenderness, and discoloration around the umbilicus.
   c. Percussions, palpation, and auscultation
   d. Auscultation, percussion, and palpation

18. High-pitched gurgles head over the right lower quadrant are:
a. A sign of increased bowel motility
b. A sign of decreased bowel motility
c. Normal bowel sounds
d. A sign of abdominal cramping

19. A patient about to undergo abdominal inspection is best placed in which of the following positions?
   a. Prone
   b. Trendelenburg
   c. Supine
   d. Side-lying

20. For a rectal examination, the patient can be directed to assume which of the following positions?
   a. Genupecterol
   b. Sims
   c. Horizontal recumbent
   d. All of the above

21. During a Romberg test, the nurse asks the patient to assume which position?
   a. Sitting
   b. Standing
   c. Genupectoral
   d. Trendelenburg

22. If a patient’s blood pressure is 150/96, his pulse pressure is:
   a. 54
   b. 96
   c. 150
   d. 246

23. A patient is kept off food and fluids for 10 hours before surgery. His oral temperature at 8 a.m. is 99.8 F (37.7 C) This temperature reading probably indicates:
   a. Infection
   b. Hypothermia
   c. Anxiety
   d. Dehydration

24. Which of the following parameters should be checked when assessing respirations?
   a. Rate
   b. Rhythm
   c. Symmetry
   d. All of the above

25. A 38-year old patient’s vital signs at 8 a.m. are axillary temperature 99.6 F (37.6 C); pulse rate, 88; respiratory rate, 30. Which findings should be reported?
   a. Respiratory rate only
   b. Temperature only
   c. Pulse rate and temperature
   d. Temperature and respiratory rate

26. All of the following can cause tachycardia except:
a. Fever  
b. Exercise  
c. Sympathetic nervous system stimulation  
d. Parasympathetic nervous system stimulation

27. Palpating the midclavicular line is the correct technique for assessing
   a. Baseline vital signs  
   b. Systolic blood pressure  
   c. Respiratory rate  
   d. Apical pulse

28. The absence of which pulse may not be a significant finding when a patient is admitted to the hospital?
   a. Apical  
   b. Radial  
   c. Pedal  
   d. Femoral

29. Which of the following patients is at greatest risk for developing pressure ulcers?
   a. An alert, chronic arthritic patient treated with steroids and aspirin  
   b. An 88-year old incontinent patient with gastric cancer who is confined to his bed at home  
   c. An apathetic 63-year old COPD patient receiving nasal oxygen via cannula  
   d. A confused 78-year old patient with congestive heart failure (CHF) who requires assistance to get out of bed.

30. The physician orders the administration of high-humidity oxygen by face mask and placement of the patient in a high Fowler’s position. After assessing Mrs. Paul, the nurse writes the following nursing diagnosis: Impaired gas exchange related to increased secretions. Which of the following nursing interventions has the greatest potential for improving this situation?
   a. Encourage the patient to increase her fluid intake to 200 ml every 2 hours  
   b. Place a humidifier in the patient’s room.  
   c. Continue administering oxygen by high humidity face mask  
   d. Perform chest physiotherapy on a regular schedule

31. The most common deficiency seen in alcoholics is:
   a. Thiamine  
   b. Riboflavin  
   c. Pyridoxine  
   d. Pantothenic acid

32. Which of the following statement is incorrect about a patient with dysphagia?
   a. The patient will find pureed or soft foods, such as custards, easier to swallow than water  
   b. Fowler’s or semi Fowler’s position reduces the risk of aspiration during swallowing  
   c. The patient should always feed himself  
   d. The nurse should perform oral hygiene before assisting with feeding.
33. To assess the kidney function of a patient with an indwelling urinary (Foley) catheter, the nurse measures his hourly urine output. She should notify the physician if the urine output is:
   a. Less than 30 ml/hour
   b. 64 ml in 2 hours
   c. 90 ml in 3 hours
   d. 125 ml in 4 hours

34. Certain substances increase the amount of urine produced. These include:
   a. Caffeine-containing drinks, such as coffee and cola.
   b. Beets
   c. Urinary analgesics
   d. Kaolin with pectin (Kaopectate)

35. A male patient who had surgery 2 days ago for head and neck cancer is about to make his first attempt to ambulate outside his room. The nurse notes that he is steady on his feet and that his vision was unaffected by the surgery. Which of the following nursing interventions would be appropriate?
   a. Encourage the patient to walk in the hall alone
   b. Discourage the patient from walking in the hall for a few more days
   c. Accompany the patient for his walk.
   d. Consult a physical therapist before allowing the patient to ambulate

36. A patient has exacerbation of chronic obstructive pulmonary disease (COPD) manifested by shortness of breath; orthopnea; thick, tenacious secretions; and a dry hacking cough. An appropriate nursing diagnosis would be:
   a. Ineffective airway clearance related to thick, tenacious secretions.
   b. Ineffective airway clearance related to dry, hacking cough.
   c. Ineffective individual coping to COPD.
   d. Pain related to immobilization of affected leg.

37. Mrs. Lim begins to cry as the nurse discusses hair loss. The best response would be:
   a. “Don’t worry. It’s only temporary”
   b. “Why are you crying? I didn’t get to the bad news yet”
   c. “Your hair is really pretty”
   d. “I know this will be difficult for you, but your hair will grow back after the completion of chemotherapy”

38. An additional Vitamin C is required during all of the following periods except:
   a. Infancy
   b. Young adulthood
   c. Childhood
   d. Pregnancy

39. A prescribed amount of oxygen is needed for a patient with COPD to prevent:
   a. Cardiac arrest related to increased partial pressure of carbon dioxide in arterial blood (PaCO₂)
   b. Circulatory overload due to hypervolemia
   c. Respiratory excitement
   d. Inhibition of the respiratory hypoxic stimulus
40. After 1 week of hospitalization, Mr. Gray develops hypokalemia. Which of the following is the most significant symptom of his disorder?
   a. Lethargy
   b. Increased pulse rate and blood pressure
   c. Muscle weakness
   d. Muscle irritability

41. Which of the following nursing interventions promotes patient safety?
   a. Assess the patient’s ability to ambulate and transfer from a bed to a chair
   b. Demonstrate the signal system to the patient
   c. Check to see that the patient is wearing his identification band
   d. All of the above

42. Studies have shown that about 40% of patients fall out of bed despite the use of side rails; this has led to which of the following conclusions?
   a. Side rails are ineffective
   b. Side rails should not be used
   c. Side rails are a deterrent that prevent a patient from falling out of bed.
   d. Side rails are a reminder to a patient not to get out of bed

43. Examples of patients suffering from impaired awareness include all of the following except:
   a. A semiconscious or over fatigued patient
   b. A disoriented or confused patient
   c. A patient who cannot care for himself at home
   d. A patient demonstrating symptoms of drugs or alcohol withdrawal

44. The most common injury among elderly persons is:
   a. Atherosclerotic changes in the blood vessels
   b. Increased incidence of gallbladder disease
   c. Urinary Tract Infection
   d. Hip fracture

45. The most common psychogenic disorder among elderly person is:
   a. Depression
   b. Sleep disturbances (such as bizarre dreams)
   c. Inability to concentrate
   d. Decreased appetite

46. Which of the following vascular system changes results from aging?
   a. Increased peripheral resistance of the blood vessels
   b. Decreased blood flow
   c. Increased work load of the left ventricle
   d. All of the above

47. Which of the following is the most common cause of dementia among elderly persons?
   a. Parkinson’s disease
   b. Multiple sclerosis
   c. Amyotrophic lateral sclerosis (Lou Gerhig’s disease)
   d. Alzheimer’s disease

48. The nurse’s most important legal responsibility after a patient’s death in a hospital is:
Obtaining a consent of an autopsy
b. Notifying the coroner or medical examiner
c. Labeling the corpse appropriately
d. Ensuring that the attending physician issues the death certification

49. Before rigor mortis occurs, the nurse is responsible for:
a. Providing a complete bath and dressing change
b. Placing one pillow under the body’s head and shoulders
c. Removing the body’s clothing and wrapping the body in a shroud
d. Allowing the body to relax normally

50. When a patient in the terminal stages of lung cancer begins to exhibit loss of consciousness, a major nursing priority is to:
a. Protect the patient from injury
b. Insert an airway
c. Elevate the head of the bed
d. Withdraw all pain medications

Foundation of Nursing - Comprehensive Test Part 2 Answers and Rationale

1. **B.** When a patient develops dyspnea and shortness of breath, the orthopneic position encourages maximum chest expansion and keeps the abdominal organs from pressing against the diaphragm, thus improving ventilation. Bed rest and oxygen by Venturi mask at 24% would improve oxygenation of the tissues and cells but must be ordered by a physician. Allowing for rest periods decreases the possibility of hypoxia.

2. **C.** Orthopnea is difficulty of breathing except in the upright position. Tachypnea is rapid respiration characterized by quick, shallow breaths. Eupnea is normal respiration – quiet, rhythmic, and without effort.

3. **C.** A platelet count evaluates the number of platelets in the circulating blood volume. The nurse is responsible for giving the patient breakfast at the scheduled time. The physician is responsible for instructing the patient about the test and for writing the order for the test.

4. **B.** Mashed potatoes and broiled chicken are low in natural sodium chloride. Ham, olives, and chicken bouillon contain large amounts of sodium and are contraindicated on a low sodium diet.

5. **D.** All of the identified nursing responsibilities are pertinent when a patient is receiving heparin. The normal activated partial thromboplastin time is 16 to 25 seconds and the normal prothrombin time is 12 to 15 seconds; these levels must remain within two to two and one half the normal levels. All patients receiving anticoagulant therapy must be observed for signs and symptoms of frank and occult bleeding (including hemorrhage, hypotension, tachycardia, tachypnea, restlessness, pallor, cold and clammy skin, thirst and confusion); blood pressure should be measured every 4 hours and the patient should be instructed to report
promptly any bleeding that occurs with tooth brushing, bowel movements, urination or heavy prolonged menstruation.

6. **D.** The focus concepts that have been accepted by all theorists as the focus of nursing practice from the time of Florence Nightingale include the person receiving nursing care, his environment, his health on the health illness continuum, and the nursing actions necessary to meet his needs.

7. **D.** Maslow, who defined a need as a satisfaction whose absence causes illness, considered oxygen to be the most important physiologic need; without it, human life could not exist. According to this theory, other physiologic needs (including food, water, elimination, shelter, rest and sleep, activity and temperature regulation) must be met before proceeding to the next hierarchical levels on psychosocial needs.

8. **B.** The brain-dead patient’s family needs support and reassurance in making a decision about organ donation. Because transplants are done within hours of death, decisions about organ donation must be made as soon as possible. However, the family’s concerns must be addressed before members are asked to sign a consent form. The body of an organ donor is available for burial.

9. **C.** Although a new head nurse should initially spend time observing the unit for its strengths and weakness, she should take action if a problem threatens patient safety. In this case, the supervisor is the resource person to approach.

10. **D.** Studies have shown that patients and nurses both respond well to primary nursing care units. Patients feel less anxious and isolated and more secure because they are allowed to participate in planning their own care. Nurses feel personal satisfaction, much of it related to positive feedback from the patients. They also seem to gain a greater sense of achievement and esprit de corps.

11. **A.** Assault is the unjustifiable attempt or threat to touch or injure another person. Battery is the unlawful touching of another person or the carrying out of threatened physical harm. Thus, any act that a nurse performs on the patient against his will is considered assault and battery.

12. **A.** Oral communication that injures an individual’s reputation is considered slander. Written communication that does the same is considered libel.

13. **D.** Malpractice is defined as injurious or unprofessional actions that harm another. It involves professional misconduct, such as omission or commission of an act that a reasonable and prudent nurse would or would not do. In this example, the standard of care was breached; a 3-month-old infant should never be left unattended on a scale.

14. **A.** The three elements necessary to establish a nursing malpractice are nursing error (administering penicillin to a patient with a documented allergy to the drug), injury (cerebral damage), and proximal cause (administering the penicillin caused the cerebral damage). Applying a hot water bottle or heating pad to a patient without a physician’s order does not include the three required components. Assisting a patient out of bed with the bed locked in position is the correct nursing practice; therefore, the fracture was not the result of malpractice. Administering an incorrect medication is a nursing error; however, if such action resulted in a serious illness or chronic problem, the nurse could be sued for malpractice.
15. C. An Asian patient is likely to hide his pain. Consequently, the nurse must observe for objective signs. In an abdominal surgery patient, these might include immobility, diaphoresis, and avoidance of deep breathing or coughing, as well as increased heart rate, shallow respirations (stemming from pain upon moving the diaphragm and respiratory muscles), and guarding or rigidity of the abdominal wall. Such a patient is unlikely to display emotion, such as crying.

16. B. To assess for GI tract bleeding when frank blood is absent, the nurse has two options: She can test for occult blood in vomitus, if present, or in stool – through guaiac (Hemoccult) test. A complete blood count does not provide immediate results and does not always immediately reflect blood loss. Changes in vital signs may be caused by factors other than blood loss. Abdominal girth is unrelated to blood loss.

17. D. Because percussion and palpation can affect bowel motility and thus bowel sounds, they should follow auscultation in abdominal assessment. Tympanic percussion, measurement of abdominal girth, and inspection are methods of assessing the abdomen. Assessing for distention, tenderness and discoloration around the umbilicus can indicate various bowel-related conditions, such as cholecystitis, appendicitis and peritonitis.

18. C. Hyperactive sounds indicate increased bowel motility; two or three sounds per minute indicate decreased bowel motility. Abdominal cramping with hyperactive, high pitched tinkling bowel sounds can indicate a bowel obstruction.

19. C. The supine position (also called the dorsal position), in which the patient lies on his back with his face upward, allows for easy access to the abdomen. In the prone position, the patient lies on his abdomen with his face turned to the side. In the Trendelenburg position, the head of the bed is tilted downward to 30 to 40 degrees so that the upper body is lower than the legs. In the lateral position, the patient lies on his side.

20. D. All of these positions are appropriate for a rectal examination. In the genupectoral (knee-chest) position, the patient kneels and rests his chest on the table, forming a 90 degree angle between the torso and upper legs. In Sims’ position, the patient lies on his left side with the left arm behind the body and his right leg flexed. In the horizontal recumbent position, the patient lies on his back with legs extended and hips rotated outward.

21. B. During a Romberg test, which evaluates for sensory or cerebellar ataxia, the patient must stand with feet together and arms resting at the sides—first with eyes open, then with eyes closed. The need to move the feet apart to maintain this stance is an abnormal finding.

22. A. The pulse pressure is the difference between the systolic and diastolic blood pressure readings – in this case, 54.

23. D. A slightly elevated temperature in the immediate preoperative or post operative period may result from the lack of fluids before surgery rather than from infection. Anxiety will not cause an elevated temperature. Hypothermia is an abnormally low body temperature.

24. D. The quality and efficiency of the respiratory process can be determined by appraising the rate, rhythm, depth, ease, sound, and symmetry of respirations.
25. D. Under normal conditions, a healthy adult breathes in a smooth uninterrupted pattern 12 to 20 times a minute. Thus, a respiratory rate of 30 would be abnormal. A normal adult body temperature, as measured on an oral thermometer, ranges between 97° and 100°F (36.1° and 37.8°C); an axillary temperature is approximately one degree lower and a rectal temperature, one degree higher. Thus, an axillary temperature of 99.6°F (37.6°C) would be considered abnormal. The resting pulse rate in an adult ranges from 60 to 100 beats/minute, so a rate of 88 is normal.

26. D. Parasympathetic nervous system stimulation of the heart decreases the heart rate as well as the force of contraction, rate of impulse conduction and blood flow through the coronary vessels. Fever, exercise, and sympathetic stimulation all increase the heart rate.

27. D. The apical pulse (the pulse at the apex of the heart) is located on the midclavicular line at the fourth, fifth, or sixth intercostal space. Base line vital signs include pulse rate, temperature, respiratory rate, and blood pressure. Blood pressure is typically assessed at the antecubital fossa, and respiratory rate is assessed best by observing chest movement with each inspiration and expiration.

28. C. Because the pedal pulse cannot be detected in 10% to 20% of the population, its absence is not necessarily a significant finding. However, the presence or absence of the pedal pulse should be documented upon admission so that changes can be identified during the hospital stay. Absence of the apical, radial, or femoral pulse is abnormal and should be investigated.

29. B. Pressure ulcers are most likely to develop in patients with impaired mental status, mobility, activity level, nutrition, circulation and bladder or bowel control. Age is also a factor. Thus, the 88-year old incontinent patient who has impaired nutrition (from gastric cancer) and is confined to bed is at greater risk.

30. A. Adequate hydration thins and loosens pulmonary secretions and also helps to replace fluids lost from elevated temperature, diaphoresis, dehydration and dyspnea. High- humidity air and chest physiotherapy help liquefy and mobilize secretions.

31. A. Chronic alcoholism commonly results in thiamine deficiency and other symptoms of malnutrition.

32. C. A patient with dysphagia (difficulty swallowing) requires assistance with feeding. Feeding himself is a long-range expected outcome. Soft foods, Fowler’s or semi-Fowler’s position, and oral hygiene before eating should be part of the feeding regimen.

33. A. A urine output of less than 30ml/hour indicates hypovolemia or oliguria, which is related to kidney function and inadequate fluid intake.

34. A. Fluids containing caffeine have a diuretic effect. Beets and urinary analgesics, such as pyridium, can color urine red. Kapectate is an anti diarrheal medication.

35. C. A hospitalized surgical patient leaving his room for the first time fears rejection and others staring at him, so he should not walk alone. Accompanying him will offer moral support, enabling him to face the rest of the world. Patients should begin ambulation as soon as possible after surgery to decrease complications and to regain strength and confidence. Waiting to consult a physical therapist is unnecessary.
36. A. Thick, tenacious secretions, a dry, hacking cough, orthopnea, and shortness of breath are signs of ineffective airway clearance. Ineffective airway clearance related to dry, hacking cough is incorrect because the cough is not the reason for the ineffective airway clearance. Ineffective individual coping related to COPD is wrong because the etiology for a nursing diagnosis should not be a medical diagnosis (COPD) and because no data indicate that the patient is coping ineffectively. Pain related to immobilization of affected leg would be an appropriate nursing diagnosis for a patient with a leg fracture.

37. D. “I know this will be difficult” acknowledges the problem and suggests a resolution to it. “Don’t worry..” offers some relief but doesn’t recognize the patient’s feelings. “..I didn’t get to the bad news yet” would be inappropriate at any time. “Your hair is really pretty” offers no consolation or alternatives to the patient.

38. B. Additional Vitamin C is needed in growth periods, such as infancy and childhood, and during pregnancy to supply demands for fetal growth and maternal tissues. Other conditions requiring extra vitamin C include wound healing, fever, infection and stress.

39. D. Delivery of more than 2 liters of oxygen per minute to a patient with chronic obstructive pulmonary disease (COPD), who is usually in a state of compensated respiratory acidosis (retaining carbon dioxide (CO2)), can inhibit the hypoxic stimulus for respiration. An increased partial pressure of carbon dioxide in arterial blood (PACO2) would not initially result in cardiac arrest. Circulatory overload and respiratory excitement have no relevance to the question.

40. C. Presenting symptoms of hypokalemia (a serum potassium level below 3.5 mEq/liter) include muscle weakness, chronic fatigue, and cardiac dysrhythmias. The combined effects of inadequate food intake and prolonged diarrhea can deplete the potassium stores of a patient with GI problems.

41. D. Assisting a patient with ambulation and transfer from a bed to a chair allows the nurse to evaluate the patient’s ability to carry out these functions safely. Demonstrating the signal system and providing an opportunity for a return demonstration ensures that the patient knows how to operate the equipment and encourages him to call for assistance when needed. Checking the patient’s identification band verifies the patient’s identity and prevents identification mistakes in drug administration.

42. D. Since about 40% of patients fall out of bed despite the use of side rails, side rails cannot be said to prevent falls; however, they do serve as a reminder that the patient should not get out of bed. The other answers are incorrect interpretations of the statistical data.

43. C. A patient who cannot care for himself at home does not necessarily have impaired awareness; he may simply have some degree of immobility.

44. D. Hip fracture, the most common injury among elderly persons, usually results from osteoporosis. The other answers are diseases that can occur in the elderly from physiologic changes.

45. A. Sleep disturbances, inability to concentrate and decreased appetite are symptoms of depression, the most common psychogenic disorder among elderly persons. Other symptoms include diminished memory, apathy, disinterest in
appearance, withdrawal, and irritability. Depression typically begins before the onset of old age and usually is caused by psychosocial, genetic, or biochemical factors.

46. D. Aging decreases elasticity of the blood vessels, which leads to increased peripheral resistance and decreased blood flow. These changes, in turn, increase the work load of the left ventricle.

47. D. Alzheimer’s disease, sometimes known as senile dementia of the Alzheimer’s type or primary degenerative dementia, is an insidious; progressive, irreversible, and degenerative disease of the brain whose etiology is still unknown. Parkinson’s disease is a neurologic disorder caused by lesions in the extrapyramidal system and manifested by tremors, muscle rigidity, hypokinesia, dysphagia, and dysphonia. Multiple sclerosis, a progressive, degenerative disease involving demyelination of the nerve fibers, usually begins in young adulthood and is marked by periods of remission and exacerbation. Amyotrophic lateral sclerosis, a disease marked by progressive degeneration of the neurons, eventually results in atrophy of all the muscles; including those necessary for respiration.

48. C. The nurse is legally responsible for labeling the corpse when death occurs in the hospital. She may be involved in obtaining consent for an autopsy or notifying the coroner or medical examiner of a patient’s death; however, she is not legally responsible for performing these functions. The attending physician may need information from the nurse to complete the death certificate, but he is responsible for issuing it.

49. B. The nurse must place a pillow under the deceased person’s head and shoulders to prevent blood from settling in the face and discoloring it. She is required to bathe only soiled areas of the body since the mortician will wash the entire body. Before wrapping the body in a shroud, the nurse places a clean gown on the body and closes the eyes and mouth.

50. A. Ensuring the patient’s safety is the most essential action at this time. The other nursing actions may be necessary but are not a major priority.

Foundation of Nursing - Comprehensive Test Part 3

1. Which element in the circular chain of infection can be eliminated by preserving skin integrity?
   a. Host
   b. Reservoir
   c. Mode of transmission
   d. Portal of entry

2. Which of the following will probably result in a break in sterile technique for respiratory isolation?
   a. Opening the patient’s window to the outside environment
   b. Turning on the patient’s room ventilator
   c. Opening the door of the patient’s room leading into the hospital corridor
d. Failing to wear gloves when administering a bed bath

3. Which of the following patients is at greater risk for contracting an infection?
   a. A patient with leukopenia
   b. A patient receiving broad-spectrum antibiotics
   c. A postoperative patient who has undergone orthopedic surgery
   d. A newly diagnosed diabetic patient

4. Effective hand washing requires the use of:
   a. Soap or detergent to promote emulsification
   b. Hot water to destroy bacteria
   c. A disinfectant to increase surface tension
   d. All of the above

5. After routine patient contact, hand washing should last at least:
   a. 30 seconds
   b. 1 minute
   c. 2 minute
   d. 3 minutes

6. Which of the following procedures always requires surgical asepsis?
   a. Vaginal instillation of conjugated estrogen
   b. Urinary catheterization
   c. Nasogastric tube insertion
   d. Colostomy irrigation

7. Sterile technique is used whenever:
   a. Strict isolation is required
   b. Terminal disinfection is performed
   c. Invasive procedures are performed
   d. Protective isolation is necessary

8. Which of the following constitutes a break in sterile technique while preparing a sterile field for a dressing change?
   a. Using sterile forceps, rather than sterile gloves, to handle a sterile item
   b. Touching the outside wrapper of sterilized material without sterile gloves
   c. Placing a sterile object on the edge of the sterile field
   d. Pouring out a small amount of solution (15 to 30 ml) before pouring the solution into a sterile container

9. A natural body defense that plays an active role in preventing infection is:
   a. Yawning
   b. Body hair
   c. Hiccupping
   d. Rapid eye movements

10. All of the following statement are true about donning sterile gloves except:
      a. The first glove should be picked up by grasping the inside of the cuff.
      b. The second glove should be picked up by inserting the gloved fingers under the cuff outside the glove.
      c. The gloves should be adjusted by sliding the gloved fingers under the sterile cuff and pulling the glove over the wrist
      d. The inside of the glove is considered sterile
11. When removing a contaminated gown, the nurse should be careful that the first thing she touches is the:
   a. Waist tie and neck tie at the back of the gown
   b. Waist tie in front of the gown
   c. Cuffs of the gown
   d. Inside of the gown

12. Which of the following nursing interventions is considered the most effective form or universal precautions?
   a. Cap all used needles before removing them from their syringes
   b. Discard all used uncapped needles and syringes in an impenetrable protective container
   c. Wear gloves when administering IM injections
   d. Follow enteric precautions

13. All of the following measures are recommended to prevent pressure ulcers except:
   a. Massaging the reddened area with lotion
   b. Using a water or air mattress
   c. Adhering to a schedule for positioning and turning
   d. Providing meticulous skin care

14. Which of the following blood tests should be performed before a blood transfusion?
   a. Prothrombin and coagulation time
   b. Blood typing and cross-matching
   c. Bleeding and clotting time
   d. Complete blood count (CBC) and electrolyte levels.

15. The primary purpose of a platelet count is to evaluate the:
   a. Potential for clot formation
   b. Potential for bleeding
   c. Presence of an antigen-antibody response
   d. Presence of cardiac enzymes

16. Which of the following white blood cell (WBC) counts clearly indicates leukocytosis?
   a. 4,500/mm³
   b. 7,000/mm³
   c. 10,000/mm³
   d. 25,000/mm³

17. After 5 days of diuretic therapy with 20mg of furosemide (Lasix) daily, a patient begins to exhibit fatigue, muscle cramping and muscle weakness. These symptoms probably indicate that the patient is experiencing:
   a. Hypokalemia
   b. Hyperkalemia
   c. Anorexia
   d. Dysphagia

18. Which of the following statements about chest X-ray is false?
   a. No contradictions exist for this test
   b. Before the procedure, the patient should remove all jewelry, metallic objects, and buttons above the waist
c. A signed consent is not required
d. Eating, drinking, and medications are allowed before this test

19. The most appropriate time for the nurse to obtain a sputum specimen for culture is:
   a. Early in the morning
   b. After the patient eats a light breakfast
   c. After aerosol therapy
   d. After chest physiotherapy

20. A patient with no known allergies is to receive penicillin every 6 hours. When administering the medication, the nurse observes a fine rash on the patient’s skin. The most appropriate nursing action would be to:
   a. Withhold the medication and notify the physician
   b. Administer the medication and notify the physician
   c. Administer the medication with an antihistamine
   d. Apply corn starch soaks to the rash

21. All of the following nursing interventions are correct when using the Z-track method of drug injection except:
   a. Prepare the injection site with alcohol
   b. Use a needle that’s at least 1” long
   c. Aspirate for blood before injection
   d. Rub the site vigorously after the injection to promote absorption

22. The correct method for determining the vastus lateralis site for I.M. injection is:
   a. Locate the upper aspect of the upper outer quadrant of the buttock about 5 to 8 cm below the iliac crest
   b. Palpate the lower edge of the acromion process and the midpoint lateral aspect of the arm
   c. Palpate a 1” circular area anterior to the umbilicus
   d. Divide the area between the greater femoral trochanter and the lateral femoral condyle into thirds, and select the middle third on the anterior of the thigh

23. The mid-deltoid injection site is seldom used for I.M. injections because it:
   a. Can accommodate only 1 ml or less of medication
   b. Bruises too easily
   c. Can be used only when the patient is lying down
   d. Does not readily parenteral medication

24. The appropriate needle size for insulin injection is:
   a. 18G, 1 ½” long
   b. 22G, 1” long
   c. 22G, 1 ½” long
   d. 25G, 5/8” long

25. The appropriate needle gauge for intradermal injection is:
   a. 20G
   b. 22G
   c. 25G
   d. 26G

26. Parenteral penicillin can be administered as an:
a. IM injection or an IV solution  
b. IV or an intradermal injection  
c. Intradermal or subcutaneous injection  
d. IM or a subcutaneous injection

27. The physician orders gr 10 of aspirin for a patient. The equivalent dose in milligrams is:  
a. 0.6 mg  
b. 10 mg  
c. 60 mg  
d. 600 mg

28. The physician orders an IV solution of dextrose 5% in water at 100ml/hour. What would the flow rate be if the drop factor is 15 gtt = 1 ml?  
a. 5 gtt/minute  
b. 13 gtt/minute  
c. 25 gtt/minute  
d. 50 gtt/minute

29. Which of the following is a sign or symptom of a hemolytic reaction to blood transfusion?  
a. Hemoglobinuria  
b. Chest pain  
c. Urticaria  
d. Distended neck veins

30. Which of the following conditions may require fluid restriction?  
a. Fever  
b. Chronic Obstructive Pulmonary Disease  
c. Renal Failure  
d. Dehydration

31. All of the following are common signs and symptoms of phlebitis except:  
a. Pain or discomfort at the IV insertion site  
b. Edema and warmth at the IV insertion site  
c. A red streak exiting the IV insertion site  
d. Frank bleeding at the insertion site

32. The best way of determining whether a patient has learned to instill ear medication properly is for the nurse to:  
a. Ask the patient if he/she has used ear drops before  
b. Have the patient repeat the nurse’s instructions using her own words  
c. Demonstrate the procedure to the patient and encourage to ask questions  
d. Ask the patient to demonstrate the procedure

33. Which of the following types of medications can be administered via gastrostomy tube?  
a. Any oral medications  
b. Capsules whole contents are dissolve in water  
c. Enteric-coated tablets that are thoroughly dissolved in water  
d. Most tablets designed for oral use, except for extended-duration compounds

34. A patient who develops hives after receiving an antibiotic is exhibiting drug:
a. Tolerance
b. Idiosyncrasy
c. Synergism
d. Allergy

35. A patient has returned to his room after femoral arteriography. All of the following are appropriate nursing interventions except:
   a. Assess femoral, popliteal, and pedal pulses every 15 minutes for 2 hours
   b. Check the pressure dressing for sanguineous drainage
   c. Assess a vital signs every 15 minutes for 2 hours
   d. Order a hemoglobin and hematocrit count 1 hour after the arteriography

36. The nurse explains to a patient that a cough:
   a. Is a protective response to clear the respiratory tract of irritants
   b. Is primarily a voluntary action
   c. Is induced by the administration of an antitussive drug
   d. Can be inhibited by “splinting” the abdomen

37. An infected patient has chills and begins shivering. The best nursing intervention is to:
   a. Apply iced alcohol sponges
   b. Provide increased cool liquids
   c. Provide additional bedclothes
   d. Provide increased ventilation

38. A clinical nurse specialist is a nurse who has:
   a. Been certified by the National League for Nursing
   b. Received credentials from the Philippine Nurses’ Association
   c. Graduated from an associate degree program and is a registered professional nurse
   d. Completed a master’s degree in the prescribed clinical area and is a registered professional nurse.

39. The purpose of increasing urine acidity through dietary means is to:
   a. Decrease burning sensations
   b. Change the urine’s color
   c. Change the urine’s concentration
   d. Inhibit the growth of microorganisms

40. Clay colored stools indicate:
   a. Upper GI bleeding
   b. Impending constipation
   c. An effect of medication
   d. Bile obstruction

41. In which step of the nursing process would the nurse ask a patient if the medication she administered relieved his pain?
   a. Assessment
   b. Analysis
   c. Planning
   d. Evaluation

42. All of the following are good sources of vitamin A except:
   a. White potatoes
b. Carrots
c. Apricots
d. Egg yolks
43. Which of the following is a primary nursing intervention necessary for all patients with a Foley Catheter in place?
   a. Maintain the drainage tubing and collection bag level with the patient’s bladder
   b. Irrigate the patient with 1% Neosporin solution three times a day
   c. Clamp the catheter for 1 hour every 4 hours to maintain the bladder’s elasticity
   d. Maintain the drainage tubing and collection bag below bladder level to facilitate drainage by gravity
44. The ELISA test is used to:
   a. Screen blood donors for antibodies to human immunodeficiency virus (HIV)
   b. Test blood to be used for transfusion for HIV antibodies
   c. Aid in diagnosing a patient with AIDS
   d. All of the above
45. The two blood vessels most commonly used for TPN infusion are the:
   a. Subclavian and jugular veins
   b. Brachial and subclavian veins
   c. Femoral and subclavian veins
   d. Brachial and femoral veins
46. Effective skin disinfection before a surgical procedure includes which of the following methods?
   a. Shaving the site on the day before surgery
   b. Applying a topical antiseptic to the skin on the evening before surgery
   c. Having the patient take a tub bath on the morning of surgery
   d. Having the patient shower with an antiseptic soap on the evening and the morning of surgery
47. When transferring a patient from a bed to a chair, the nurse should use which muscles to avoid back injury?
   a. Abdominal muscles
   b. Back muscles
   c. Leg muscles
   d. Upper arm muscles
48. Thrombophlebitis typically develops in patients with which of the following conditions?
   a. Increases partial thromboplastin time
   b. Acute pulsus paradoxus
   c. An impaired or traumatized blood vessel wall
   d. Chronic Obstructive Pulmonary Disease (COPD)
49. In a recumbent, immobilized patient, lung ventilation can become altered, leading to such respiratory complications as:
   a. Respiratory acidosis, atelectasis, and hypostatic pneumonia
   b. Appneustic breathing, atypical pneumonia and respiratory alkalosis
c. Cheyne-Strokes respirations and spontaneous pneumothorax  
d. Kussmaul’s respirations and hypoventilation  

50. Immobility impairs bladder elimination, resulting in such disorders as  
a. Increased urine acidity and relaxation of the perineal muscles, causing incontinence  
b. Urine retention, bladder distention, and infection  
c. Diuresis, natriuresis, and decreased urine specific gravity  
d. Decreased calcium and phosphate levels in the urine  

Foundation of Nursing - Comprehensive Test Part 3 Answers and Rationale  

1. D. In the circular chain of infection, pathogens must be able to leave their reservoir and be transmitted to a susceptible host through a portal of entry, such as broken skin.  
2. C. Respiratory isolation, like strict isolation, requires that the door to the door patient’s room remain closed. However, the patient’s room should be well ventilated, so opening the window or turning on the ventricular is desirable. The nurse does not need to wear gloves for respiratory isolation, but good hand washing is important for all types of isolation.  
3. A. Leukopenia is a decreased number of leukocytes (white blood cells), which are important in resisting infection. None of the other situations would put the patient at risk for contracting an infection; taking broad-spectrum antibiotics might actually reduce the infection risk.  
4. A. Soaps and detergents are used to help remove bacteria because of their ability to lower the surface tension of water and act as emulsifying agents. Hot water may lead to skin irritation or burns.  
5. A. Depending on the degree of exposure to pathogens, hand washing may last from 10 seconds to 4 minutes. After routine patient contact, hand washing for 30 seconds effectively minimizes the risk of pathogen transmission.  
6. B. The urinary system is normally free of microorganisms except at the urinary meatus. Any procedure that involves entering this system must use surgically aseptic measures to maintain a bacteria-free state.  
7. C. All invasive procedures, including surgery, catheter insertion, and administration of parenteral therapy, require sterile technique to maintain a sterile environment. All equipment must be sterile, and the nurse and the physician must wear sterile gloves and maintain surgical asepsis. In the operating room, the nurse and physician are required to wear sterile gowns, gloves, masks, hair covers, and shoe covers for all invasive procedures. Strict isolation requires the use of clean gloves, masks, gowns and equipment to prevent the transmission of highly communicable diseases by contact or by airborne routes. Terminal disinfection is the disinfection of all contaminated supplies and equipment after a patient has been discharged to prepare them for reuse by another patient. The purpose of protective (reverse) isolation is to prevent a person with seriously impaired resistance from coming into contact who potentially pathogenic organisms.
8. C. The edges of a sterile field are considered contaminated. When sterile items are allowed to come in contact with the edges of the field, the sterile items also become contaminated.

9. B. Hair on or within body areas, such as the nose, traps and holds particles that contain microorganisms. Yawning and hiccupping do not prevent microorganisms from entering or leaving the body. Rapid eye movement marks the stage of sleep during which dreaming occurs.

10. D. The inside of the glove is always considered to be clean, but not sterile.

11. A. The back of the gown is considered clean, the front is contaminated. So, after removing gloves and washing hands, the nurse should untie the back of the gown; slowly move backward away from the gown, holding the inside of the gown and keeping the edges off the floor; turn and fold the gown inside out; discard it in a contaminated linen container; then wash her hands again.

12. B. According to the Centers for Disease Control (CDC), blood-to-blood contact occurs most commonly when a health care worker attempts to cap a used needle. Therefore, used needles should never be recapped; instead they should be inserted in a specially designed puncture resistant, labeled container. Wearing gloves is not always necessary when administering an I.M. injection. Enteric precautions prevent the transfer of pathogens via feces.

13. A. Nurses and other health care professionals previously believed that massaging a reddened area with lotion would promote venous return and reduce edema to the area. However, research has shown that massage only increases the likelihood of cellular ischemia and necrosis to the area.

14. B. Before a blood transfusion is performed, the blood of the donor and recipient must be checked for compatibility. This is done by blood typing (a test that determines a person’s blood type) and cross-matching (a procedure that determines the compatibility of the donor’s and recipient’s blood after the blood types has been matched). If the blood specimens are incompatible, hemolysis and antigen-antibody reactions will occur.

15. A. Platelets are disk-shaped cells that are essential for blood coagulation. A platelet count determines the number of thrombocytes in blood available for promoting hemostasis and assisting with blood coagulation after injury. It also is used to evaluate the patient’s potential for bleeding; however, this is not its primary purpose. The normal count ranges from 150,000 to 350,000/mm³. A count of 100,000/mm³ or less indicates a potential for bleeding; count of less than 20,000/mm³ is associated with spontaneous bleeding.

16. D. Leukocytosis is any transient increase in the number of white blood cells (leukocytes) in the blood. Normal WBC counts range from 5,000 to 100,000/mm³. Thus, a count of 25,000/mm³ indicates leukocytosis.

17. A. Fatigue, muscle cramping, and muscle weaknesses are symptoms of hypokalemia (an inadequate potassium level), which is a potential side effect of diuretic therapy. The physician usually orders supplemental potassium to prevent hypokalemia in patients receiving diuretics. Anorexia is another symptom of hypokalemia. Dysphagia means difficulty swallowing.

18. A. Pregnancy or suspected pregnancy is the only contraindication for a chest X-ray. However, if a chest X-ray is necessary, the patient can wear a lead apron to
protect the pelvic region from radiation. Jewelry, metallic objects, and buttons would interfere with the X-ray and thus should not be worn above the waist. A signed consent is not required because a chest X-ray is not an invasive examination. Eating, drinking and medications are allowed because the X-ray is of the chest, not the abdominal region.

19. A. Obtaining a sputum specimen early in this morning ensures an adequate supply of bacteria for culturing and decreases the risk of contamination from food or medication.

20. A. Initial sensitivity to penicillin is commonly manifested by a skin rash, even in individuals who have not been allergic to it previously. Because of the danger of anaphylactic shock, the nurse should withhold the drug and notify the physician, who may choose to substitute another drug. Administering an antihistamine is a dependent nursing intervention that requires a written physician’s order. Although applying corn starch to the rash may relieve discomfort, it is not the nurse’s top priority in such a potentially life-threatening situation.

21. D. The Z-track method is an I.M. injection technique in which the patient’s skin is pulled in such a way that the needle track is sealed off after the injection. This procedure seals medication deep into the muscle, thereby minimizing skin staining and irritation. Rubbing the injection site is contraindicated because it may cause the medication to extravasate into the skin.

22. D. The vastus lateralis, a long, thick muscle that extends the full length of the thigh, is viewed by many clinicians as the site of choice for I.M. injections because it has relatively few major nerves and blood vessels. The middle third of the muscle is recommended as the injection site. The patient can be in a supine or sitting position for an injection into this site.

23. A. The mid-deltoid injection site can accommodate only 1 ml or less of medication because of its size and location (on the deltoid muscle of the arm, close to the brachial artery and radial nerve).

24. D. A 25G, 5/8” needle is the recommended size for insulin injection because insulin is administered by the subcutaneous route. An 18G, 1 ½” needle is usually used for I.M. injections in children, typically in the vastus lateralis. A 22G, 1 ½” needle is usually used for adult I.M. injections, which are typically administered in the vastus lateralis or ventrogluteal site.

25. D. Because an intradermal injection does not penetrate deeply into the skin, a small-bore 25G needle is recommended. This type of injection is used primarily to administer antigens to evaluate reactions for allergy or sensitivity studies. A 20G needle is usually used for I.M. injections of oil-based medications; a 22G needle for I.M. injections; and a 25G needle, for subcutaneous insulin injections.

26. A. Parenteral penicillin can be administered I.M. or added to a solution and given I.V. It cannot be administered subcutaneously or intradermally.

27. D. gr 10 x 60mg/gr 1 = 600 mg

28. C. 100ml/60 min X 15 gtt/ 1 ml = 25 gtt/minute

29. A. Hemoglobinuria, the abnormal presence of hemoglobin in the urine, indicates a hemolytic reaction (incompatibility of the donor’s and recipient’s blood). In this reaction, antibodies in the recipient’s plasma combine rapidly with donor RBC’s;
the cells are hemolyzed in either circulatory or reticuloendothelial system. Hemolysis occurs more rapidly in ABO incompatibilities than in Rh incompatibilities. Chest pain and urticaria may be symptoms of impending anaphylaxis. Distended neck veins are an indication of hypervolemia.

30. C. In real failure, the kidney loses their ability to effectively eliminate wastes and fluids. Because of this, limiting the patient’s intake of oral and I.V. fluids may be necessary. Fever, chronic obstructive pulmonary disease, and dehydration are conditions for which fluids should be encouraged.

31. D. Phlebitis, the inflammation of a vein, can be caused by chemical irritants (I.V. solutions or medications), mechanical irritants (the needle or catheter used during venipuncture or cannulation), or a localized allergic reaction to the needle or catheter. Signs and symptoms of phlebitis include pain or discomfort, edema and heat at the I.V. insertion site, and a red streak going up the arm or leg from the I.V. insertion site.

32. D. Return demonstration provides the most certain evidence for evaluating the effectiveness of patient teaching.

33. D. Capsules, enteric-coated tablets, and most extended duration or sustained release products should not be dissolved for use in a gastrostomy tube. They are pharmaceutically manufactured in these forms for valid reasons, and altering them destroys their purpose. The nurse should seek an alternate physician’s order when an ordered medication is inappropriate for delivery by tube.

34. D. A drug-allergy is an adverse reaction resulting from an immunologic response following a previous sensitizing exposure to the drug. The reaction can range from a rash or hives to anaphylactic shock. *Tolerance* to a drug means that the patient experiences a decreasing physiologic response to repeated administration of the drug in the same dosage. *Idiosyncrasy* is an individual’s unique hypersensitivity to a drug, food, or other substance; it appears to be genetically determined. *Synergism*, is a drug interaction in which the sum of the drug’s combined effects is greater than that of their separate effects.

35. D. A hemoglobin and hematocrit count would be ordered by the physician if bleeding were suspected. The other answers are appropriate nursing interventions for a patient who has undergone femoral arteriography.

36. A. Coughing, a protective response that clears the respiratory tract of irritants, usually is involuntary; however it can be voluntary, as when a patient is taught to perform coughing exercises. An antitussive drug inhibits coughing. Splinting the abdomen supports the abdominal muscles when a patient coughs.

37. C. In an infected patient, shivering results from the body’s attempt to increase heat production and the production of neutrophils and phagocytic action through increased skeletal muscle tension and contractions. Initial vasoconstriction may cause skin to feel cold to the touch. Applying additional bed clothes helps to equalize the body temperature and stop the chills. Attempts to cool the body result in further shivering, increased metabolism, and thus increased heat production.

38. D. A clinical nurse specialist must have completed a master’s degree in a clinical specialty and be a registered professional nurse. The National League of Nursing accredits educational programs in nursing and provides a testing service to evaluate student nursing competence but it does not certify nurses. The American
Nurses Association identifies requirements for certification and offers examinations for certification in many areas of nursing, such as medical surgical nursing. These certification (credentialing) demonstrates that the nurse has the knowledge and the ability to provide high quality nursing care in the area of her certification. A graduate of an associate degree program is not a clinical nurse specialist; however, she is prepared to provide bed side nursing with a high degree of knowledge and skill. She must successfully complete the licensing examination to become a registered professional nurse.


40. D. Bile colors the stool brown. Any inflammation or obstruction that impairs bile flow will affect the stool pigment, yielding light, clay-colored stool. Upper GI bleeding results in black or tarry stool. Constipation is characterized by small, hard masses. Many medications and foods will discolor stool – for example, drugs containing iron turn stool black.; beets turn stool red.

41. D. In the evaluation step of the nursing process, the nurse must decide whether the patient has achieved the expected outcome that was identified in the planning phase.

42. A. The main sources of vitamin A are yellow and green vegetables (such as carrots, sweet potatoes, squash, spinach, collard greens, broccoli, and cabbage) and yellow fruits (such as apricots, and cantaloupe). Animal sources include liver, kidneys, cream, butter, and egg yolks.

43. D. Maintaining the drainage tubing and collection bag level with the patient’s bladder could result in reflux of urine into the kidney. Irrigating the bladder with Neosporin and clamping the catheter for 1 hour every 4 hours must be prescribed by a physician.

44. D. The ELISA test of venous blood is used to assess blood and potential blood donors to human immunodeficiency virus (HIV). A positive ELISA test combined with various signs and symptoms helps to diagnose acquired immunodeficiency syndrome (AIDS)

45. D. Tachypnea (an abnormally rapid rate of breathing) would indicate that the patient was still hypoxic (deficient in oxygen). The partial pressures of arterial oxygen and carbon dioxide listed are within the normal range. Eupnea refers to normal respiration.

46. D. Studies have shown that showering with an antiseptic soap before surgery is the most effective method of removing microorganisms from the skin. Shaving the site of the intended surgery might cause breaks in the skin, thereby increasing the risk of infection; however, if indicated, shaving, should be done immediately before surgery, not the day before. A topical antiseptic would not remove microorganisms and would be beneficial only after proper cleaning and rinsing. Tub bathing might transfer organisms to another body site rather than rinse them away.

47. C. The leg muscles are the strongest muscles in the body and should bear the greatest stress when lifting. Muscles of the abdomen, back, and upper arms may be easily injured.

48. C. The factors, known as Virchow’s triad, collectively predispose a patient to thromboplebitis; impaired venous return to the heart, blood hypercoagulability,
and injury to a blood vessel wall. Increased partial thromboplastin time indicates a prolonged bleeding time during fibrin clot formation, commonly the result of anticoagulant (heparin) therapy. Arterial blood disorders (such as pulsus paradoxus) and lung diseases (such as COPD) do not necessarily impede venous return of injured vessel walls.

49. A. Because of restricted respiratory movement, a recumbent, immobilized patient is at particular risk for respiratory acidosis from poor gas exchange; atelectasis from reduced surfactant and accumulated mucus in the bronchioles, and hypostatic pneumonia from bacterial growth caused by stasis of mucus secretions.

50. B. The immobilized patient commonly suffers from urine retention caused by decreased muscle tone in the perineum. This leads to bladder distention and urine stagnation, which provide an excellent medium for bacterial growth leading to infection. Immobility also results in more alkaline urine with excessive amounts of calcium, sodium and phosphate, a gradual decrease in urine production, and an increased specific gravity.