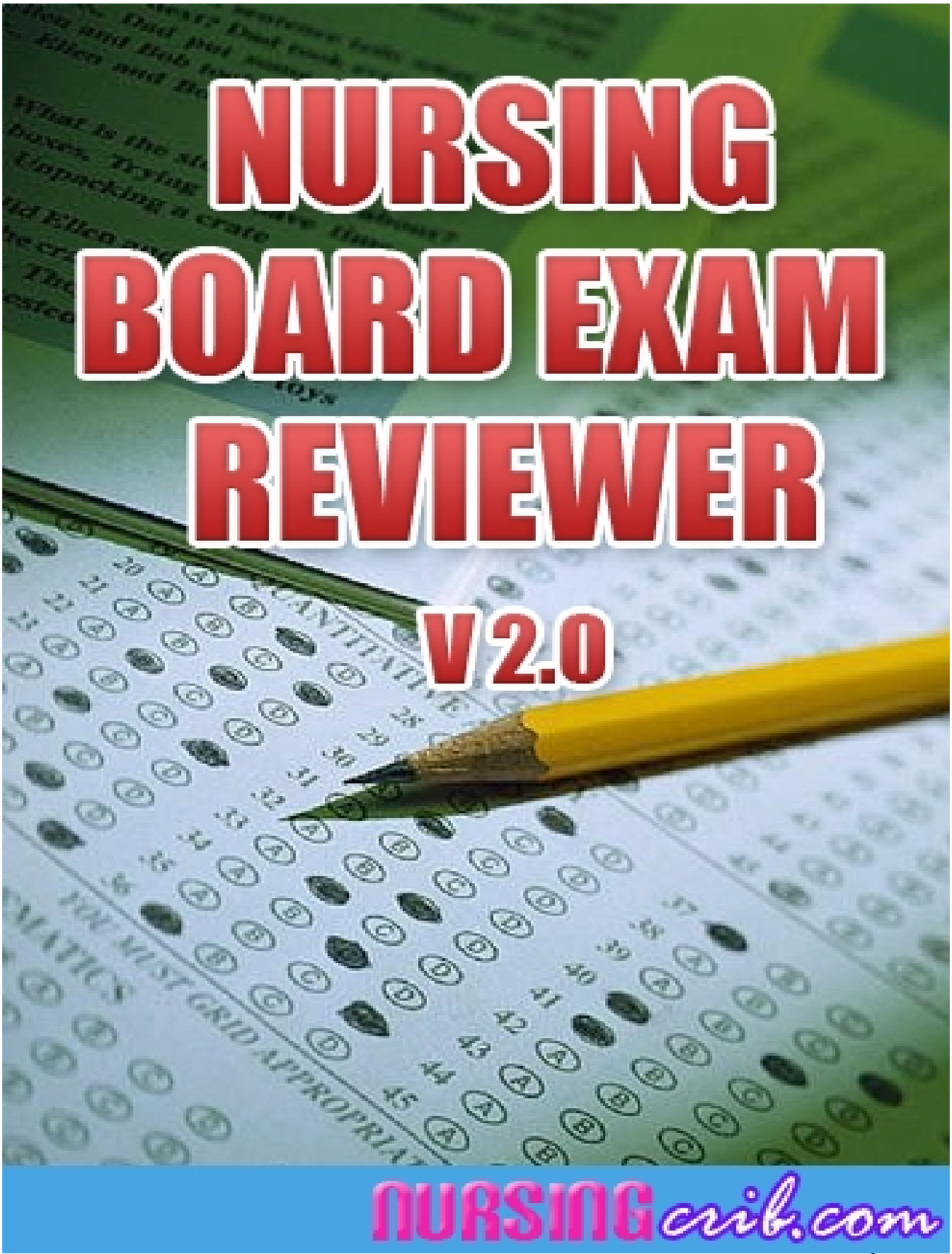
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# Table of Contents

**Test I - Foundation of Nursing, Nursing Research, Professional Adjustment, Leadership and Management**

1. A nurse has just received a unit of packed red blood cells from the blood bank to transfuse into a client as ordered. Before, preparing the blood for transfusion the nurse noticed the presence of bubbles in the bag. The nurse should take which of the following actions?

    a. The nurse must look for another registered nurse to double check the bag
    b. The nurse must add 10ml of normal saline to the bag to remove the bubbles
    c. The nurse must return the bag to the blood bank for replacement
    d. The nurse must add 100 units of Heparin to the bag

2. A nurse is assisting the physician in inserting a chest tube to the client. The nurse selects which of the following materials to be used as the first layer of the dressing at the chest tube insertion site?

    a. The nurse must prepare a 4x4 sterile gauze
    b. The nurse must put absorbent kelix dressing
    c. Petrolatum jelly gauze
    d. Gauze with betadine

3. A physician orders 1L of ½ normal saline to infuse over 8hours. The drop factors is 15 drops per 1ml. A nurse prepares to set the flow rate at how many drops per minute?

    a. 20 gtts/minute
    b. 28 drops per minute
    c. 31 gtts/minute
    d. 22 drops per minute

4. A nurse enters a client's room to perform physical assessment. The nurse wants to test the reflexes of the client. The nurse does which of the following as the most appropriate nursing action?

    a. Use a penlight to shine a light towards the bridge of the nose
    b. Stimulate the back of the throat using a tongue depressor
    c. Pull down the client's lower eyelids
    d. Ask the client to swallow

5. Mr. Cruz, 40 year old client was diagnosed with chronic pancreatitis. The nurse checks the laboratory results, anticipating a laboratory report that indicates a serum amylase level of

    a. 100 units/L
    b. 500 units/L
    c. 45 units/L
    d. 300 units/L

6. At 8:00 AM a nurse is preparing to change the Total Parenteral Nutrition (TPN) solution bag and tubing. The client's central venous line is located in the right subclavian vein. The nurse would instruct the client to do which of the following most essential items during the tubing change?

    a. instruct the client to breathe normally

b. the nurse must turn the head of the client to the right
c. ask the client to take a deep breath, hold it, bear down
d. tell the client to exhale slowly and evenly until tubing change is done

7. A client begins to exhibit atrial fibrillation and has a ventricular rate at 150 beats per minute. The nurse assess the client for

a. nausea and vomiting
b. flat neck veins
c. hypotension and dizziness
d. hypertension and headache

8. A nurse is making initial rounds at the beginning of the shift. She enters the room of a client receiving total parenteral nutrition (TPN) and discovers that the bag is empty. Which of the following solutions readily available on the nursing unit should the nurse hang until another TPN solution is mixed and delivered to the nursing unit?

a. 10% dextrose in water
b. 5% dextrose in water
c. 5% dextrose in 0.9% sodium chloride
d. NOTA

9. A physician tells a nurse that the client's intravenous line will be discontinued. A nurse obtains which of the following supplies from the unit supply area for use in applying pressure to the site after removing the intravenous (IV) catheter?

a. Sterile gauze
b. Adhesive bandage
c. Betadine swab
d. Alcohol swab

10. A physician's order reads Potassium chloride 30mEq to be added to 1L ml normal saline and to be given over 10-hour period. The available potassium chloride is 40mEq per 20ml. A nurse prepares how many milliliters of Potassium Chloride to administer the correct dose of medication?

a. 15ml
b. 10ml
c. 50ml
d. 20ml

11. A nurse is assisting a physician performing a liver biopsy. A nurse places the client in which of the following most appropriate position following the procedure?

a. supine
b. Prone
c. At right side-lying position with a small pillow or folded towel under the puncture site
d. At the left side-lying position with a small pillow or folded towel under the puncture site

12. An anxious client comes to the Emergency Department with chief complaint of pain on the left side of his chest. A chest X-ray examination reveals a left pneumothorax. When assessing the left side of the client's chest, the nurse would expect to find:

a. a vocal fremitus on palpation
b. a dull sound on percussion
c. an absence of breath sounds on auscultation
d. rales and rhonchi on auscultation

13. A nurse is inserting an indwelling urinary catheter into a male client. The client complains of pain as the nurse inflates the balloon with a syringe. The nurse does which of the following:

a. aspirates the fluid from the balloon, advances the catheter farther then reinflates the balloon
b. removes the syringe from the balloon because discomfort is normal and temporary
c. aspirates the fluid from the balloon, waits until the discomfort subsides, then reinflates the balloon
d. aspirates the fluid from the balloon, removes the catheter, reinsert a new catheter

14. A female client is admitted to the hospital, before performing a venipuncture to the client to initiate continuous intravenous (IV) therapy, a nurse should :

a. place a cool compress over the vein
b. Apply a tourniquet below the chosen vein site
c. Inspect the IV solution for particles or contamination
d. Secure an arm board to the joint located above the IV site

15. A client comes to the clinic for a check up and suspected of having Tuberculosis. The nurse understands the most accurate method for confirming the diagnosis is:

a. obtaining client's health history
b. a positive Purified Protein Derivative Test (PPD)
c. a chest X-ray positive for lung lesion
d. a sputum culture positive for Mycobacterium Tuberculosis

16. A nurse is assessing a client who had a Miller-Abbott tube in place for 24 hours, which assessed finding indicates that the tube is located in the intestines?

a. bowel sounds are absent
b. the client is nauseous
c. aspirate from the tube has a pH of 7
d. abdominal X-ray reveals that the tube is above the pylorus

17. A physician tells the nurse to obtain a 24-hour urine collection to a client with renal problem. The nurse avoids which of the following to ensure proper collection of the 24-hour specimen.

a. discard the first voiding and save all subsequent voiding during the 24 hour time period
b. have the client void at the end time and place this specimen in the container
c. place the container on ice, or inside a refrigerator
d. have the client void at the start time, and place this specimen in the container

18. A client is admitted to the hospital with a diagnosis of left pneumothorax by chest X-ray. The client is complaining of difficulty in breathing. Which of the following observed by the nurse indicates that the pneumothorax is rapidly worsening?

a. pain with respiration
b. Hypertension
c. Tracheal deviation to the right
d. Tracheal deviation to the left

19. A nurse is caring for a client who is suspected of having a pleural effusion. The nurse assesses the client, knowing that a typical manifestation of this respiratory problem is :

a. Dyspnea on exertion and moist, productive cough
b. Dyspnea at rest and moist, productive cough
c. Dyspnea on exertion and dry, nonproductive cough
d. Dyspnea at rest and dry, nonproductive cough

20. A physician ordered to administer Apmhotericin B (Fungizone) intravenously to the client diagnosed with histoplasmosis. The nurse plans to do which of the following during administration of the medication?

a. assess the intravenous infusion site
b. monitor for hypothermia
c. monitor for an excessive urine output
d. administer a concurrent fluid challenge

21. A client has not voided for 6 hours and has a distended bladder and the nurse inserted an indwelling Foley catheter. After the tubing is secured and the collection bag is hung on the bed frame, the nurse notices that 800 ml of urine has drained into the collection bag. What would be the appropriate nursing action for the safety of the client?

a. clamp the tubing for 30minutes and then release
b. raise the collection bag high enough to slow the rate of drainage
c. provide suprapubic pressure to maintain a steady flow of urine
d. check the specific gravity of the urine

22. A nurse is caring for a client with a chest tube attached to a Pleurevac drainage system. Which of the following actions would the nurse must avoid preventing a tension pneumothorax?

a. clamping the chest tube
b. taping the connection between the chest tube and the drainage system
c. adding water to the suction chamber as it evaporates
d. maintaining the collection chamber below the client's waist

23. A client with a chest tube attached to a Pleurevac drainage system wants to get out of bed. While the nurse is assisting the client, the chest tubing accidentally gets caught in the bed rail and disconnects and the Pleur-Evac drainage system falls over and cracks. The nurse takes which immediate action?

a. clamps the chest tube
b. applies a petroleum gauze over the end of the chest tube
c. immerses the chest tube in a bottle of sterile normal saline
d. calls the physician

24. A nurse is making a plan of care for a female client receiving enteral feedings. The nurse emphasizes which nursing diagnosis as the highest priority for this client?

a. Risk for Aspiration

b. Risk for Deficient Fluid Volume
c. Imbalanced Nutrition, Less than Body Requirements
d. Diarrhea

25. A client is scheduled for indirect visualization of the larynx to assess the function of the vocal cords. As the physician is performing the procedure, the nurse instructed the client to do which of the following?

a. roll the tongue to the back of the mouth
b. Hold the breath
c. Breathe normally
d. Try to swallow

26. A registered nurse instructed a nursing student to check the breath sound of the client. As she is observing the nursing student in auscultation, the nurse intervene when the student perform which of the inappropriate action?

a. places the stethoscope directly to the client's skin
b. uses the bell of the stethoscope
c. asks the client breathe slowly
d. asks the client to sit up straight

27. A physician tells a nurse to instill otic solution to a adult client left ear. While performing the procedure, the nurse avoids doing which of the following?

a. placing the tip of the dropper on the edge of the ear canal
b. warming the solution to room temperature
c. placing the client on the side-lying position with the ear facing up
d. pulling the auricle backward and upward

28. A female client has undergone left pneumonectomy. A nurse is formulating a plan of care to this client. The nurse plans to do which of the following immediate action after the clients was transferred from the post anesthesia care unit?

a. position the client supine
b. assist the client to sit in the bedside chair
c. place the client's intravenous fluid
d. position the client on the left side

29. A client becomes disoriented during the night and at risk for falls. The physician ordered for vest restraint from 10:00 PM to 7:00 AM. At 11:00 AM the charge nurse makes rounds on all of the clients with the vest restraints. Which observation by the charge nurse would indicate that the nurse who cared for this client performed an unsafe action of the use of the restraint.

a. the restraint was applied tightly
b. a hitch knot was used to secure the restraint
c. the client's record indicates that the restraint must be released every two hour
d. The call light was placed within reach of the client

30. A physician scheduled the client for pulmonary angiography. The client is fearful about the procedure and asks the nurse if it is painful and if there is radiation exposure. The nurse provides reassurance to the client based on the understanding that:

a. There is absolutely no pain, although a moderate amount of radiation must be used to get accurate result.
b. There is very mild pain throughout the procedure and the exposure to radiation is negligible
c. The procedure is somewhat painful, but there is minimal exposure to radiation
d. Discomfort my occur with needle insertion and there is minimal exposure to radiation

31. A nurse is assigned to care for an anxious client who has an open pneumothorax and sucking chest wound. An occlusive dressing has been applied to the site. Which of the following action of the nurse would best relieve the client's anxiety?

a. Stay with the client as necessary
b. Interpreting the arterial blood gas report
c. Encouraging the client to cough and deep breath
d. Distracting the client with television

32. A female client is to have arterial blood gases drawn. While the nurse is performing the Allen test, the client asks the nurse about the significance of the test and what procedure she is doing because no one else has done the same procedure before. The nurse makes which therapeutic response to the client.

a. " I assure you that I am doing the correct procedure, I cannot account for what others do"
b. "This is a routine precautionary step that simply makes certain circulation is intact before obtaining a blood sample"
c. Oh? "You have questions about this? You should insist that they all do this procedure before drawing up your blood"
d. This step is crucial to safe blood withdrawal, I would not let anyone take my blood until they do this"

33. A physician scheduled a male client for an arteriogram using a radiopaque dye. The nurse assesses which most critical item before the procedure/

a. Allergy to iodine
b. Vital signs
c. Height and weight
d. Intake and output

34. A nurse has given medication instruction to client who is receiving furosemide (lasix). The nurse determines that the client needs further instructions if the client states that:

a. "I need to talk to my physician about the use of alcohol"
b. "I need to avoid the use of salt substitutes because they contain potassium"
c. "I need to be careful not to get overheated in warm weather"
d. "I need to change positions slowly"

35. A nurse is assisting in planning care to a newly admitted client. On entering the room of the client, the nurse notes that the client's legs are elevated, the trunk is position flat and the head and shoulder are slightly elevated. The position of the client is appropriate for prevention of:

a. Increased Intracranial Pressure
b. Shock
c. A head injury

d. Respiratory insufficiency

36. A nurse is caring for a 12-year old client with chest pain. As she is making her rounds, she enters the room of her client and finds that the toy is on fire. The nurse immediately assists the client to get out of the room. What would be the next nursing action in this event?

    a. activate the fire alarm
    b. call for help
    c. extinguish the fire
    d. Confine the fire by closing the door of the room

37. A nurse has just finished suctioning the tracheostomy of a female client. The nurse plans to monitor the effectiveness of the procedure of which of the following item?

    a. respiratory rate
    b. oxygen saturation level
    c. capillary refill
    d. breath sound

38. A nurse is monitoring the status of a client with chest tube. The chest tube is attached to a Pleur-Evac drainage system. The nurse notes that the fluid in the water seal chamber is less than 2cm mark. The nurse determines that:

    a. water should be added to the chamber
    b. there is leak in the system
    c. suction should be added to the system
    d. this is caused by client pneumothorax

39. A client is admitted to a surgical unit postoperatively with a wound drain in place. A nurse assesses the client's surgical incision for sign of infection. Which finding by the nurse would be interpreted as s normal finding at the surgical site?

    a. red, hard skin
    b. purulent drainage
    c. serous drainage
    d. warm, tender skin

40. A nurse in a surgical unit receives a postoperative client form the post anesthesia care unit. After the initial assessment of the client, the nurse plans to monitor and continue with post operative assessment activities. Which of the following would be appropriate?

    a. every 15minutes for the first hour, every 30minutes for the second hour, every hour for 4 hours and then every four hour as needed.
    b. every 5minutes for the first half hour, every 15 minutes for two hours, every 30minutes for four hours and then every hour as needed
    c. every 30minutes for the first hour, every hour for two hours, then every four hours as needed
    d. every hour for two hours, then every four hours as needed

41. A client with cast on the forearm is complaining of skin irritation from the edges of a cast. The nurse observes that the skin edges are pink and irritated. The nurse plans to do which of the following as a corrective action?

    a. shake a small amount of powder under the cast rim

b. petal the edges of the cast with tape
c. use hair dryer set on a cool high setting to soothe the irritation
d. Massage the skin at the rim of the cast

42. A family member wishes to donate a blood for the upcoming surgery of the client and asks the nurse, “How will I know if our blood type will match?”. In formulating an appropriate response, the nurse incorporates that which test will be used to test compatibility?

a. direct coombs’
b. indirect coombs’
c. monocyte count
d. eosinophil count

43. A nurse has conducted preoperative teaching for a client scheduled for endoscopic retrograde cholangiospancreatography (ERCP) procedure. The nurse determines that the client needs additional teaching if he states that:

a. An anesthetic through spray will be used
b. Medication will be given orally for sedation
c. It is important to lie still during the procedure
d. A signed informed consent is necessary

44. After surgery, the client asks a nurse what is the significance of deep breathing and coughing. In formulating a response the nurse incorporates the understanding that retained pulmonary secretion in a post operative client can lead to:

a. Pneumonia
b. pulmonary edema
c. carbon dioxide retention
d. fluid imbalance

45. A nurse is performing tracheostomy care to the client and replaced the tracheostomy tube holder. The nurse ensures that the tube holder is not too tight by checking if:

a. the client nods that he or she feels comfortable
b. the tracheostomy does not move more than ½ inch when the client is coughing
c. two fingers can be slid comfortably under the holder
d. four fingers can be slid comfortably under the holder

46. A nurse is conducting a preoperative teaching with a client for radical neck dissection. Initially, the nurse would focus on which piece of information?

a. information given to the client by the surgeon
b. client’s coping behavior
c. post operative communication techniques
d. client’s support system

47. A female client arrives at the emergency room and scheduled for emergency surgery because of perforated gastric ulcer. A narcotic analgesic was administered and the client was sedated and cannot sign the operative consent form. What appropriate nursing action should be taken in the care of this client?

a. obtain the consent form from family member and have the consent witnessed by two persons

b. have the hospital chaplain signed the consent form immediately
c. obtain court order for surgery
d. send the client to surgery without the consent form being signed.

48. A nurse is developing a plan of care to a postoperative client. The nurse assesses the client for the presence of Homan's sign and determines that this sign is positive or which of the following is observed?

a. absent bowel sound
b. incisional pain
c. pain with dorsiflexion of the foot
d. crackles on auscultation of the lungs

49. A nurse is formulating a plan of care for a client scheduled for surgery. On the day of the operation, the nurse would do which of the following activities in the nursing care plan for client?

a. have the client void immediately before surgery
b. avoid oral hygiene and rinsing with mouthwash
c. report immediately any slight increase in blood pressure or pulse
d. verify that the client has not eaten for the last 24 hour

50. A physician ordered to transfuse a unit of packed RBC for an assigned client. In planning coverage for the client, the nurse just looked for another available nurse to check the blood to be transfused. Once the blood was double checked, how long will the assigned nurse stay with the client?

a. 15 minutes
b. 5 minutes
c. 30 minutes
d. 45 minutes

51. A client arrives in the emergency room and is assessed by the nurse. The client complains of a headache from drinking alcohol and asking for medication. The nurse explains to the client that assessment must be performed first before the administration of any medication. The client becomes verbally abusive and the nurse threatens to place the client in the restraints. Which of the following that the client can legally charge the nurse?

a. assault
b. negligence
c. invasion of privacy
d. battery

52. The nurse is trying to contact the physician who gave an order for a new medication for the client. The prescribe medication has a high dosage and the nurse is reluctant to administer. Efforts have been made to look for the physician but the nurse failed to clarify the order. Which of the following actions should the nurse take?

a. hold the medication until the physician can be contacted
b. administer the dose prescribed
c. administer the recommended dose until the physician can be located
d. contact the nursing supervisor

53. The ICU is understaffed and needs additional nurses to care for the client. The nurse manager assigned the nurse to report to the ICU for the day. The nurse had no experience in the ICU. Which of the following is most appropriate nursing action?

    a. refuse to work (float) to the ICU
    b. call the hospital lawyer
    c. call the nursing supervisor
    d. report to the ICU and identify tasks that can be performed safely

54. An incorrect dose of a medication was administered by the assigned nurse to a client. The nurse notifies the nursing supervisor about the error and calls the physician to report the occurrence. The nurse who administered the medication inaccurately understands that the:

    a. error will result in suspension
    b. incident report is a method of promoting quality care and risk management
    c. incident will be reported to the BON
    d. incident will be documented in the personnel file

55. A nurse enters the medication room and finds another nurse inside that is about to insert a needle attached to the syringe containing a clear fluid into the antecubital area. The nurse appropriate initial action is:

    a. call the police
    b. call the secure
    c. lock the nurse inside the medication room until help is obtained
    d. all the nursing supervisor

56. A living will of the client was prepared and the lawyer will be bringing the will to the hospital as soon as possible for witness signature. The client asks help from the nurse to obtain a witness to his will. The most appropriate response to the clients is which of the following?

    a. “I will sign as a witness to your signature”
    b. “You will need to find a witness on your own”
    c. “I will call the nursing supervisor to seek assistance regarding your request”
    d. “Whoever is available at the time will sign as a witness for you”

57. A nurse has made an inaccurate documentation on her assessment on a client and obtains the client’s record to correct the error. Which action should the nurse take to correct the error?

    a. using whiteout to delete the error and writing the correct data
    b. trying to erase the error for space to write in the correct data
    c. documenting a late entry into the client’s record
    d. drawing one line through the error, initialing and dating the line and then documenting the correct data

58. The laboratory personnel instructed the nurse that the result of the laboratory test of the client will be forwarded through facsimile machine. After 20minutes the facsimile machine activates and the nurse is expecting to receive the laboratory result but instead receives a sexually oriented photograph. The most appropriate nursing action is to:

    a. call the laboratory department and ask for the individual’s name that sent the photograph

b. cut up the photograph and throw it away
c. call the nurse manager and show the photograph and throw it away
d. call the nursing supervisor and report the incident

59. A nurse is discussing to the nursing students about the right of the clients. The nurse asks the student to identify a scenario that would represent invasion of privacy of the client. Which of the following, if identified by the nursing student, indicates an understanding of a violation of this client right?

a. threatening to give a client a medication
b. performing a procedure without consent
c. telling the client that he/she cannot leave the hospital
d. observing care provided to the client without the client's permission

60. The nursing instructor provides a lecture to the nursing students regarding some rights of the clients. The instructor asks the student to identify a situation that represents an example of battery. Which of the following items indicates an understanding of a violation of this right?

a. performing a procedure without consent of the client
b. sharing the client's record to other personnel not involve in providing care
c. threatening the client that he cannot leave the hospital
d. threatening to give a client a medication

61. The nursing staff taking their morning breaks. One of the nursing assistants tells the group that the ward supervisor has acquired immunodeficiency syndrome. The nursing assistant proceeds to tell the nursing staff that the supervisor probably got the disease from her drug addict husband. Which legal tort has the nursing assistant violated?

a. Libel
b. Slander
c. Assault
d. Negligence

62. A nurse is making rounds and hears one of the clients is calling for help. A nurse immediately checks the client and finds it lying on the floor. The nurse assisted the client back to bed and performs a thorough assessment. The incident was documented and the physician was notified. Which of the following would the nurse documents on the incident report?

a. the client climbed over the side rails
b. the client fell out of bed
c. the client became restless and tried to get out of bed
d. the client was found lying on the floor

63. A client is rushed to the emergency room. The client sustained a severe head injury, multiple fractures, and unconscious. An emergency craniotomy is required. Regarding informed consent for the surgical procedure, which of the following is the best action?

a. call the police to identify the client and locate the family
b. ask the medical emergency team to sign the informed consent
c. transport the client to the operating room for surgery without consent
d. obtain a court order for surgical procedure

64. A nurse is administering a medication to a client but refuses to take the prescribed medication. The nurse threatens the client telling if the medication is not taken orally, then it will be given by injection. This action by the nurse constitutes which legal tort?

    a. invasion of privacy
    b. negligence
    c. assault
    d. battery

65. The nurse is reviewing the prescribed medication of a newly admitted client. The nurse reviewed the order and notes that the physician has ordered the dose that is twice the amount the client is taking before admission. The nurse verifies the medication dosage before the administration. What is the next most appropriate nursing action?

    a. administer the drug even the dosage is twice the amount because that is the order of the physician
    b. Verify the prescribed medication by calling the nurse supervisor
    c. Contact the physician and verifies the order
    d. Carry out the order because there is no question about it

66. A client is scheduled for a cardiac catheterization and has numerous questions regarding the procedure and has requested to speak to the physician. The nurse calls the physician and informs that the client wants to talk to him. When the physician arrives at the unit to visit the client he is very upset with the nurse. The nurse is outside the client's room and hears the physician tells the client in a derogatory manner that the nurse "doesn't know anything". Which legal tort has the physician violated?

    a. Slander
    b. Libel
    c. Assault
    d. Negligence

67. An individual wishes to donate his organ for transplantation. The person asks the nurse how to become an organ donor. The nurse includes which statement in the response to the client?

    a. the donor must be 25 years of age or older
    b. the family is responsible for making organ donor decision at the time of death
    c. the donation is done by written consent
    d. the witness and a family member must be present to sign a form if an individual wants to donate his or her own organs for transplant.

68. A client has returned to the nursing unit after surgery. A nurse is assigned to monitor the client's condition. Over the past four hour, the client's vital signs are deteriorating and the nurse does not recognize the significance of these changes in vital signs and take no action. The client later requires emergency surgery. The nurse could be prosecuted for inaction according to the definition of which of these terms?

    a. Tort
    b. Misdemeanor
    c. Common Law
    d. Statutory Law

69. A client, which as a famous police officer, is admitted to the hospital with a diagnosis of Parkinson's disease. The nurse gives medical information regarding the client's condition

to a person who is assumed to be a family member. Later, the nurse found out that this person is not a family member of the client and the nurse realizes that she has violated which legal concept of the nurse-client relationship?

a. performing focused physical assessment
b. client's right to privacy
c. nurse's lack of experience
d. teaching and learning principles

70. A nurse was hired to be a home care nurse to assist the family in caring for a newborn with congenital tracheoesopahgeal fistula who is receiving enteral feedings. The nurse receives a telephone call and a woman introduced herself to the nurse as a family friend and wishes to know the condition of the client and inquire if there is anything she can do to assist the parents. The best nursing action is to:

a. inform the friend that the family has no need for assistance at this time because the nurse is making daily visits
b. inform the friend to directly contact the family and offer her assistance to them
c. report the friend's telephone call to the nurse manager for referral to the client's social worker
d. request that the friend come to the client's home, where she can be taught to administer the feedings

71. A nurse is assigned to care for a male client recovering home from a disabling lung infection. In her assessment of the health history of the client, the nurse found out that the infection is probably the result of HIV. The nurse is a religious person and informs the client that she is morally opposed to homosexuality and cannot care for him. The nurse then leaves the client's home. Which of the following is true regarding the nurse's actions?

a. the nurse has a duty to provide competent care to assigned clients in a nondiscriminatory manner
b. the nurse has the right to refuse to care for any client without justifying that refusal
c. the nurse has the duty to protect self from client care situations that are morally repellent
d. the nurse has a legal right to inform the client any barriers in providing care

72. A client diagnosed with cancer wishes to speak to his lawyer. The nurse contacted the lawyer to visit the client in the nursing unit. The client requested the lawyer to prepare a living will. The client requested the nurse to be the witness for the will. The nurse takes which appropriate action?

a. refuse to help the client because it is against the agency policy
b. agrees to act as a witness, anyway it is the client's last request
c. informs the client that a nurse caring for a client cannot serve as a witness to a living will
d. calls the physician to act as one of the witness

73. The nurse is caring to a client diagnosed with leukemia. The client asks the nurse about how to prepare a living will. The nurse informs the client that the first step to do in preparing this document is to:

a. talk to the hospital chaplain
b. consult with the cancer society

c. contact a lawyer
d. discuss the request with the physician

74. A nurse is assigned to care for a newly admitted client with a diagnosis of a bowel tumor. During the assessment period, the client tells the nurse that he prepared a living will four years ago. The client asks the nurse if this will is still effective. The nurse makes which appropriate response to the client?

a. “yes it is”
b. “you will have to ask your lawyer”
c. “is should be reviewed yearly with your physician”
d. “I have no idea”

75. A nurse is assigned to a client scheduled for a colonoscopy and the physician has provided detailed information to the client about the procedure. After confirming if the client clearly understands the procedure, the nurse prepares the informed consent for the client to sign it. Then the client informs the nurse that he does not know how to write. What is the nurse appropriate action?

a. contact a family member to represent for the client and sign the inform consent form
b. contact the physician and inform that the client cannot write
c. obtain a second nurse to also act as a witness and ask the client to sign the form with an X
d. send the client for the procedure without a signed informed consent

76. A Clinical Instructor is lecturing professional liability insurance with the graduating nursing students. The Instructor should advise the nursing students who will be graduating in the next month:

a. that most lawsuits are filed against physician
b. that malpractice insurance is not required and expensive
c. to obtain their own malpractice insurance
d. to discuss liability insurance with the employment agency

77. A client who had a colon resection is given a regular diet. The client refuses to eat solid food and asked that the physician be called. The nurse insisted that the solid food is an advised diet. The client was convinced and ate the food that was offered. Subsequently, the client had emergency surgery as a result of complications. The determination of negligence in this situation is based on:

a. the nurse’s persistence
b. a duty existed and it was breached
c. not calling the physician
d. the dietary department sending the wrong food

78. The Registered Nurse working in the emergency room observes that his co-worker is not performing well in providing care to the client. He suspects that his /her co-worker is substance impaired and notes signs of alcohol intoxication. The Nurse Practice Act requires that the Registered Nurse do which of the following

a. ask the colleague to go to the nurse’s lounge to sleep for a while
b. talk with the colleague
c. report the information to a nursing supervisor
d. call the impaired nurse organization

79. A nurse lawyer is conducting an educational session to the nursing staff regarding client rights. The nursing staff requested the lawyer to give an example that may give them a clear idea relating to invasion of client privacy. Which of the following indicates a violation of this right?

    a. performing a surgical procedure without consent
    b. telling the client that he/she cannot leave the hospital
    c. taking photographs of the client without consent
    d. threatening to place a client in restraints

80. A home care nurse arrives at the client's home for the scheduled home visit. The client tells the home care nurse of his decision to refuse external cardiac massage. Which of the following is the most appropriate initial nursing action?

    a. discuss the client's request with the family
    b. notify the physician of the client's request
    c. conduct a client conference with the home care staff to share the client's request
    d. document the client's request in the home care nursing care plan

81. A newly hired staff nurse is attending an orientation regarding the nursing model of practice implemented in the agency's facility. The nurse was informed that the model of practice used is a team nursing approach. The nurse understands that the nursing care delivery will be patterned on which characteristic of this type of nursing model of practice?

    a. single registered nurse is responsible for providing nursing care to a group of client
    b. a task approach method is used to provide care to clients
    c. managed care concepts and tools are used to provide care to client
    d. nursing personnel are led by an RN leader in providing to a group of client

82. The nurse was informed that the nurse manager has implemented change in the method of the nursing delivery system. The delivery system was changed from functional to team nursing. A nursing assistant was reluctant to the change and is not taking an active part in facilitating the process of change. Which of the following would be best approach in dealing with the nursing assistant?

    a. provide a positive reward system for the nursing assistant
    b. ignore the resistance
    c. exert coercion with the nursing assistant
    d. confront the nursing assistant to encourage verbalization of feelings regarding the change

83. The nurse is formulating the client assignment for the day. Which of the following is the most appropriate assignment for the nursing assistant?

    a. a client with difficulty swallowing food and fluids
    b. a client who requires a colostomy irrigation
    c. a client receiving continuous tube feeding
    d. a client requires urine specimen collection

84. The nurse manager implemented team nursing approach in the unit and planning assignments for the clients. The RN needs to assign four clients and has a licensed

practical nurse and three nursing assistant on a team. Which of the following clients would the nurse most appropriately assign to the licensed practical nurse?

a. a client who requires a bed bath
b. an older client requiring frequent ambulation
c. a client who requires a Fleet enema
d. A client with an abdominal wound requiring wound irrigation and dressing change every 3 hours

85. On the day shift, the registered nurse has just received an assignment. While making initial rounds and checking all the assigned clients, which clients will the registered nurse give first priority of care?

a. a post operative client who has just received pain medication
b. a client who is ambulatory
c. a client scheduled for physical therapy at 1 PM
d. a client with a fever who is diaphoretic and restless

86. The nurse was given an assignment to care for four clients. At the start of the rounds, the nurse develops a plan. Which client would the nurse assess first?

a. a client requiring every day dressing change
b. a client scheduled for a chest X-ray
c. a client receiving oxygen via nasal cannula who had difficulty breathing during the previous shift
d. a postoperative client preparing for discharge

87. The nurse was assigned to perform bed bath to the client. The nurse assistant enters the client room and tells the nurse that another assigned client is in pain and needs pain medication. The most appropriate nursing action is which of the following?

a. cover the client, raise the side rails, tell the client that you will return shortly, and administer the pain medication to other client
b. finish the bed bath and then administer the medication to other client
c. Ask the nursing assistant to tell the client in pain that medication will be administered as soon as the bed bath is complete.
d. Ask the nursing assistant to find out when the last medication was given to the client.

88. The home health care is formulating a plan of visit to the clients for the day. The nurse is scheduled to visit a client requiring twice daily abdominal dressing changes. Another client to be seen is a client whose spouse is performing daily dressing changes. The nurse is also assigned to admit a client who was discharged yesterday from the hospital following a diagnosis of pneumonia. The last client to be seen will be visited by a home health aide and the nurse needs to orient the aide and provide supervision of client care. The client decided to begin the visit in the morning and clients live within a 5-mile radius. How would the nurse start the assignment for the day?

a. the client requiring admission, the client regarding supervision of the dressing change, client requiring twice daily dressing changes, client being visited by the home health aide, client requiring a second twice daily dressing change
b. client requiring twice daily dressing changes, client being visited by the home health aide, the client regarding supervision of the dressing change, the client requiring admission, the client requiring the second twice daily dressing change

c. client being visited by the home health aide, the client requiring admission, the client regarding supervision of the dressing change client requiring twice daily dressing changes, client requiring second twice daily dressing changes
d. the client being visited by the home health aide, client requiring twice daily dressing changes, the client requiring admission, the client regarding supervision of the dressing change, the client requiring the second twice daily dressing change

89. In a night shift, a nurse was in-charged in the emergency department and is assigned to triage clients arriving to the emergency room for treatment. The nurse would assign highest priority to which of the following clients?

a. client complaining of muscle aches, headache, and malaise
b. client with chest pain who states that he just ate pizza that was made with a very spicy sauce
c. client who twisted her ankle when she fell while rollerblading
d. client with minor laceration on the index finger sustained while cutting an eggplant

90. The nurse on the day shift is scheduled to care for three clients. One client is scheduled for a cardiac catheterization at 10AM; the other has a tracheostomy and is on a mechanical ventilator. And the other client was newly diagnosed with diabetes mellitus and is scheduled for discharged to home. How would the nurse plan the order of care of the clients for the day?

a. a client with diabetes mellitus, client scheduled for a cardiac catheterization, client with tracheostomy
b. a client scheduled for a cardiac catheterization, client with diabetes mellitus and for discharged to home, client with tracheostomy
c. a client with tracheostomy and is on mechanical ventilator, client scheduled for a cardiac catheterization followed by the client with diabetes mellitus scheduled for discharged.
d. A client with tracheostomy and scheduled for cardiac catheterization would at the same time be given the highest priority in the plan of care, client for discharge does not need much attention

91. A registered nurse is delegating a task to the nursing staff. Which among the tasks listed is a least appropriate to the nursing assistant?

a. accompanying a man being discharged to his transportation to home
b. assisting a post cardiac catheterization client who needs to lie flat to eat lunch
c. collecting a urine specimen from a client
d. obtaining frequent oral temperature on a client

92. A nurse has a licensed practical nurse on the nursing team. In planning the client assignments, which client would the nurse most appropriately assign to the LPN?

a. a client who was treated for dehydration and is weak and needs assistance with bathing
b. a client who is scheduled for an electrocardiogram and a chest X-ray
c. a client with stable congestive heart failure who has early stage Alzheimer's disease
d. a client with emphysema who is receiving oxygen at 2L by nasal cannula and becomes dyspneic on exertion

93. A nurse manager conducting a forum with the nursing staff regarding concerns and proposals for actions related to the nursing unit. The nurse manager discusses her/his opinion, own analysis of the problem and proposals for action to team members, and invites each member to comment and provide input. Which style of leadership is the nurse manager specifically employing?

    a. laissez fair
    b. authoritarian
    c. situational
    d. participative

94. A registered nurse assigned the licensed practical nurse to change the colostomy bag on a client. The LPN informed the registered nurse that he/she has no experience in performing the procedure on a client and was afraid he/she might not do it correctly. The appropriate action of the registered nurse is to:

    a. Request that the LPN review the materials from the inservice before performing the procedure
    b. Request that the LPN observes another LPN perform the procedure
    c. Perform the procedure with the LPN
    d. Request that the LPN review the procedure in the hospital manual and bring the written procedure into the client's room for guidance during the procedure

95. A newly nursing graduate is attending an orientation regarding the nursing model of practice implemented in the hospital. The nurse is told that the nursing model is a primary nursing approach. The nurse understands that which of the following is a characteristic of this type of nursing model of practice?

    a. critical paths are used in providing client care
    b. the nurse manager assigns tasks to the staff members
    c. a single registered nurse is responsible for planning and providing individualized nursing care
    d. Nursing staff are led by an RN leader in providing care to a group of clients

96. A nurse manager is providing a lecture for the staff nurses about case management. The nurse manager determines that a review of the material needs to be done if a staff nurse stated that case management:

    a. is designed to promote appropriate use of hospital personnel and material resources
    b. represents a primary health prevention focus managed by a single case manager
    c. manages client care by managing the client care environment
    d. maximizes hospital revenues while providing for optimal outcome of client care

97. A registered nurse is in-charge in preparing the assignments of the nursing staff in the nursing unit for the day. The registered nurse assign a nursing assistant to make beds and bathe one of the clients on the unit and assigns another nursing assistant to fill the water pitchers and serve juice to all of the clients. Another registered nurse in the nursing unit is assigned to administer all medication. Based on the assignments scheduled by the registered nurse, which type of nursing care is being practiced?

    a. primary nursing
    b. team nursing
    c. functional nursing
    d. exemplary model of nursing

98. A hospital administration has implemented a new method in the diatribution of assignments of nurses to nursing units. Nurses will now be required to work in other nursing department and will not be specifically assigned to a nursing unit. A group of registered nurse is resistant to the change and nursing administration anticipates that the nurses will not facilitate the process of change. Which of the following would be the best approach on the part of administration in dealing with the resistance?

    a. manipulate the nurses to participate in the change
    b. ignore the resistance
    c. confront the nurses to encourage verbalization of feelings regarding the change
    d. exert coercion with the nurses

99. A nurse manager is formulating a plan to implement a new method of documentation system in the nursing unit. Many problems have encountered as a result of the present documentation system, and the nurse manager determines that a new system must be used. The initial step in the process of using a new system for the nurse manager is which of the following?

    a. identify potential solutions and strategies for the new system
    b. plan strategies to implement the change
    c. set goals and priorities regarding the change process
    d. identify the inefficiency that needs improvement or correction

100. A nurse in charge observes that the staff nurse is not providing quality care to the client, not able to meet Client's needs in a reasonable time frame, does not solve any problems in the nursing unit and does not prioritize nursing care. Which of the following is the responsibility of the charge nurse?

    a. report the staff nurse to the supervisor so that something is done to resolve the problem
    b. supervise the staff nurse more closely so tasks are completed
    c. provide support and identify the underlying cause of the staff nurse's problems
    d. ask other staff members to help the staff nurse get the work done

**Test II - Maternal and Child Health, Community Health Nursing, Communicable Diseases, Integrated Management of Childhood Illness**

1. A nurse is in the labor room and caring for a client that is believed to be in the beginning of the second stage of labor. Which of the following assessment that will help the nurse to determine that the client is in the right stage of labor?

    a. The cervix is dilated completely
    b. The membranes have ruptured.
    c. The contractions are regular.
    d. The client begins to expel clear vaginal fluid.

2. A client is rushed to the emergency room and directly transferred to the delivery room. On the assessment of the nurse, the client is in active stage of labor. The nurse is assessing the fetal patterns and notes a late deceleration on the monitor strip. The most appropriate nursing action is to:

    a. Place the mother in a supine position.
    b. Increase the rate of the oxytocin (Pitocin) Intravenous infusion.
    c. Administer oxygen via face mask.
    d. Document the findings and continue to monitor the fetal patterns.

3. A client is scheduled for a cesarean delivery. The nurse is completing the assessment on the client. Which assessment finding would indicate a need to call the physician?

    a. Hemoglobin of 11.0 g/dL
    b. Fetal heart rate of 180 beats per minute.
    c. White blood cell count of 12,000 cells/mm3
    d. Maternal pulse rate of 85 beats per minute

4. The nurse in the emergency department prepares the client in labor to be transferred to the delivery room for cesarean delivery. While waiting in for the physician in the delivery room, the nurse places the client in the:

    a. Semi-Fowler's position with a pillow under the knees.
    b. Trendelenburg position with the legs in stirrups.
    c. Prone position with the legs separated and elevated.
    d. Supine position with a wedge under the right hip.

5. On the day before discharge from the hospital, the nurse provides instruction to the client who delivered a healthy baby by cesarean delivery. Which of the following statement if made by the client indicates a need for further instruction?

    a. "I will lift nothing heavier than the newborn infant for at least 2 weeks."
    b. "I will notify the physician if I develop a fever."
    c. "I will turn on my side and push up with my arms to get out of bed."
    d. "I will begin abdominal exercises immediately."

6. A nurse is admitting a pregnant client to the labor room and prepares to auscultate the fetal heart rate by using a Doppler ultrasound device. The nurse most accurately determines tht the fetal heart sounds are heard by:

    a. Noting if the heart rate is greater than 140 beats per minute.
    b. Performing Leopold's maneuvers first to determine the location of the fetal heart rate.

c. Palpating the maternal radial pulse while listening to the fetal heart rate.
d. Placing the diaphragm of the Doppler on the mother's abdomen.

7. The physician ordered oxytocin (Pitocin) by intravenous infusion to a client in labor to stimulate uterine contractions. Which assessment findings would indicate to the nurse that the infusion needs to be discontinues.

    a. A fetal heart rate of 90 beats per minute.
    b. Adequate resting tone of the uterus palpated between contractions.
    c. Three contractions occurring within a 10-minute period.
    d. Increase urinary output.

8. The nurse is caring for a client in labor who will start receiving oxytocin (Pitocin) by intravenous infusion. The nurse ensures that which of the following is implemented before initiating the infusion?

    a. Placing a code cart at the client's bedside
    b. An intravenous infusion of antibiotics
    c. Continuous electronic fetal monitoring
    d. Placing the client on complete bed rest

9. The nurse is caring for a client in active labor. The nurse is performing fetal monitoring and notes that the fetal heart rate between contractions is 100 beats per minute. And the client is having contraction every 3 minutes that last 45 seconds. Which of the following nursing actions is most appropriate?

    a. Notify the physician or nurse-midwife.
    b. Continue monitoring the fetal heart rate.
    c. Encourage the client to continue pushing each contraction.
    d. Encourage the client's coach to continue to encourage breathing techniques.

10. A nurse is caring to a client admitted in the labor room. The nurse performs an assessment and monitors the fetal heart rate patterns. The nurse notes the presence of episodic accelerations on the electronic fetal monitor tracing. Which of the following actions is most appropriate?

    a. Document the findings and tell the mother that the monitor indicates fetal well-being.
    b. Notify the physician or nurse-midwife of the findings.
    c. Reposition the mother and check the monitor for changes in the fetal tracing.
    d. Take the mother's vital signs and tell the mother that bed rest is required to conserve oxygen.

11. A client is rushed to the labor room. The nurse in charge is monitoring a client with dysfunctional labor for signs of fetal or maternal compromise. Which of the following assessment findings would alert the nurse to a compromise?

    a. Maternal fatigue
    b. Progressive changes in the cervix
    c. Persistent non-reassuring fetal heart rate
    d. Coordinated uterine contractions

12. A nurse is assigned to car for a client with hypotonic uterine dysfunction and signs of a slowing labor. The nurse is reviewing the client's chart and checks the physician's orders and would expect to note which of the following prescribed treatments for this condition?

a. Increased hydration
b. Oxytocin (Pitocin) infusion
c. Medication that will provide sedation
d. Administration of a tocolytic medication

13. The client labor with hypertonic uterine dysfunction is transferred from emergency room to labor room. The nurse is preparing to care for the client and found out that the client is experiencing uncoordinated contractions that are erratic in their frequency, duration, and intensity. The priority nursing intervention in caring for the client is to:

    a. Provide pain relief measures.
    b. Prepare the client for an amniotomy.
    c. Promote ambulation every 30 minutes.
    d. Monitor the oxytocin (Pitocin) infusion closely.

14. A nurse is providing emergency measure to a client in labor who has been diagnosed with a prolapsed cord. The client becomes frightened and tells the nurse, “Why are all of these people in here? Is my baby is going to be all right? ” Which of the following nursing diagnoses would be most appropriate for this client at this time?

    a. Fatigue
    b. Fear
    c. Powerlessness
    d. Ineffective Coping

15. A nurse formulated a plan of care for a client experiencing dystocia and includes several nursing intervention in the plan of care. The nurse emphasizes the plan of car and selects which of the following nursing interventions as the highest priority?

    a. Providing comfort measures
    b. Monitoring the fetal heart rate
    c. Changing the client’s position frequently
    d. Keeping the significant other informed of the progress of the labor

16. The maternity nurse is assigned to care for a pregnant client in labor who will be delivering twins. The nurse monitors the fetal heart rates by placing the external fetal monitor:

    a. Over the fetus that is most anterior to the mother’s abdomen.
    b. Over the fetus that is most posterior to the mother’s abdomen.
    c. So that the fetus is monitored for a 15-minute period followed by a 15-minute fetal monitoring period for the second fetus.
    d. So that each fetal heart rate is monitored separately.

17. A nurse is developing a plan of care for a client who just delivered a live but weak baby. After an hour the baby died. The most appropriate initial intervention in planning to meet the emotional needs of the client and her spouse is which of the following?

    a. Allow the family members to name the baby.
    b. Allow the client and the spouse to hold the baby.
    c. Assess the client and the spouse’s perception of the event.
    d. Encourage the client to talk about the dead fetus.

18. A client who just delivered a newborn infant following a pregnancy with a placenta previa is in the postpartum unit. The nurse is assigned to care for the client. The nurse reviews

the plan of care and prepares to monitor the client for which of the following risks associated with placenta previa?

a. Infection
b. Hemorrhage
c. Chronic Hypertension
d. Disseminated intravascular coagulation

19. A nurse is assisting the physician with the delivery of a newborn infant. Following the delivery of the newborn, the nurse assists in delivering the placenta. Which observation would indicate that the placenta has separated from the uterine wall and is ready for delivery?

a. A soft and boggy uterus
b. Changes in the shape of the uterus
c. Maternal complaints of severe uterine cramping
d. The umbilical shortens in length and changes in color.

20. A nurse is caring for a client admitted in the labor room. The nurse is completing an assessment on a pregnant client in labor. The nurse notes the presence of the umbilical cord protruding from the vagina. Which of the following would be the initial nursing action?

a. Place the client in Trendelenburg position.
b. Gently push the cord into the vagina.
c. Find the closest telephone and stat page the physician.
d. Call the delivery room to notify the staff that the client will be transported immediately.

21. A nurse is assigned to care to a client who just delivered a healthy newborn infant. The nurse is aware that in the immediate postpartum period it is necessary to monitor the client's vital signs:

a. Every 15 minutes during the first hour and then every 30 minutes for the next 2 hours.
b. Every 30 minutes during the first hour and then every hour for the next 2 hours.
c. Every hour for the first 2 hours and then every 4 hours.
d. Every 5 minutes for the first 30 minutes and then every hour for the next 4 hours.

22. The client delivered a healthy newborn infant four hours ago. The postpartum nurse is taking the vital signs of the client. The nurse notes that the client's temperature is 100.2 degrees Fahrenheit. Which of the following actions would be the most appropriate?

a. Notify the physician.
b. Document the findings.
c. Retake the temperature in 15 minutes.
d. Increase hydration by encouraging oral fluids.

23. A nurse is monitoring a client who is 6 hours postpartum following a delivery of a full-term healthy newborn infant. While making assessment on the, the client complains to he nurse of feelings of faintness and dizziness. Which of the following nursing actions would be most appropriate?

a. Obtain hemoglobin and hematocrit levels
b. Instruct the mother to request help when getting out of bed

c. Inform the nursery room nurse to avoid bringing the newborn infant to the mother until the feelings of light-headedness and dizziness have subsided.
d. Elevate the mother's legs

24. The nurse is performing a fundal assessment on a postpartum client. Which of the following is the initial nursing action in performing a fundal assessment?

    a. Ask the mother to urinate and empty her bladder
    b. Ask the client to lie flat on her back with the knees and legs flat and straight
    c. Massage the fundus gently before determining the level of the fundus
    d. Ask the client to lie on her side

25. The nurse is assigned to monitor the condition of a 1 day postpartum client in the postpartum room. The nurse notes that the lochia discharge of the client is red and has a foul-smelling odor. The nurse determines that this assessment findings is:

    a. Indicates the presence of infection
    b. Normal
    c. Indicates the need for increasing oral fluids
    d. Indicates the need for increasing ambulation

26. The postpartum nurse is performing an assessment on a client; a nurse notes the presence of clots in the lochia. The nurse closely checks and examines the clots and notes that the clots are larger than 1 cm. Which of the following nursing actions is most appropriate?

    a. Notify the physician
    b. Document the findings
    c. Encourage increased oral intake of fluids
    d. Reassess the client in 2 hours

27. The nurse is conducting a health teaching regarding lochia and the amount of expected lochia drainage to the clients in the postpartum unit. The nurse instruct the mothers that the normal amount of lochia may vary but should never exceed the need for:

    a. Three peripads a day
    b. Eight peripads a day
    c. One peripads a day
    d. Two peripads a day

28. A nurse is performing and assessment and giving instruction to a mother who is preparing to breast-feed the infant. Which of the following breast assessment findings would the nurse determine to be the most effective for breast-feeding?

    a. Erectile nipples.
    b. Flat nipples.
    c. Inverted nipples.
    d. Nipples that are level with the skin surface.

29. A woman has delivered a healthy newborn infant. The nurse is aware that she needs to provide instructions regarding bowel elimination. The nurse instruct the mother that she should expect normal bowel elimination to return:

    a. 3 days postpartum.
    b. 7 days postpartum.
    c. On the day of delivery.

d. Within 2 weeks postpartum.

30. A nurse assigned a nursing student to perform a cardiovascular assessment on a postpartum woman. The nurse asks the student about the procedure to elicit Homan's sign. Which response by the nursing student would indicate an understanding of this assessment technique?

    a. "I will ask the woman to raise the legs up to the waist and then lower the legs slowly."
    b. "I will ask the woman to raise the legs and to try to lower them against pressure from my hand."
    c. "I will ask the woman to extend the legs flat on the bed, and I will grasp the foot and sharply extend it backward."
    d. "I will ask the woman to extend her legs flat on the bed, and I will grasp the foot and gently dorsiflex it forward."

31. A client who has received an epidural anesthesia is assigned is transferred to a postpartum unit and a nurse is assigned to monitor for the presence of vulvar hematoma of the client. Which finding would best indicate the presence of hematoma?

    a. Changes in vital signs
    b. Complaints of intense pain
    c. Complaints of tearing sensation
    d. Signs of heavy bruising

32. The nurse is assigned to care for a postpartum client with a small vulvar hematoma. In developing a plan of care, the nurse includes which specific interventions in the plan during the first 12 hours after giving birth to a healthy newborn infant?

    a. Assess vital signs every 4 hours.
    b. Measure fundal height every 4 hours.
    c. Prepare an ice pack for application to the area.
    d. Inform health care provider of assessment findings.

33. The client received epidural anesthesia during labor and had a forceps delivery after pushing for 2 hours. At 6 hours postpartum, her Blood pressure decreased 20 points in systolic BP and 10 points in diastolic BP, her pulse is 120 beats per minute and the client appears to be anxious and restless. On further assessment, a vulvar hematoma is verified. After notifying the physician, the nurse immediately plans to:

    a. Reassure the client.
    b. Monitor fundal height.
    c. Prepare the client for surgery.
    d. Apply perineal pressure.

34. Following surgical evacuation and repair of a paravaginal hematoma, the mother is discharged 4 days postpartum. A nurse is aware that the new mother needs further discharge instructions when she states that:

    a. "The only medication I will take are prenatal vitamins and stool softeners."
    b. "My husband and I will not have intercourse until the stitches are healed."
    c. "I will probably need my mother to help me with housekeeping"
    d. "Because I am so sore, I will nurse the baby while lying on my side."

35. A nurse is caring for a post partum client and monitoring for signs of bleeding. Which of the following signs, if noted in the mother, would be an early sign of excessive blood loss?

    a. a temperature of 100.4 degree Fahrenheit
    b. a BP change from 130/88 to 124/80 mmHg
    c. an increase in the respiratory rate from 18 to 22 breaths per minute
    d. an increase in the pulse rate from 88 to 102 beats per minute

36. A nurse is assessing the uterine fundus of a client in the immediate postpartum period. When the nurse feels the fundus of the client, she notes that the uterus feels soft and boggy. Which of the following nursing interventions would be most appropriate initially?

    a. elevate the mother's legs
    b. massage the fundus until it is firm
    c. encourage the mother to void
    d. push on the uterus to assist in expressing clots

37. A postpartum nurse is assessing a client who gave birth to a healthy newborn infant by cesarean section. The nurse is monitoring the client for sign and symptoms of superficial venous thrombosis. Which of the following signs of symptoms would the nurse note if superficial venous thrombosis were present?

    a. paleness of the calf area
    b. coolness of the calf area
    c. palpable dorsalis Pedis pulses
    d. enlarged, hardened veins

38. A nurse is caring for a postpartum client who was diagnosed with superficial venous thrombosis. In preparing a plan of care, which of the following interventions would be a component of the plan of care?

    a. elevation of the affected extremity
    b. application of the ice packs to the affected area
    c. ambulation 4-6 times daily
    d. administration of prescribed anticoagulants

39. A client in a postpartum unit tells the nurse in charge that she feels sudden sharp chest pain. The nurse notes that the client is tachycardic and the respiratory rate is increasing. The nurse suspects a pulmonary embolism. The initial nursing action would be which of the following.

    a. initiate an intravenous line
    b. assess the clients blood pressure
    c. prepare to administer morphine sulfate
    d. administer oxygen at 8-10 L/minute by face mask

40. A nurse is teaching a mother who has been diagnosed with mastitis. Which of the following statements if made by the client indicates a need for further teaching?

    a. " I need to stop breast feeding until this condition resolves"
    b. " I need to wear a supportive bra to relieve the discomfort"
    c. "I need to take antibiotics, and I should begin to feel better in 24-48 hours"
    d. "I can use analgesics to assess in alleviating some of the discomfort

41. The physician assigned a postpartum nurse to monitor the postpartum client in the fourth stage of labor. Which of the following findings the nurse will not that would indicate a complications related to a laceration of the birth canal?

    a. The presence of dark red lochia
    b. Palpation of the fundus at the level of the umbilicus
    c. The saturation of more than 1 peripads per hour
    d. The palpation of the uterus as a firm contracted ball

42. The client is recovering in the postpartum unit from a cesarean delivery. The nurse is aware that the client is at risk of thrombophlebitis. In preparing a plan of care, the nurse would give priority in preventing thrombophlebitis and the nurse would encourage the woman to:

    a. Elevate the legs
    b. Ambulate frequently
    c. Remain on bedrest
    d. Apply warm moist packs to the legs

43. The post partum client is suffering from deep venous thrombophlebitis. The nurse would anticipate that the client's response to treatment will be evaluated by regularly assessing the client for:

    a. Hematuria, ecchymosis, vertigo
    b. Hematuria, ecchymosis, epistaxis
    c. Epistaxis, hematuria, dysuria
    d. Dysuria, ecchymosis, vertigo

44. The nurse is caring for a post partum client with femoral thrombophlebitis. On further assessment, the nurse found out that the client has developed a pulmonary embolism. The nurse is aware that the immediate nursing action would be:

    a. Monitor vital signs
    b. Initiate an intravenous line if one is not already in place
    c. Elevate the head of the bed to 30-45 degrees
    d. Administer oxygen by face mask at 8-10 L/min

45. A nurse is completing the assessment to a client who is 4 hours postpartum. Following assessment, the nurse notes that the client has cool, clammy skin and observed that the client is also restless and excessively thirsty. The nurse prepares immediately to:

    a. Begin hourly pad counts and reassure the client
    b. Begin fundal massage and start oxygen by mask
    c. Elevate the head of the bed and assess vital signs
    d. Assess for hypovolemia and notify the healthcare provider

46. The nurse checks the fundus of the client who is in the fourth stage of labor. The nurse notes that the fundus is firm and bleeding is excessive. The first nursing action of the nurse would be which of the following?

    a. Notify the physician
    b. Record the findings
    c. Massage the fundus
    d. Place the mother in Trendelenburg position

47. The client visits the clinic after 2 weeks of giving birth to a healthy newborn infant. The client is complaining that she feels as though she has the flu and complains of fatigue and aching muscles. On further assessment of the clinic nurse, the nurse found out a localized area of redness on the left breast and the mother was diagnosed with mastitis. The mother wishes to know about the condition. The most appropriate nursing response to the client is which of the following?

    a. “The infection usually is caused by wearing a supportive bra”
    b. “The infection usually involves both breast”
    c. “The infection can occur at anytime during breast feeding”
    d. “The infection is most common for women who have breast fed in the past”

48. The nurse is providing an instruction to a new mother who is breast-feeding her newborn infant about measures to prevent postpartum mastitis before the mother is discharge. The nurse wants to assess if the instruction is clear. Which of the following if stated by the mother would indicate a need for further instructions?

    a. “I should breast feed every 2-3 hours”
    b. “I should wash my hands well before breast feeding
    c. “I should change the breast pads frequently”
    d. “I should wash the nipple daily with soap and water

49. The home care nurse is assigned to follow up the client who delivered a healthy newborn infant via normal delivery. An episiotomy was performed, and the client has developed a wound infection at the episiotomy site. The nurse is conducting a health teaching to the mother regarding care related to the infection. Which of the following statement if made by the client would indicate a need for further teaching?

    a. “I need to take antibiotic as prescribed”
    b. “I need to take warm sitz baths to promote healing”
    c. “I need to apply warm compresses to provide comfort”
    d. “I need to isolate the infant for 48 hour after the initiation of the antibiotic”

50. A post partum client with a diagnosis of deep vein thrombosis is receiving a continuous intravenous infusion of heparin sodium. The nurse reviews the laboratory results and wants to know if the client is given an appropriate dose of heparin. Which of the following laboratory results the nurse would check to determine if an effective dose of the heparin is being delivered?

    a. Platelet count
    b. Prothrombin time
    c. International normalized ratio
    d. Activated partial thromboplastin time

51. A school nurse is observing a child. The nurse suspects that the child may have strabismus. Which of the following observations of the nurse might indicate this condition?

    a. The child has difficulty hearing
    b. The child does not respond when spoken to
    c. The child consistently tilts the head to see
    d. The child consistently turns the head to see

52. A mother sought advice of what would be the best solution to her newborn infant diagnosed with strabismus. The physician suggested that surgery will be necessary to

realign the weakened eye muscles. The mother asks the nurse when the surgery might be performed?

a. Immediately
b. Before the child is 2 years old
c. Before the child begins to read
d. Shortly before the child starts school

53. The mother brings her 6-year-old son at the clinic because the child has been experiencing scratch, red and swollen eyes. The nurse gets a sample of the discharge in the eye and sends a culture to the laboratory for analysis. Following the laboratory analysis Chlamydial conjunctivitis is diagnosed. Based on this condition, the nurse determines that which of the following would require further investigation?

a. Possible trauma
b. Possible sexual abuse
c. the presence of an allergy
d. the presence of respiratory infection

54. A nurse is providing an instruction to a mother of a child diagnosed with bacterial conjunctivitis. Which of the following, if stated by the mother, would indicate a need for further instruction?

a. "I need to wash my hands frequently"
b. "It is okay to share towels and washcloths"
c. "I need to clean the eye as prescribed'
d. "I need to give the eye drops as prescribed"

55. The mother of the child who had a myringotomy with insertion of tympanostomy was so worried when the tubes have fallen out. The mother calls the nurse and asks for an immediate action. Which of the following is the most appropriate response of the nurse to the mother?

a. "This is an emergency and requires immediate intervention. Bring the child to the emergency room"
b. "This is NOT an emergency; I will speak to the physician and call you right back"
c. "Place the tubes in hydrogen peroxide for 1 hour before replacing them in the child's ears"\
d. "replace the tube immediately so that the created opening does not close"

56. The physician prescribed an antibiotic to a child after a myringotomy with insertion of tympanostomy tubes. The nurse provides a discharge teaching to the mother regarding to the administration of the antibiotics. Which of the following statement, if made by the mother indicates that the instruction is clearly understood?

a. "Administer the antibiotics if the child has a fever"
b. "Administer the antibiotics until the child feels better"
c. "Begin to taper the antibiotics after 3 days of a whole course"
d. "Administer the antibiotics until they are gone"

57. The mother of a child who underwent a myringotomy with insertion of tympanostomy tubes brings her child to the clinic and tells the nurse that her child is complaining of discomfort. Which of the following is the most appropriate response?

a. "I will speak to the physician so that a narcotic can be prescribed"

b. “You need to speak to the physician because the child should not be having any discomfort”
c. “Give the child children’s aspirin for the discomfort”
d. “Give the child acetaminophen (Tylenol) for the discomfort

58. A nurse caring for a child who underwent a myringotomy with insertion of tympanostomy tube is providing a discharge instruction to the mother. The nurse will know if the instruction is clearly understood or not. Which of the following statement will help the nurse determine if the mother needs additional instruction?

a. to place earplugs with petroleum jelly in the ears during baths and showers
b. to be sure to give her child soft tissue to blow his nose
c. that swimming in deep water is prohibited
d. that swimming in lake water needs to be avoided

59. A nurse is caring for a child that is scheduled for tonsillectomy. The nurse reviews the laboratory results of the child. The nurse determines that which laboratory values is most significant to review?

a. Creatinine
b. Blood urea nitrogen
c. Prothrombin time
d. Sedimentation rate

60. The nurse is developing a plan of care to a child scheduled for a tonsillectomy. A nurse is aware which of the following would present the highest risk of aspiration during surgery.

a. difficulty in swallowing
b. Exudate in the throat area
c. Bleeding during surgery
d. The presence of loose teeth

61. A nurse is caring for an infant with bronchiolitis and underwent several diagnostic tests. The diagnostic tests have confirmed respiratory syncytial virus. Based on the result, which of the following would be the most appropriate nursing action?

a. Initiate strict enteric precaution
b. Move the infant to a room with another child RSV
c. Leave the infant in the present room because RSV is not contagious
d. Inform the staff that they must wear a mask when caring for the child

62. The physician prescribed Ribavirin (Virazole) to a hospitalized child with respiratory syncytial virus. The nurse knows and prepares to administer this drug via which of the following routes?

a. oral
b. Oxygen tent
c. Intramuscular
d. Subcutaneous

63. A 10-year-old child suffering from asthma is admitted to the emergency room. Treatment for acute exacerbation is given. A nurse reports which of the following, knowing that it would be alarming and indicates a worsening of the condition?

a. Warm dry skin
b. A pulse rate of 90 beats per minute

c. Increase wheezing
d. Decrease wheezing

64. The mother of an 8 year old child being treated for right lower lobe pneumonia calls the emergency department and tells the nurse that the child complains of discomfort on the right side and that the prescribed Tylenol is not effective anymore. The nurse most appropriately tells the mother to:

    a. Encourage the client to lie on the left side
    b. Encourage the client to lie on the right side
    c. Increase the dose of acetaminophen
    d. Increase the frequency of the acetaminophen

65. The nurse in the nursery is caring for a newborn infant. A new employee will be assign to the unit and the nurse needs to provide a teaching session regarding sudden infant syndrome to her colleague. The nurse tells the new employee that SIDS usually occurs during sleep and

    a. Most frequently occurs in girls
    b. Most frequently occurs in toddlers
    c. Most frequently occurs during the summer months
    d. Most frequently occurs from 2-4 months of life

66. A new mother is so worried about sudden infant syndrome. She asks the nurse how to position her new infant for sleep. The nurse most appropriately tells the mother that the infant should be place on his:

    a. Back or prone
    b. Side or prone
    c. Stomach with the face turn
    d. Back rather than on the stomach

67. A child with a suspected diagnosis of cystic fibrosis is admitted to the clinic and ordered for a sweat test. The nurse caring for the child reviews the test results and determines that which of the following is a positive result for cystic fibrosis?

    a. Chloride level of 70 mEq/L
    b. Chloride level of 40 mEq/L
    c. Chloride level of 20 mEq/L
    d. Chloride level of 30 mEq/L

68. A clinic nurse is providing instruction to a mother of a child diagnosed with cystic fibrosis regarding the schedule of the immunization for the child. Which of the following instruction would the nurse make to the mother of the child?

    a. “The child should not receive any hepatitis vaccine”
    b. ‘”the child will receive the recommended basic series of immunizations along with a yearly pneumococcus and influenza vaccination”
    c. “The immunization schedule will need to be altered”
    d. “The child will receive all of the immunization except for the polio series

69. A 3-year old child underwent a Mantoux test. The nurse in charge reviews the result of the Mantoux test. The result of the test indicates an area of induration measuring of 10mm. The nurse would interpret these results as:

    a. positive

b. Negative
c. Inconclusive
d. definitive and requiring a repeat test

70. The physician prescribed Isoniazid (INH) to a 2-year old child with human immunodeficiency virus infection who has a positive Mantoux test. The mother of the child asks the nurse how long will her child need to take the prescribed medicine. The nurse informs the mother that the medication will need to be taken for:

a. 6 months
b. 9 months
c. 4 months
d. 12 months

71. A nurse is assigned to care for a client with congenital heart disease. The nurse should closely monitor the child for signs of congestive heart failure. The nurse assess the infant closely for which early sign of CHF?

a. Tachycardia
b. Cough
c. Slow and shallow breathing
d. Pallor

72. A physician has prescribed oxygen administration as needed for an infant with congestive heart failure. The nurse is aware that the oxygen is best administered to the infant during:

a. Changing the infant's diaper
b. Feeding
c. When the mother is holding the infant
d. When drawing blood for electrolyte values

73. A physician ordered a diuretic therapy for an infant with congestive heart failure. A nurse caring for the infant is close monitoring the intake and output. The nurse uses which most appropriate method to measure the urine output?

a. Weighing the diaper
b. Measuring the amount of water added to formula
c. Inserting Foley catheter
d. Comparing intake with output

74. A nurse assigned to care for an infant with congestive heart failure is monitoring the daily weight of the client. Which of the following signs that would alert the nurse to suspect fluid accumulation and the need to call the physician?

a. A weight gain of 1 lb in 1 day
b. Decreased blood pressure
c. Diaphoresis
d. Bradypnea

75. The home health nurse is conducting a home care instruction to the parents of the child with congestive heart failure regarding the procedure for the administration of digoxin (Lanoxin). Which statement if made by the parents indicates the need for further instructions?

a. "If the child vomits after medication administration, I will repeat the dose."
b. "I will not mix the medication with food."

c. “I will take the child’s pulse before administering the medication.”
d. “If more than 1 dose is missed I will call the physician.”

76. A nurse is caring for an infant with a diagnosis of tricuspid atresia. The nurse is to develop a plan of care. The nurse plans care, knowing that in this disorder:

a. No communication exist between the systemic and pulmonary circulation
b. Single vessel overrides both ventricles
c. Frequent episode of hypercyanotic spells occur
d. No communication exist from the right atrium to the right ventricle

77. A physician prescribed Prostaglandin E1 to a child with transposition of the great arteries. The mother of the child is a registered nurse and asks the nurse why the child needs the medication. The most appropriate nursing would be to tell the mother that the medication:

a. Prevents tet spells
b. Maintain inadequate hormonal level
c. Maintains the position of the great arteries
d. Provides adequate oxygen saturation and maintains cardiac output

78. The mother brought her child to the clinic for follow-up visit. The nurse reviews the record of the child. The physician has documented a diagnosis of suspected aortic stenosis. The nurse expects to note documentations of which of the following clinical manifestation specifically found in this disorder?

a. Hyperactivity
b. Pallor
c. Exercise intolerance
d. Gastrointestinal disturbances

79. A nurse has provided home care instruction to the mother of a child who is being discharged after cardiac surgery. Which statement made by the mother of the child indicates a need for additional instructions?

a. “I can apply lotion or powder to the incision if it is itchy”
b. “Large crowd of people need to be avoided”
c. “At least 2 weeks following surgery”
d. “A balance of rest and exercise is important”

80. The admitting office calls the nursing unit and informs the nurse in charge that a child with rheumatic fever will be arriving in the unit for admission. On admission, the nurse prepares to ask the mother of the child which question to elicit assessment information specific to the development of rheumatic fever?

a. “Has the child had nausea or vomiting?”
b. “Did the child have a sore throat or an unexplained fever within the last 2 months?”
c. “Has the child complained of headaches?”
d. “Has the child complained of back pain?”

81. A physician prescribed Acetylsalicylic acid (aspirin) to a child with rheumatic fever. A nurse would doubt and question the order of the physician if there were documented evidence that the child had which of the following?

a. Joint pain
b. Facial edema

c. Viral infection
d. Arthralgia

82. A nurse is assigned to care for a child with a suspected diagnosis of rheumatic fever. The nurse requested to have the copy to the laboratory results. The nurse reviews the result, knowing that which laboratory study would assist in confirming the diagnosis of this disease?

a. Red blood cell count
b. White blood cell count
c. Immunoglobulin
d. ASO titer

83. The nurse is caring for a child with a diagnosis of Kawasaki disease. The mother is so worried and doesn't know how the child got the disease. The mother asks the nurse about the disorder. The nurse would tell the mother of the child that:

a. It is an inflammatory autoimmune disease that affects the connective tissue of the heart, joints and subcutaneous tissue
b. It is an acquired cell mediated immuno deficiency disorder
c. It is also called mucocutaneous lymph node syndrome and is febrile generalized vasculitis of unknown origin
d. It is a chronic multisystem autoimmune disease characterized by the inflammation of connective tissue

84. A child with a diagnosis of acute-stage of Kawasaki disease is admitted. The nurse caring for the child is completing an assessment. On assessment of the child, the nurse expects to note which clinical manifestation of the acute stage of the disease?

a. Cracked lips
b. Conjunctival hyperemia
c. A normal appearance
d. Desquamation of the skin

85. A nurse caring for the child with Kawasaki disease who just admitted to the hospital is reviewing the order of the physician. The nurse expects to note an order which of the following as part of the treatment plan for the child?

a. Immune globulin
b. Heparin infusion
c. Digoxin
d. Morphine sulfate

86. A mother brings her 3-year old child to the emergency room. The child is hospitalized because of persistent vomiting. A nurse in charge will closely monitor the child for:

a. Metabolic acidosis
b. Metabolic alkalosis
c. Diarrhea
d. Hyper active bowel sounds

87. A 12 months old infant has been hospitalized for diarrhea. The nurse caring for the infant is monitoring for signs of dehydration. The nursing student is assigned to take the temperature of the client. The nurse would instruct the student that in taking temperature with the infant suffering from diarrhea to avoid which method of measurement?

a. Axillary
b. Tympanic
c. Electronic
d. Rectal

88. The mother of a child with cleft palate is asking the nurse regarding the proper feeding of her child. The nurse provides instruction to the mother. Which of the following statement if made by the mother indicates a need for additional instruction?

    a. "I will stimulate sucking by rubbing the nipple on the lower lip"
    b. "I will allow the infant time to swallow"
    c. "I will use a nipple with a small hole to prevent choking
    d. "I will allow the infant to rest frequently to provide time swallowing what has been placed in the mouth"

89. An infant underwent a surgical repair of a cleft lip located on the right side of the lip. The infant has return to the nursing unit. The nurse is aware that the infant has just undergone a lip surgery. The nurse places the infant in which most appropriate position?

    a. On the right side
    b. On the left side
    c. Prone
    d. Supine

90. The mother of a child with a diagnosis of esophageal atresia with tracheoesopahgeal fistula brings her child to the clinic. A nurse reviews the record of the infant. And the nurse expects to note which most likely sign of this condition documented in the record?

    a. severe projectile vomiting
    b. Incessant crying
    c. Coughing at night time
    d. Choking with feedings

91. A nurse in charge is conducting a health teaching to the parents of a child with gastroesophageal reflux regarding proper positioning in managing reflux. The nurse emphasizes to the parents that the infant should be maintained in which position after feeding and at night?

    a. 30 degree when supine
    b. 60 degree when supine
    c. 20 degree when supine
    d. Head elevated prone position

92. A nurse is providing a feeding technique to a mother of an infant with a diagnosis of gastroesophageal reflux. To assist in reducing the episodes of emesis, the nurse instructs the mother to:

    a. Provide less frequent, larger feeding
    b. Burp the infant less frequent during feeding
    c. Thin the feedings by adding water to the formula
    d. Thicken the feeding by adding rice cereal to the formula

93. An infant with pyloric stenosis is admitted to the hospital. The nurse in charge is conducting an assessment to the client. On assessment, which data would the nurse expect to obtain when asking the mother about the child's symptoms?

a. Vomiting a large amount of bile
b. Projectile vomiting
c. Watery diarrhea
d. Increased urine output

94. A home care nurse visits the child with lactose intolerance. The nurse provides instruction to the mother about dietary measures suitable to her child. The nurse tells the mother that is necessary to provide which dietary supplement in the child's diet?

a. Calcium
b. Fats
c. Zinc
d. Protein

95. A nurse provides a home care instruction to the parents of a child diagnosed with celiac disease. The nurse teaches the parents of the child to include which of the following food items in the child's diet?

a. Rice
b. Oatmeal
c. Rye toast
d. Wheat bread

96. A physician has just documented on the record of a 3-week old infant a diagnosis of suspected Hirschsprung's disease. The nurse reviews the assessment findings documented in the record, knowing that in which symptom most likely alarmed the mother to seek consultation of her infant?

a. Projectile vomiting
b. Foul smelling ribbon like stools
c. Diarrhea
d. Regurgitation of feedings

97. A nurse is caring for a newborn infant with a suspected diagnosis of imperforate anus. In monitoring the condition of the infant, the nurse notes which of the following is a clinical manifestation associated with this disorder?

a. Sausage shaped mass palpated on the upper right abdominal quadrant
b. Bile stained fecal emesis
c. The passage of currant jelly like stool
d. Failure to pass meconium stool in first 24 hours after birth

98. A child is admitted and diagnosed with intussusception. In preparing to care for a child, the nurse reviews the record and expects to note which symptoms of this disorder documented?

a. Watery diarrhea
b. Ribbon like stool
c. Profuse projectile vomiting
d. Bright red blood and mucus in the stool

99. The physician prescribed Succimer (Chemet) to a child for a treatment of lead poisoning. A nurse in charge monitors which of the following most important laboratory results?

a. Blood urea nitrogen
b. Potassium level

c. Red blood cell count
d. White blood cell count

100. A mother brought her child to the emergency room after the ingestion of about one half bottle of acetylsalicylic acid (aspirin). The nurse in charge in the emergency room anticipates that the most likely first treatment will be:
a. Administration of sodium bicarbonate
b. Dialysis
c. Administration of syrup of ipecac
d. Administration of vitamin K

**Test III - Medical and Surgical Nursing**

1. A client has a family history of prostate cancer. He is worried and he sought consultation regarding this disease. On initial assessment, the nurse is teaching the client to do testicular self-examination. The nurse instructs the client;

    a. That the best time for the examination is after a shower
    b. To examine the testicles while lying down
    c. That testicular examination should be done at least every 6 months
    d. To gently feel the testicle with one finger to feel for a growth

2. The community nurse is assigned to conduct health promotion activities at a local school and is discussing the risk factors associated with cancer. Which of the following, if identified by the client as a risk factors indicates a need for further instructions?

    a. stress
    b. low-fat and high-fiber diets
    c. exposure to radiation
    d. viral factors

3. A client is on chemotherapy for a treatment of cancer. On the assessment of the nurse in charge, he observes that the client develops thrombocytopenia. The nurse identifies which intervention as the highest priority in the nursing care plan?

    a. ambulation 3 times daily
    b. monitoring the platelet counts
    c. monitoring for pathological fractures
    d. monitoring temperature

4. Following laboratory test, the nurse got the laboratory result of the client who will be receiving chemotherapy. The nurse would determine that the white blood cell count is normal if which of the following results were present/

    a. 3000 – 8000 cells/$mm^3$
    b. 5000 – 10,0000 cells/$mm^3$
    c. 7000 – 15,000 cells/$mm^3$
    d. 2000 – 5,000 cells/$mm^3$

5. The community health nurse is promoting cancer awareness program and conducting a lecture on the female clients about breast examination. The nurse would instruct the clients to perform the examination:

    a. 1 week after menstruation begins
    b. Every month during ovulation
    c. At the onset on menstruation period
    d. Weekly at the same time of the day

6. The nurse is caring for a client who has a vaginal hysterectomy 2 days ago. The nurse avoids which of the following in the care of this client?

    a. Checking placement of pneumatic compression boots
    b. Removal of antiembolism stockings twice daily
    c. Elevating the knee gatch on the bed
    d. Assisting with the range-of-motion leg exercises

7. A client comes to the emergency room and is complaining of abdominal discomfort. The client suspected of an ovarian tumor and is scheduled for a pelvic ultrasound. The nurse provides with pre-procedure instruction to the client.

    a. Eat a light breakfast only.
    b. Maintain NPO status before the procedure.
    c. Wear comfortable clothing and shoes for the procedure.
    d. Drink six to eight glasses of water without voiding before the test.

8. The 18 year old male client is diagnosed. Many diagnostic test are prescribed to confirm the diagnosis. The nurse expects which of the following tests will confirm the diagnosis of malignancy?

    a. Abdominal ultrasound
    b. Computerized tomography scan
    c. Magnetic resonance imaging
    d. Biopsy of the tumor

9. A client is complaining of weakness and fatigue. He is admitted and diagnosed with multiple myeloma. The client asks the nurse about the disease. The nurse appropriate response would be:

    a. Altered red blood cell production
    b. Malignant exacerbation in the number of leukocytes
    c. Malignant proliferation of plasma cells and tumor within the bone
    d. Altered production of lymph nodes

10. A nurse is caring for a client with multiple myeloma. In reviewing the laboratory results, which of the following would the nurse expect to note specifically in this disorder?

    a. Decreased blood urea nitrogen
    b. Increased calcium level
    c. Decreased number of plasma cells in the bone marrow
    d. Increased white blood cells

11. The nurse is formulating a care plan for the client diagnosed with multiple myeloma. The nurse would include which priority nursing intervention in the plan of care?

    a. Encouraging fluids
    b. Coughing and deep breathing
    c. Monitoring the red blood cell count
    d. Providing frequent oral care

12. The oncology nurse specialist is conducting an educational session to nursing staff regarding the characteristics of Hodgkin's disease. The nurse determines that further teaching is needed if a nursing staff member states that which of the following is a characteristics of the disease?

    a. Presence of Reed-Sternberg cells
    b. Prognosis depends on the stage of the disease
    c. Involvement of lymph nodes, spleen, and liver
    d. Occurs most often in the older client

13. The community health nurse is assigned to provide a health promotional awareness program regarding testicular cancer to community members. The nurse determines that

further health program needs to be provided if a community member states that which of the following is a sign of testicular cancer?

a. Alopecia
b. Heavy sensation in the scrotum
c. Painless testicular swelling
d. Back pain

14. The nurse is monitoring the health condition of the client with cancer of the larynx. The client is receiving external radiation to the neck. The most likely side effects to be expected is
    a. Dyspnea.
    b. Constipation.
    c. Diarrhea.
    d. Sore throat.

15. The nurse is caring for a client with an internal radiation implant. The nurse should observe which of the following principles?

    a. Individuals less than 16 years old may be allowed to go in the room as long as they are 6 feet away from the client.
    b. Limit the time with the client to 1 hour per shift.
    c. Do not allow pregnant women into the client's room.
    d. Remove dosimeter badge when entering the client's room.

16. A client with cervical cancer sought advice for treatment. A cervical radiation implant is placed in the client. The nurse initiates what most appropriate activity order for this client?

    a. Bed rest
    b. Out of bed ad lib
    c. Out of bed in a chair only
    d. Ambulate to the bathroom only

17. The client is admitted for insertion of an internal cervical radiation implant. While giving care, the nurse finds the radiation implant in the bed. The initial action of the nurse is to:

    a. Call the physician.
    b. Pick up the implant with long handled forceps and place it in a lead container.
    c. Reinsert the implant into the vagina immediately.
    d. Pick up the implant with gloved hands and flush it down the toilet.

18. A client is on chemo therapy and develops hematologic toxicity. The nurse formulates a care plan for the client. The nurse plans to

    a. Restrict fluid intake.
    b. Restrict all visitors.
    c. Insert an indwelling urinary catheter to prevent skin breakdown.
    d. Restrict fresh fruits and vegetables in the diet.

19. The nurse is monitoring the laboratory results of a client receiving chemotherapy. The platelet count is 10,000 cells/mm3. Based on the laboratory value the priority nursing assessment is which of the following?

    a. Assess skin turgor.
    b. Assess level of consciousness.
    c. Assess temperature.

d. Assess bowel sounds.

20. The home health care nurse visits a client with cancer. The client is complaining of pain. The most appropriate nursing assessment of the client's pain would include which of the following?

    a. The client's pain rating
    b. Nonverbal cues from the client
    c. The nurse's impression of the client's pain
    d. Pain relief after appropriate nursing intervention

21. Following a traumatic accident, a client is admitted to the emergency room with a blood pressure of 100/60 and the physician suspects of ruptured spleen. The nurse should assess the client for an early sign of decreased arterial pressure such as:

    a. warm, flushed skin
    b. weak radial pulse
    c. increased pulse pressure
    d. lethargy with confusion

22. The client is receiving oxygen by nasal cannula. The nurse plans to use safety precautions in the room because oxygen:

    a. converts to an alternate form of matter
    b. is flammable
    c. supports combustion
    d. has unstable properties

23. A client is complaining of chest ache, the physician ordered electrocardiogram for the client. An early finding in the lead over an infarcted area would be:

    a. Elevated ST segment
    b. Elevated T waves
    c. Disappearance of Q waves
    d. Absence of P waves

24. Bed rest is advised to a post operative client who has pulmonary embolus. The client asks why all activities are restricted. The nurse's best response is based on the principle of bed rest:

    a. Enhances the peripheral circulation deep vessels
    b. Presents further platelet aggregation
    c. Maximizes the amount of blood available to damage tissue
    d. Decreases the potential for further dislodgement of emboli

25. A nurse is developing a plan of care for a client who has had a cardiac catheterization, which of the following would the nurse include?

    a. keeping the client NPO for 4 hours after the procedure
    b. ambulating the client 2 hours after the procedure
    c. maintaining the supine position for a minimum of 4 hours
    d. checking the vital signs every 15 minutes for 8 hours

26. For the first several hour following a cardiac catheterization, it would be important for the nurse to:

a. keep the head of the client's bed elevated 45 degrees
b. monitor the clients apical pulse and blood pressure frequently
c. encourage the client to cough and deep breathing every 2 hours
d. check the client's temperature every hour until returns to normal

27. A 58 year old housewife has a history of angina. She is scheduled for a cardiac catheterization. The catheter entry will be through the femoral area. The nurse should instruct the client that she will:

a. Experience a feeling of warmth during procedure
b. Have to remain in the semi-fowler's position for 12 hours after the procedure
c. Be able to ambulate shortly after the procedure
d. Be fully alert and awake during the procedure

28. The nurse is completing an assessment to a 60 year old client with angina. The nurse understand that the most common characteristic of angina pain is that it is:

a. precipitated by light activity
b. described as sharp or knifelike
c. unchanged by rest
d. relieved by sublingual nitroglycerin

29. A male client who is hospitalized after a myocardial infarction asks the nurse the reason why he needs to take morphine. The appropriate response of the nurse would be that morphine:

a. decreases anxiety and restlessness
b. helps present fibrillation of the heart
c. dilates coronary blood vessels
d. relieves pain and presents shock

30. The client had an emergency coronary artery bypass surgery. The wife of the client ask the nurse about the purpose of the dressing on the left leg of her husband, the nurse best explain to the client's wife that:

a. the arteries in distal extremities are examined during surgery
b. This is the access site for the heart-lung machine
c. A filter is inserted in the leg to prevent embolization
d. The saphenous vein was used to bypass the coronary artery

31. A football coach is admitted to the coronary care unit and complains of chest pain that fells like a pressure or weight on the chest. The client also states, "I feel nauseated and very weak". The nurse should:

a. explore and then discuss possible sources of stress
b. perform a nutritional assessment
c. provide reassurances while helping the client
d. summon medical help for a potential emergency

32. A client with a family history of atherosclerosis is advised to follow a diet. To help reduce a client's risk factors for heart disease, the nurse, when discussing dietary guidelines, should teach the client to:

a. decrease the amount of fat binding fiber
b. avoid eating between meals
c. increase the ration of complex carbohydrates

d. limit the amount of unsaturated fat

33. A client returns from a cardiac catheterization and is to remain in the supine position for six hours with the affected leg straight. The nurse is completing the assessment when the client complains of tingling sensations in the affected leg. The nurse should first:

    a. assess for bleeding at the catheter insertion site
    b. compare the femoral, popliteal and pedal pulse in both legs
    c. evaluate the affected leg for heat, edema, and pain
    d. obtain the temperature, pulse, respirations and blood pressure

34. A female client tells the nurse that the physician just told her that she will be receiving a 2 gram sodium-restricted diet. The nurse is aware that the foods lowest in sodium is:

    a. meat and fish
    b. fruit and juice
    c. milk and cheese
    d. dry cereals and grains

35. A client returns to his room following heart surgery. The nurse is aware that Thrombus formation is a danger of all postoperative clients. The nurse should act independently to prevent this complication by:

    a. massaging the client's extremities gently with lotion
    b. assisting the client to exercise in bed
    c. urging the client to drink adequate fluids
    d. massaging the client's extremities

36. A machine operator is brought to the emergency department by co-worker and is admitted with a possible Myocardial Infarction. The client complains of severe chest pain and appears diaphoretic and his pulse rate is 110 beats per minute. The nurse should immediately;

    a. take a 12-lead electrocardiogram
    b. notify the physician and administer the morphine
    c. Increase the oxygen flow
    d. Administer nitroglycerin until the pain subsides

37. A nurse is monitoring for sign and symptoms of a hypertensive client. An early finding that would indicate that a client is hypertensive is:

    a. an achy, throbbing headache over the left eye when arising in the morning
    b. an extended Korotkoff's sound
    c. a regular pulse of 92 beats/minute
    d. a diastolic blood pressure that remains greater than 90 mmHg

38. A 72-year old retired school teacher has a right upper lobectomy and scheduled for the removal of cancerous lesions. Following surgery, the nurse is tasks to monitor the client for the most life-threatening complication, which would be?

    a. hemothorax due to decrease mediastinal shift
    b. dyspnea due to increased intrathoracic pressure
    c. decreased cardiac output due to mediastinal shift
    d. pneumothorax due to increased abdominal pressure

39. A client with myocardial infarction is admitted to cardiac care unit. The physician ordered for Isoenzyme laboratory studies for the client. The must reliable early indicator of MI would be:

    a. AST
    b. Myoglobin
    c. Troponin T and I
    d. CK-MB and CPK totals

40. A newly admitted client with an acute myocardial infarction asks the nurse what are the complications accompany this disease. The question of the client makes the nurse is aware that there is a possibility of death from complications. The nurse should monitor the client during the first 48 hours is:

    a. failure of the Right ventricle
    b. pulmonary edema
    c. ventricular tachycardia
    d. pulmonary embolism

41. The client will be scheduled for a modified radical mastectomy. The family decides to donate blood if incase blood transfusion will be needed. The client has a type A negative blood. Blood could be used from family members whose blood is:

    a. Type O positive
    b. Type AB negative
    c. Type A or O negative
    d. Type A or AB negative

42. A female client is admitted due to extreme bleeding. The nurse checks the client and suspected to be in hypovolemic shock and the laboratory results has a hematocrit value of 25%. The nurse should anticipate that the physician will order:

    a. Ringer's lactate
    b. Blood pressure
    c. Serum albumin
    d. High molecular dextran

43. While the blood transfusion is on-going, the client complains of lumbar pain. The nurse stops the transfusion. What would be the next nursing intervention the nurse should do?

    a. notify the physician
    b. assess the pain further
    c. obtain the vital signs
    d. increase the flow of normal saline

44. A client comes to the emergency room with hematemesis. The physician orders a 2 units of blood to be infused into a client. When administering blood the priority nursing intervention would be to:

    a. use an infusion pump to increase accuracy of infusion
    b. infuse blood at slow rate during 5 – 10 minutes
    c. warm the blood to body temperature to prevent chills
    d. draw blood samples from the client after each unit is transferred

45. Following an abdominal surgery, the client develops internal hemorrhage, The nurse performs further assessment, the nurse should expect the client to exhibit:

a. Polyuria
b. Hypertension
c. Bradypnea
d. Tachycardia

46. A farmer has been admitted with a diagnosis of acute lymphoblastic leukemia. The physician scheduled the client for chemotherapy. The nurse should monitor the client for the development of life-threatening thrombocytopenia, the nurse should monitor the client for:

    a. fever
    b. headache
    c. hematuria
    d. diarrhea

47. A client who has had bone pairs of insidious onset for 4 months is suspected of having multiple myeloma. The nurse understands that the most definite test to confirm a diagnosis of multiple myeloma is:

    a. serum test for hypercalcemia
    b. bone marrow biopsy
    c. x-ray films of the ribs, spine and skull
    d. urine test for Bence-Jones protein

48. On admission, a client has been diagnosed of leukemia. The physician ordered a bone marrow aspiration. Immediately after the procedure, the nurse should:

    a. monitor the vital signs every hour for 4 hours
    b. swab the site with an antiseptic solution
    c. apply brief pressure to the site
    d. ask the client to lie on the affected side

49. A client is suspected of having pernicious anemia, schilling test is ordered by the physician. The nurse is aware that the primary purpose of the schilling test is to determine the client's ability to:

    a. store vitamin B12
    b. produce vitamin B12
    c. digest vitamin B12
    d. absorb vitamin B12

50. A client diagnosed with multiple myeloma asks the nurse how the disease may progress. In providing information to this client, the nurse should discuss the possibility that:

    a. Intravenous therapy may be administered at home
    b. Blood Transfusion may be necessary
    c. The disease is exacerbated by exposure to ultra violet rays
    d. Frequent Urinary Tract Infection may result

51. A client is transferred from the operating room following thyroidectomy. Postoperatively, the nurse should understand that with this surgery, priority intervention should be:

    a. elevate the client's head to limit edema of the neck
    b. assess the client's level of consciousness to determine recovery from anesthesia
    c. encourage the client to cough and deep breathe to prevent atelectasis

d. monitor the client's intake and output to assess for fluid overload

52. After a client has a thyroidectomy, the nurse should observe the client for possible complications. During early post operative period, the observation that has the highest priority would be:

    a. hemorrhage
    b. thyrotoxic crisis
    c. hypocalcemic tetany
    d. airway obstruction

53. 3 days after the subtotal thyroidectomy for a tumor, the client complains of a "funny, jittery feeling". On the basis of this statement, the nurse's best action would be to:

    a. take the vital signs and place the client in a high fowler's position
    b. test for Chvostek's and Trousseau's sign and notify the physician and the complaints
    c. explain that this type of reaction is expected after thyroid surgery
    d. request STAT serum calcium and phosphorus level and chart the results

54. A client returns from the operating room after thyroidectomy. When planning care for a client in the first 24 hours after thyroidectomy, the nursing action should be given highest priority is:

    a. checking the back and sides of the operative dressing
    b. encouraging the client to ventilate feelings about the surgery
    c. supporting the head during mild range-of-motion exercises
    d. advising the client that regular activities can be resumed immediately

55. When preparing a client for discharge after a thyroidectomy, the nurse should teach a client to observe for sign of hyperthyroidism. The nurse would be aware that the client understands the teaching when the client says, " I should call my physician if I develop:

    a. tachycardia and an increase in weight
    b. fatigue and an increased pulse rate
    c. muscle cramping and sluggishness
    d. dry hair and an intolerance to cold

56. Immediately after a thyroidectomy, the nurse is monitoring the client for thyrotoxic, which would be evidenced by:

    a. an increase temperature and pulse rate
    b. a decrease blood pressure
    c. an increase pulse deficit
    d. a decrease heart rate and respiration

57. The nurse is aware that the nursing diagnosis with least significance for patients with pulmonary embolism is:

    a. altered pattern of breathing related to dyspnea.
    b. impaired gas exchange related to decreased diffusion.
    c. pain related to pleural irritation.
    d. anxiety related to hypoxia.

58. A client visits the clinic because of concerns about insomia and recent weight loss. A tentative diagnosis of hyperthyroidism is made. When assessing a client, The nurse would expect to find a history of:

    a. menorrhagia
    b. sensitivity to cold
    c. diaphoresis
    d. dry, brittle hair

59. When planning for a client's return from the room after a subtotal thyroidectomy, the nurse would know that with this surgery:

    a. small part of the gland is left intact
    b. the entire thyroid gland is removed
    c. One portion of the thyroid and 4 parathyroid are removed
    d. One parathyroid gland is also removed

60. An older client is admitted for hypertension and serum electrolytes studies have abnormal results. The physician scheduled the client for an Aldosteronoma scan. The nurse recognizes that this scan is ordered to rule out disease of the:

    a. Adrenal cortex
    b. Pituitary gland
    c. Kidney cortex
    d. Thyroid gland

61. A 24-year old graduate student recently diagnosed with Type I diabetes. The nurse is obtaining a health history form the client. The nurse should expect the client to mention symptoms associated with classis signs of diabetes such as:

    a. Polydipsia, Polyuria, irritability
    b. Polydipsia, polyphagia, frequent urination
    c. Polydipsia, polyphagia, nocturia
    d. Polyphagia, diaphoresis, Polyuria

62. A young adolescent recently diagnosed with Type I diabetes, when obtaining history, the nurse would expect to identify the presence of:

    a. edema
    b. anorexia
    c. weight loss
    d. hypoglycemic episode

63. A 25 year-old gym instructor has been complaining of feeling tired and comes to the clinic for check-up. The client is diagnosed Type I diabetes. The nurse explains that the increase fatigue is the result of:

    a. decrease glucose secretion into the renal tubules
    b. increase the client cellular level
    c. decrease production of insulin by the pancreas
    d. increase glucose absorption from the intestines

64. An obese client with type 2 diabetes is taking one oral tablet a day. The client asks the nurse if he needs to take an extra pill if he will be engaged in exercise.

    a. "You will need to decrease your exercise

b. “You diet and needs will not be affected by exercise
c. “ No, but observe for signs of hypoglycemia while exercising
d. “An extra pill will help your body use glucose correctly

65. A client newly diagnosed as having Type I diabetes. The nurse explain to the client that self-monitoring of blood glucose is preferred to urine glucose testing because it is:

    a. easier to perform
    b. more accurate
    c. not influence by drainage
    d. done by the client

66. A nurse is conducting a health teaching to a client with Type 2 diabetes. The nurse asks the client to explain how to provide self care to prevent infection of the feet. The nurse recognizes that the teaching is effective when the client states: “I should….

    a. Apply heat intermittently to any feet or legs”
    b. Massage my feet and legs with oil or lotion”
    c. Control my diabetes through diet, exercise, and medication
    d. Eat foods high in protein and carbohydrates and calories

67. A 62-year old client is admitted and diagnosed with an aldosterone secreting adenoma. The client is scheduled for a surgery to remove the tumor. The client asks the nurse what will happen if she refuses for surgery. The nurse would base her response on the fact that:

    a. chemotherapy is as reliable as surgery to treat adenomas of this type
    b. the tumor must be removed to prevent heart and kidney damage
    c. surgery will prevent the tumor from metastasizing the other organs
    d. Radiation therapy can be just as effective as surgery if the tumor is small

68. A client with diabetic ketoacidosis who is receiving IV fluids and insulin complains of tingling and numbness of the fingers and toes and shortness of breath. U wave appears in the cardiac monitor. The nurse should recognize that these symptoms indicate:

    a. hypoglycemia
    b. hypokalemia
    c. hyponatremia
    d. hypercalcemia

69. A 20-year old male client is recently diagnosed with type 2 diabetes. A priority teaching goal of the nurse would be, “ the client will be able to:

    a. administer insulin as ordered”
    b. perform foot care daily”
    c. identify signs of hypoglycemia/hyperglycemia
    d. test urine for sugar and glucose

70. A client who has a cancer of the pancreas is admitted to the hospital for surgery. The surgery includes the removal of the stomach, the head of the pancreas, the distal end of the duodenum, the spleen. Following surgery, the nurse must be aware which manifestation by the client that requires immediate attention?

    a. weight loss
    b. hyperglycemia
    c. jaundice

d. indigestion

71. A 30 year old famous singer is admitted to the hospital and is scheduled for surgery. The client refuses ablation therapy. Surgery is the last resort of the physician for the treatment of the disease. While waiting for the surgical date, the nurse should plan to instruct the client to:

    a. schedule activities during the day
    b. eliminate coffee, tea and cola from the diet
    c. consciously attempt to calm down
    d. keep the home warm and use an extra blanket at night

72. A nurse is caring for a client with suspected pheochromocytoma. The client will be scheduled for adrenalectomy once the diagnosis is confirmed. The nurse collects urine specimens for catecholamine testing form a client. The results of the catecholamine test are reported as 20 mcg/ 100ml urine. The nurse analyzes these results as:

    a. normal
    b. insignificant and unrelated to pheochromocytoma
    c. higher than normal, indicating pheochromocytoma
    d. lower than normal, ruling out pheochromocytoma

73. A nurse is completing an assessment on an older client who is being admitted for a diagnosis of hyperparathyroidism. A physician gave an order of Calcitonin salmon (Calcimar). A nurse develops a plan of care for this client. Which of the following outcome criteria has the highest priority regarding this medication?

    a. achievement of normal serum calcium level
    b. absence of side effects
    c. relief of pain
    d. verbalization of appropriate medication knowledge

74. A nurse is caring for a client with pheochromocytoma. The client is scheduled for adrenalectomy. As part of the nursing care plan, the nurse must monitor for hypertensive crisis. In the event that hypertensive crisis occurs, the nurse would expect that the physician would prescribe which of the following medication?

    a. Propranolol (Inderal)
    b. Phentolamine mesylate (Regitine)
    c. Phenoxybenzamine hydrochloride (Dibenzyline)
    d. Prazosin hydrochloride (Minipress)

75. A nurse is providing health teaching to a client with Addison's disease regarding diet therapy. The nurse is aware that which of the following diets most likely the physician will prescribe for this client?

    a. normal sodium intake
    b. high fat intake
    c. low protein intake
    d. low carbohydrate intake

76. A nurse is providing information to a client with Diabetes Mellitus about differentiating between hypoglycemia and ketoacidosis. The client demonstrates an understanding of the information given by stating that glucose will be taken if which of the following symptoms develop?

a. shakiness
b. Polyuria
c. Blurred vision
d. Fruity breath odor

77. A nurse develops a plan of care for a client with hyperthyroidism. The most appropriate care for the client is to:

a. provide extra blanket
b. provide small meals
c. provide a restful environment
d. provide a high-fiber diet

78. A nurse is caring for a client with diabetes insipidus. The physician prescribed Desmopressin (DDAVP, Stimate) for the client. The nurse knows which of the following outcomes reflects a therapeutic effect of this medication?

a. decrease urine output
b. increased blood pressure
c. urine osmolality less than 100 mOsm/kg
d. serum osmolality greater than 320 mOsm/kg

79. A client is admitted in the emergency room and diagnosed with type 1 diabetes mellitus. The nurse is monitoring the condition of the client. Which of the client's complain would alert the nurse to the presence of possible hypoglycemic reaction?

a. hot, dry skin
b. muscle cramps
c. anorexia
d. tremors

80. A nurse is caring for a client diagnosed with Pheochromocytoma. The client is hungry and asks the nurse of something to eat and drink. The most appropriate choice of food and drinks for the client to meet nutritional needs would be which of the following?

a. Crackers with cheese and tea
b. Vanilla wagers and coffee with cream and sugar
c. Graham crackers and warm milk
d. Toast with peanut butter and cocoa

81. A 74-year old client is admitted with a diagnosis of a fractured hip and renal failure due to dehydration. For 24 hour, she has received 1500ml of IV fluid. Her next serum electrolyte series reflects hyponatremia. The nurse recognizes that this may result from an increase in:

a. glomerular filtration
b. salt intake
c. fluid intake
d. sodium absorption

82. A male client with a history of heart failure and atrial fibrillation comes to the clinic for his regular visit. The nurse is performing assessment on the client and found out that he is weight is higher that his usual weight. The nurse interprets that the most likely cause of this sudden weight gain would be:

a. abdominal distention

b. fluid retention
c. urinary retention
d. renal insufficiency

83. A physician has ordered 1L TPN in 12 hours to be infused via a subclavian catheter. When a client is to receive a TPN, it is important for the nurse to assess the:

a. blood for glucose
b. stool for occult blood
c. abdomen for bowel sounds
d. urine for specific gravity

84. When administering albumin intravenously, the nurse is aware that the shift of the body fluids occurs by the process of:

a. filtration
b. osmosis
c. active transport
d. diffusion

85. A client is to receive an IV solution. When evaluating a clients response to fluid replacement therapy, the observation that indicates adequate tissue perfusion to vital organs would be:

a. blood pressure of 50/30 and 90/40 mmHg
b. central venous pressure reading 2 cm water
c. urinary output of 30ml per hour
d. pulse rate of 120 and 110 in a 15minute period

86. The nurse is attending five patients who have follow-up visit in the clinic. The nurse reviews the health care records of the clients and determines which of the following individuals is at the highest risk for development of an Integumentary disorder?

a. an adolescent
b. an older female
c. a physical education teacher
d. an outdoor construction worker

87. A client is scheduled for a skin biopsy. The client is quite nervous about the procedure and asks the nurse how painful the procedure is. The most appropriate response of the nurse is;

a. “There is no pain associated with this procedure”
b. “The local anesthetic may cause a burning sensation”\
c. “There is some pain, but the physician will prescribe an analgesic after surgery”
d. A preoperative medication will be given so you will be sleeping and not feel any pain”

88. A client who undergone skin biopsy is for discharge. The nurse is reviewing the discharge instruction for the client. Which of the following statements, if made by the client, would indicate a need for further instruction?

a. “I will remove the dressing as soon as I get home and wash it with tap water”
b. “I will return in 7 days to have the sutures removed”
c. “I will call the physician if I see any drainage form the wound
d. “I will use the antibiotic ointment as prescribed”

89. A male client is admitted to the emergency room. The nurse assists the physician to examine the skin of the client with a Wood's Light. The nurse includes which of the following in the plan of care for this procedure?

    a. darken the room for the examination
    b. obtain an informed consent
    c. shave the skin and scrub with povidone-iodine solution
    d. prepare a local anesthetic

90. A client comes to the clinic for a check up and complains skin irritation. The client is advised to be back in the clinic 1 week for scratch skin test. The nurse provides which instruction to the client?

    a. shower using an antibacterial soap on the morning of the test
    b. do not ingest anything before the test
    c. consume only fluids on the day of the test
    d. discontinue the prescribed antihistamine 5days before the test

91. A client admitted in the clinic and has finished the patch testing. Following the procedure, the nurse gives instruction to the client. Which of the following statement if made by the client would indicate the need for further explanation?

    a. "if the patch comes off. I need to reapply it."
    b. "I need to avoid activities that will cause me to sweat"
    c. "I will return to the clinic in 2 days for the initial reading
    d. "I need to keep the test site dry at all times"

92. A nurse is formulating a teaching plan for the client who has complained of chronic dry skin and episodes of pruritus. Which of the following statements if stated by the client would indicate a need for further teaching/

    a. "I should drink 8-10 glasses of water a day"
    b. "I should limit myself to one shower a day and apply emollient to my skin after the shower"
    c. "I need to avoid using astringent on my skin"
    d. "I should use a dehumidifier especially during the winter months"

93. The camp nurse is conducting a lecture to a group of children about Lyme disease. Which of the following information would the nurse include in the lecture?

    a. Lyme disease can be cuased by the inhalation of spores from bird droppings
    b. Lyme disease can be contagious by skin contact with an infected individuals
    c. Lyme disease is caused by a tick carried by deer
    d. Lyme disease is caused by contamination from cat feces

94. A child came from a camping activities is rushed to the emergency room. The client was diagnosed with stage I of Lyme disease. The nurse assess the client for which characteristic of this stage?

    a. arthralgias
    b. Flulike symptoms
    c. Signs of neurological disorders
    d. Enlarged and inflamed joints

95. A male client arrives at the health care clinic and tells the nurse that he would like to be tested for Lyme disease. The client tells the nurse that he was bitten by a tick and removes the tick and flushed it down the toilet. Which of the following nursing actions is best in this client?

    a. tell the client that testing is not necessary unless arthralgia
    b. refer the client for a blood test immediately
    c. inform the client to return in 4-6 weeks to be tested because testing before this time is not reliable
    d. inform the client that there is not a test available for Lyme disease

96. A client was diagnosed with stage 1 Lyme disease. After the confirmation of the diagnosis, the nurse would anticipate that which of the following will be part of the treatment plan for the client?

    a. a 3-week course of oral antibiotic therapy
    b. no treatment unless symptoms develop
    c. daily oatmeal baths for a period of 2 weeks
    d. treatment with intravenously administered antibiotics

97. A nurse is teaching prevention technique to a group of cub scouts who will be in the overnight camping trip. Which of the statement by one of the cub scouts indicates a need for furthers instruction?

    a. “I should wear long-sleeved tops and long pants”
    b. “I need to bring a hat to wear during the trip”
    c. “I should use insect repellent because it will attract the ticks”
    d. “I need to wear a closed shoes and socks that can be pulled up over my pants”

98. A client comes to the emergency room and tells the nurse that he came directly in contact with poison ivy shrubs. The client asks the nurse of what is the best thing to do knowing that this may cause a skin irritation. Which of the following is the most appropriate nursing response?

    a. “Apply calamine lotion immediately to the exposed skin areas”
    b. “it is not necessary to do anything if you cannot see anything on your skin”
    c. “come to the care unit and let us put bandage on it so that it will not touch the other skin”
    d. “take a shower immediately, lathering and rinsing several times

99. The client arrives at the emergency room following a burn injury that occurred in the basement at home. An inhalation injury is suspected. The nurse will anticipate that the physician will prescribe which of the following?

    a. oxygen via nasal cannula at 15L/min
    b. 100% oxygen via an aerosol mask
    c. 100% oxygen via a tight fitting, non-breather face mask
    d. Oxygen via nasal cannula at 10 L/min

100. The nurse is caring for a client who suffered a second and third degree burns on the anterior lower legs and anterior thorax. The client is just finished for an autograft and grafting procedure. Which of the following would the nurse anticipate to be prescribed for the client?

a. bathroom privileges
b. out of bed
c. immobilization of the affected leg
d. placing the affected leg in a dependent position.

**Test IV - Medical and Surgical Nursing**

1. The nurse is preparing materials in a health teaching session about colorectal cancer to the patients in the health clinic. The nurse plans to include which of the following in a list of risk factors for colorectal cancer?

    a. High-fiber, low-fat diet
    b. Age over 30 years
    c. Personal history of ulcerative colitis or gastrointestinal polyps
    d. Distant relative with colorectal cancer

2. The client with gastroesophageal reflux disease is admitted. During the 24 hour, the client is complaining of chest discomfort that feels like heartburn after eating. The physician prescribed Antacid to the client. After administering an ordered antacid, the nurse instructed the client to lie in which of the following positions?

    a. On the stomach with the head flat
    b. On the left side with the head of bed elevated
    c. Supine with the head of bed flat
    d. On the left side with the head of bed elevated 30 degrees

3. A nurse is preparing a lecture to teach a client with gastroesophageal reflux disease about substances that will increase the lower esophageal sphincter pressure. Which of the following items would the nurse emphasize on the list:

    a. Chocolate
    b. Coffee
    c. Nonfat milk
    d. Fatty foods

4. A nurse is caring for a client who undergone esopahgogastroduodenoscopy. The nurse knows that it is important to place highest priority on which of the following items as part of the client's care plan?

    a. Giving warm gargles for a sore throat
    b. Assessing for the return of the gag reflex
    c. Monitoring complains of heartburn
    d. Monitoring temperature

5. The nurse provided the client all the information needed about the upcoming endoscopic retrograde cholangiospancreatography procedure. The nurse determines that the client needs additional information if the client makes which of the following statements?

    a. "I'm glad I don't have to lie still for this procedure"
    b. "I know I must sign the consent form"
    c. "I hope the throat spray keeps me from gagging"
    d. "I'm glad some IV medication will be given to relax me"

6. The client comes to the clinic for check-up. The physician scheduled the client for a barium swallow on the next day at 9:00 A.M. The physician assigned the nurse to give instruction to the client regarding the procedure to be done. The nurse writes down which of the following instruction for the client to follow before the test?

    a. Eat a regular supper and breakfast
    b. Fast for 8 hours before the test
    c. Monitor own bowel movement pattern for constipation

d. Continue to take all medication as scheduled

7. Following colonoscopy, the nurse has given post procedure instruction to the client. The nurse determines that the client needs additional instruction if the client stated that:

    a. It is normal to feel gassy or bloated after the procedure
    b. It is all right to drive once the client has been home for an hour or so
    c. The abdominal muscles may be tender from the procedure
    d. Intake should be light at first and then progress to regular intake

8. The nurse is performing an abdominal assessment on the client with abdominal disorder. The nurse is aware that the initial assessment technique in the abdomen is:

    a. Auscultation
    b. Percussion
    c. Inspection
    d. Palpation

9. The physician prescribed Polyethylene glycol-electrolyte solution (GoLYTELY) to a client who is scheduled for a colonoscopy. The client starts to experience diarrhea after the taking the solution. What action by the nurse is most appropriate?

    a. Start an IV infusion
    b. Cancel the diagnostic test
    c. Administer an enema
    d. Explain that diarrhea is expected

10. The nurse is assigned to monitor the client with a diagnosis of chronic gastritis. The nurse is aware that this client is at risk for which of the following vitamin deficiencies?

    a. Vitamin A
    b. Vitamin E
    c. Vitamin C
    d. Vitamin B12

11. The nurse is caring for a client with acute gastritis. Before developing a plan of care, the nurse reviews the medication record of the client. Which of the medication if noted on the client's record, would the nurse question?

    a. Digoxin (Lanoxin)
    b. Furosemide (Lasix)
    c. Propanolol hydrochloride (Inderal)
    d. Indomethacin (Indocin)

12. The nurse is assigned to monitor the client for 24 hours after cholecystectomy. The nurse notes that the T-tube has drained 750 mL of green-brown drainage. Which nursing intervention is most appropriate to the client?

    a. Documents the findings
    b. Irrigate the T-tube
    c. Notify the physician
    d. Clamp the T-tube

13. A client is admitted in the hospital with a diagnosis of peptic ulcer. The nurse is assigned to monitor the condition of the client. Which assessment finding would most likely indicate perforation of the ulcer?

a. Nausea and vomiting
b. A rigid, boardlike abdomen
c. Bradycardia
d. Numbness in the legs

14. The nurse is preparing a medical instruction to a client with peptic ulcer disease. In a half an hour session, the nurse explained thoroughly the medication therapy to the client. Which of the following statement, if made by the client, would indicate the best understanding of the therapy?

    a. “Sucralfate (Carafate) will change the fluid in my stomach”
    b. “The cimetidine (Tagamet) will cause me to produce less stomach acid”
    c. “Antacids will coat my stomach”
    d. “Omeprazole (Prilosec) will coat the ulcer and help it heal”

15. The physician scheduled the client with peptic ulcer disease for a pyloroplasty. The client wants clarification about the procedure discussed by the physician. Unfortunately, the physician is on emergency call. The client asks the nurse about the pyloroplasty procedure. The nurse plans to respond knowing that a pyloroplasty involves:

    a. Removing the distal portion of the stomach
    b. Cutting the vagus nerve
    c. An incision and resuturing of the pylorus to relax the muscle and enlarge the opening from the stomach to the duodenum
    d. Removal of the ulcer and a large portion of the cells that produce hydrochloric acid

16. The physician prescribed Propantheline Bromide (Pro-Banthine) as adjunctive treatment for peptic ulcer disease of the client. The nurse is aware of the medication and should administer this:

    a. 30 minutes before meals
    b. With antacids
    c. With meals
    d. Just after meals

17. The client is taking docusate sodium (Colace) ordered by the physician. The nurse caring for the client plans to monitor for which of the following to determine whether the client is having a therapeutic effect from the medication?

    a. Reduction in steatorrhea
    b. Regular bowel movements
    c. Absence of abdominal pain
    d. Hematest negative stools

18. The hospitalized client is taking cascara sagrada for 2 days. The client is now complaining of abdominal cramps. The nurse suspects that the client is most likely experiencing:

    a. Peptic ulcer disease
    b. A common side effect of this medication
    c. Partial bowel obstruction
    d. A case of Influenza

19. The client taking bisacodyl (Dulcolax) want to immediately experience the therapeutic effect of the medication. The nurse instructed the client to take the medication :

    a. On an empty stomach
    b. With a large meal
    c. With two glasses of juice
    d. At bedtime

20. The physician advised the client to take senna (Senokot) to treat constipation. The client is curious to know the effect of the medication. The client asks the nurse how this medication works. The nurse would incorporate which of the following when formulating a response to the client?

    a. Senna coats the bowel wall and makes it slippery
    b. Senna adds fiber and bulk to the stool
    c. Senna stimulates the vagus nerve to improve the bowel tone
    d. Senna accumulates water and increases peristalsis

21. A client is admitted with respiratory failure. The nurse is making an assessment and found out that this client does not have a history of respiratory disease. On further assessment, the nurse checks the arterial blood gas report. Which of the following results that are consistent with this disorder?

    a. PaO2 58 mmHg, PaCO2 32 mmHg
    b. PaO2 73 mmHg, PaCO2 62 mmHg
    c. PaO2 49 mmHg, PaCO2 52mmHg
    d. PaO2 60 mmHg, PaCO2 45 mmHg

22. The client is admitted with chronic respiratory failure. The physician advised the client to use a metered dose inhaler. The client does not know how to use it correctly and asks the nurse to teach him. The nurse instructed the client to:

    a. Inhale quickly
    b. Take two inhalations during one breath
    c. Hold the breath after inhalation
    d. Inhale through the nose

23. A nurse is assessing a client with multiple traumas who is at risk for developing acute respiratory distress syndrome. The nurse is familiar with the disease of the client assigned to him. The nurse would note on the assessment for which of the earliest sign of acute respiratory distress syndrome.

    a. Bilateral Wheezing
    b. Increased Respiratory rate
    c. Inspiratory Crackles
    d. Intercostals Retraction

24. The nurse is assigned to take the pulmonary artery catheter measurement of a client with acute respiratory distress syndrome. The pulmonary capillary wedge pressure reading is 12 mmHg. The nurse concludes that this reading is:

    a. Low and unexpected
    b. High and expected
    c. Normal and expected
    d. Uncertain and unexpected

25. A nurse is completing an assessment with a client with chronic airflow limitations and notes that the client has a “barrel chest”. The nurse expects that this client has which of the following forms of chronic airflow limitation?

    a. Bronchial asthma
    b. Chronic obstructive bronchitis
    c. Emphysema
    d. Bronchial asthma and bronchitis

26. The physician gave an order to the nurse to administer albuterol (Proventil) to a client. Before the administration of the drug, the nurse assesses which of the following parameter?

    a. Nausea and vomiting
    b. Headache and level of consciousness
    c. Urine output and blood urea nitrogen
    d. Lung sounds and presence of dyspnea

27. The home care nurse visits a client with respiratory disorder. The nurse has observed that the client is taking a dose of metaproterenol sulfate (Alupent) via metered dose inhaler. The client tells the nurse that it is a self administered dose. Within a short time, the client begins to wheeze loudly. The nurse tells the client that the wheezing is due to:

    a. Insufficient dosage of the medication, which needs to be increased
    b. Tolerance to the medication, indicating a need for a stronger type of bronchodilator
    c. Probable interaction of this medication with an over-the-counter cold remedy
    d. Paradoxical bronchospasm, which must be reported to the physician

28. The physician ordered to the nurse to give a client metaproterenol (Alupent), 2 puffs, and beclomethasone (Vanceril), 2 puffs, by metered dose inhaler. The nurse administer the medication prescribed by the physician by giving the:

    a. Alternating a single puff of each, beginning with the metaproterenol
    b. Beclomethasone first and then the metaproterenol
    c. Alternating a single puff of each, beginning with the beclomethasone
    d. Metaproterenol first and then the beclomethasone

29. The physician gave an order to the nurse that the client must have a blood test. The client is receiving theophylline due to have a theophylline level drawn. The nurse question the client to ensure that the client has not ingested which of the following substances before the blood sample is drawn.

    a. Sedatives
    b. Caffeine
    c. Narcotics
    d. Glucose

30. A client is starting a therapy with oxtriphylline (Choledyl). A nurse plans to teach the client to limit the intake of which of the following while taking the medication?

    a. Coffee, cola and chocolate
    b. Cottage cheese, cream cheese, and dairy creamers
    c. Oysters, lobster and shrimp
    d. Grapefruit, oranges and pineapple

31. A nurse is assigned to care for a client who has had a renal biopsy. Following the procedure, which of the following intervention would the nurse avoid in the care of this client?

    a. Administering narcotics as needed
    b. Ambulating the client in the room and hall for short distances
    c. Testing serial samples with dipstick for occult blood.
    d. Encouraging fluids at least 3 L in the first 24 hours

32. On the assessment made by the nurse to a client with urolithiasis. The nurse found out that the client has a history of chronic urinary tract infection. The nurse notes that this client most likely has which of the following types of urinary stones?

    a. Struvite
    b. Cystine
    c. Uric Acid
    d. Calcium Oxalate

33. The client who has a history of gout also is diagnosed with urolithiasis. The stones are determined to be of uric acid type. The nurse prepares a plan of care regarding food restriction to the client. Which of the following food item the client would avoid?

    a. Liver
    b. Apples
    c. Milk
    d. Carrots

34. The client who has had percutaneous ultrasonic lithotripsy for calculuses in the renal pelvis is transferred to the nursing unit from the postanethesia care unit. The nurse assigned to care for the client anticipates that the plan of care will involve monitoring which of the following?

    a. Jackson-Pratt drain
    b. Ureteral stent
    c. Suprapubic tube
    d. Nephrostomy tube

35. A client comes to the emergency department for check up. While waiting for the physician the client starts complaining of low abdominal pain and hematuria. The client is afebrile. The nurse next assesses the client to determine a history of:

    a. Glomerulonephritis
    b. Renal cancer in the client's family
    c. Pyelonephritis
    d. Blow or trauma to the bladder or abdomen

36. A client is rushed to the emergency department due to a motor vehicle accident. The client was wearing a lap seat belt when the accident occurred. The client complains of abdominal pain and a blood in the urine. To determine further whether the pain is due to bladder trauma, the nurse asks the client if the pain is referred to which of the following areas?

    a. Costovertebral angle
    b. Shoulder
    c. Umbilicus
    d. Hip

37. An ambulance arrives in the emergency department with a female equestrian following a fall from a horse. The physician orders insertion of a Foley catheter. The nurse notes blood on the urinary meatus while preparing for the procedure. The nurse should:

    a. Notify the physician.
    b. Use a smaller size catheter.
    c. Administer pain medication before inserting the catheter.
    d. Use extra povidone-iodine solution in cleansing the meatus.

38. A client is receiving hemodialysis for the treatment of chronic renal failure. The nurse checks the patency of an arteriovenous fistula in the left arm of the client. Which finding indicates that the fistula is patent?

    a. Palpation of a thrill over the fistula.
    b. Presence of a radial pulse in the left wrist.
    c. Absence of a bruit on auscultation of the fistula.
    d. Capillary refill less than 3 seconds in the nail beds of the fingers on the left hand

39. A male client has a tentative diagnosis of urethritis. The nurse is preparing the client for assessment, the nurse will note in assessing the client for which of the following manifestations of the disorder?

    a. Hematuria and pyuria
    b. Hematuria and penile discharge
    c. Dysuria and penile discharge
    d. Dysuria and proteinuria

40. The nurse is planning to conduct a teaching session with the female client who is diagnosed with urethritis caused by infection with Chlamydia. The nurse would plan to include which of the following points in the teaching session?

    a. Sexual partners during the last 12 months should be notified and treated.
    b. The most serious complication of this infection is sterility.
    c. The infection can be prevented by using spermicidal to alter the pH in the perineal area.
    d. Medication therapy should be continued for 3 weeks without interruption.

41. The physician prescribed Trimethoprim-sulfamethoxazole (Bactrim) to the client with recurrent urinary tract infection. This medication is to be administered via intravenous infusion. The nurse would administer this medication:

    a. Over 30 minutes
    b. Over 60-90 minutes
    c. Piggybacked into the peripheral line containing TPN.
    d. Piggybacked into the existing infusion of normal saline and potassium chloride

42. Nalidixic acid ( NegGram) is prescribed by the physician to a client with a urinary tract infection. The nurse reviews the record of the client. Following the review of the record, the nurse notes that the client is taking warfarin sodium (Coumadin) daily. Which prescription would the nurse anticipate because the client is taking this anticoagulant orally?

    a. an increase in the anti – coagulation dosage
    b. the need to discontinue the anti – coagulant
    c. the need to administer an alternative medication to treat UTI

d. a decrease anti – coagulant dosage

43. A nurse plans to teach a client receiving sulfisoxazole (Gantrisin) a discharge instruction. Which of the following would be included in the list of instructional?

    a. Maintain a high fluid intake
    b. Restrict fluid intake
    c. If the urine turns dark brown, call the physician immediately
    d. Decrease the dosage when symptoms are improving to prevent an allergic response

44. A client with a urinary tract infection is taking Sulfamethoxazole (Gantanol) prescribed by the physician. The client had also diabetes mellitus and is taking tolbutamide (Orinase). Based on the case of this client taking medication in combination, which of the following would the nurse anticipate in the order?

    a. An increase dosage of the sulfamethoxazole
    b. An increase dosage of the tolbutamide
    c. A decrease dosage of the sulfamethoxazole
    d. A decrease dosage of the tolbutamide

45. A nurse is caring for a client taking Trimethoprim-sulfamethoxazole (Bactrim) A nurse instructed the client to report sign of symptoms that might be developed during the course of the therapy:

    a. Diarrhea
    b. Sore throat
    c. Headache
    d. Nausea

46. The nurse is caring for a client that has an impairment of cranial nerve II. With this impairment the plan of care the nurse will develop is which of the following to ensure the safety of the client?

    a. Speak loudly to the client
    b. Check the temperature of the food on the dietary tray
    c. Test the temperature of the shower water
    d. Provide a clear path for ambulation without obstacles

47. The client has a neurological deficit involving the limbic system. Specific to this type of deficit the nurse assigned to this client would note which of the following information related to the client's behavior?

    a. Affect is flat with periods of emotional lability
    b. Cannot recall what was eaten for breakfast today
    c. Demonstrate inability to add and subtract, does not know who is the president
    d. Is disoriented to person, place and time

48. The nurse is assessing the client in the clinic. In planning to test the function of the trigeminal nerve (cranial nerve V), the nurse would gather which of the following items to perform the test?

    a. Flashlight, pupil size chart or millimeter ruler
    b. Snellen's chart, ophthalmoscope
    c. Tuning fork and audiometer
    d. Safety pin, hot and cold water in test tubes, cotton wisp

49. The nurse is going to test the coordinated functioning of cranial nerves III, IV, VI of the client who was admitted for 3 days. To do this correctly, the nurse would test the:

    a. Corneal reflex
    b. Six cardinal fields of gaze.
    c. Pupil response to light and accommodation
    d. Pupil response to light

50. The client is unconscious and the physician assigned the nurse to do an assessment. The nurse is assessing the motor function of the client. The nurse would plan to use which of the following to test the client's peripheral response to pain?

    a. Nail bed pressure
    b. Sternal rub
    c. Pressure on the orbital rim
    d. Squeezing of the sternocleidomastoid muscle

51. The client is admitted to the hospital with a neurological problems and the physician informed the nurse that magnetic resonance imaging may be done an hour. The nurse interprets that the client may be ineligible for this diagnostic procedure based on the health history of the client:

    a. Heart failure
    b. Hypertension
    c. Prosthetic valve replacement.
    d. Chronic obstructive pulmonary disorder

52. The client is presently having lumbar puncture procedure. The nurse would plan to place the client in which appropriate position for the procedure?

    a. Prone, with a pillow under the abdomen
    b. Prone, in slight Trendelenburg position
    c. Side-lying, with a pillow under the hip
    d. Side-lying, with legs pulled up and head bent down onto chest

53. Following computerized tomography scanning with a contrast medium, the client is transferred to the nursing unit. The nurse is providing an instruction regarding the post procedure care. The nurse would evaluate that the client understands post procedure care if the client states:

    a. Increase fluid intake for the day
    b. Eat lightly for the remainder of the day
    c. Rest quietly for the remainder of the day
    d. Hold medication for at least 4 hours.

54. The nurse is assisting with caloric testing of the oculovestibular reflex of an unconscious client. The nurse injected cold water into the left auditory canal. The client exhibits eye conjugate movements toward the left followed by rapid nystagmus toward the right. The nurse understands that this indicates the client has

    a. Brain death
    b. A cerebral lesion.
    c. A temporal lesion.
    d. An intact brainstem.

55. A client is admitted in a short stay unit after the myelogram. A water-based contrast agent was used. The nurse would give information to the client regarding activity restrictions. Which of the following activity would the client avoid?

    a. Bedrest for 2-4 hours, with head of bed flat
    b. Bedrest for 6-8 hours, with head of bed flat
    c. Bedrest for 6-8 hours, with the head of the bed elevated 15-30 degrees
    d. Bedrest for 2-4 hours, with the head of the bed elevated 15-30 degrees

56. The nurse is assigned to care for a client with increased intracranial pressure. The nurse would note which of the following trends in vital signs if the intracranial pressure is rising?

    a. Decreasing temperature, increasing pulse, decreasing respiration, increasing blood pressure
    b. Decreasing temperature, decreasing pulse, increasing respirations, decreasing blood pressure
    c. Increasing temperature, increasing pulse, increasing respirations, decreasing blood pressure
    d. Increasing temperature, decreasing pulse, decreasing respiration, increasing blood pressure

57. A nurse is caring for a client with increased intracranial pressure. The nurse needs to position the client. Which of the following position would the nurse avoid?

    a. Head turned to the side
    b. Head of the bed elevated 30-45 degrees
    c. Head midline
    d. Neck in neutral position

58. The client recovering from a head injury is participative to the nursing care. The nurse determines that the client understands measures in the prevention of the elevation in intracranial pressure. Which of the following if observed by the nurse that the client is doing activities that prevent increased intracranial pressure?

    a. Isometric exercise
    b. Blowing nose
    c. Coughing vigorously
    d. Exhaling during reposition

59. After the basilar skull fracture, the nurse has experience a clear fluid leaking from the nose. The nurse assesses that this is cerebrospinal fluid if the fluid:

    a. Separates into concentric rings and tests positive for glucose
    b. Clamps together on the dressing and has a pH of 7
    c. is grossly bloody in appearance and has a pH of 6
    d. is clear and tests negative for glucose

60. The nurse inserted a Foley catheter to a hospitalized client with head injury. The client has begun urinating copious amount of dilute urine through the catheter. The urine output is 3000ml. The nurse implements which of the following new physician order to administer?

    a. Dexamethasone (Decadron)
    b. Desmopressin ( DDAVP, Stimate)
    c. Mannitol (Osmotri)
    d. Ethacrynic acid (Edecrin)

61. The physician treated the client after a fall that sprained an ankle. X – ray examination has ruled out a fracture on the ankle of the client. The nurse instructed the client to avoid which of the following in the next 24 hours?

    a. Resting the foot
    b. Application of a heating pad
    c. Application of an ace wrap
    d. Elevating the ankle on a pillow while sitting or lying down

62. The client is at risk for osteoporosis. The nurse is providing a dietary instruction. The nurse evaluates the understanding of the clients to the instruction if the client stated he or she should increase intake of which food?

    a. Chicken
    b. Sardines
    c. Rice
    d. Yogurt

63. The nurse is conducting screening for osteoporosis. The nurse would know which of the clients in the clinic, those are present for checks up, are at risk of osteoporosis?

    a. A 25 year old woman who jogs
    b. A 36 year old woman who has asthma
    c. A sedentary 65 year old woman who's smoke cigarettes
    d. A 70 year old man who consume excess alcohol

64. The home health nurse is preparing to teach a client with osteoporosis about home modification to prevent or minimize the risk of fall. Which of the following recommendations would be unnecessary to include in the teaching plan?

    a. Use of night lights
    b. Use of staircase railings
    c. Removing wall to wall carpeting
    d. Placing handrails in the bathroom

65. The nurse assigned a nursing student to formulate a post procedure plan of care to a client who undergone bone biopsy. The nurse determines that the student needs to research further about post procedure care if which inaccurate intervention is documented?

    a. Elevating the limb for 24 hours
    b. Monitoring Vital signs every 4 hours
    c. Monitoring Site for swelling, bleeding or hematoma
    d. Administering Narcotic Analgesic intramuscularly

66. Following arthroscopy of the knee, the nurse provides instruction to the client before returning home. The nurse would evaluate that the client understands the instructions if the clients states to:

    a. Resume regular exercise the following day
    b. Stay off the leg entirely for the rest of the day
    c. Report fever or site inflammation to the physician
    d. Refrain from eating food for the remainder of the day

67. The client is scheduled to have an arthrogram with a contrast medium. Which assessment by the nurse would be of highest priority?

    a. Allergy to iodine or shellfish
    b. Whether the client wishes to void before the procedure
    c. Whether the cient has any remaining questions about the procedure
    d. Ability of the client to remain still during the procedure

68. The physician scheduled the client with possible rib fracture for chest radiograph. Before the procedure, the nurse in charge would plan to tell the client which of the following items about the procedure?

    a. Removal of jewelries and any other metal objects are necessary
    b. The X-rays stimulates a small amount of pain
    c. The x-ray technologist will stand next to the client during the procedure
    d. The client will be asked to breathe in and out as the radiograph is taken

69. A client just had a bone scan. The nurse is assigned to provide a discharge instruction to the client. The nurse would check if the client understands the elements of follow-up care If the client states that he or she should:

    a. Eat only small meals for the remainder of the day
    b. Ambulate atleast three times before the end of the day
    c. Report any feeling of nausea and flushing
    d. Drink plenty of water for 1-2 days following the procedure

70. The client is admitted in the emergency room for a lower leg injury. The deformity of the leg of the client is visible, and the affected leg is shorter than the other. The area is painful, swollen, and beginning to become ecchymotic. The nurse interprets that this client has experienced a

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

71. The nurse witness a vehicle hit a pedestrian at fairly low speed on a small street. The nurse checks the victim and found it dazed and tries to get up. The leg appears fracture. The nurse would initially plan to:

    a. Try to reduce the fracture manually
    b. Stay with the person and encourage the person to remain still
    c. Assist the person to get up and walk to the sidewalk
    d. Leave the person for a few moments to call for an ambulance

72. A nurse is planning to teach a client with a left arm cast about measures to keep the left shoulder form becoming stiff and frozen. Which of the following suggestion would the nurse include in the teaching plan?

    a. Use a sling on the left arm
    b. Lift the left arm up over the head
    c. Lift the right arm up over the head
    d. Make a fist with the hand of the casted arm

73. The client lower leg is casted made of fiberglass materials. The client asks the nurse when he can be able to walk in casts. The nurse replies that the client will be able to bear weight on the cast:

    a. In 24 hours
    b. In 48 hours
    c. In about 8 hours
    d. Within 20-30 minutes of application

74. The nurse is providing a discharge instruction regarding cast care at home to a client with a leg cast. The nurse would evaluate that the client needs further instruction If the client makes which of the following statements?

    a. "I should avoid walking on wet, slippery floors"
    b. "If the cast gets wet, I can dry it with the hair dyer turn to the warmest setting"
    c. "Its okay to wipe dirt off the top of the cast with the damp cloth"
    d. "I'm not supposed to scratch the skin underneath the cast

75. The surgeon scheduled the client with hip fracture to be on Buck's extension traction before the surgery. The client asks the nurse why there is a need for the application of this traction. The nurse's response is based on the understanding that Buck's extension traction primarily:

    a. Allows bony healing to begin before surgery
    b. Lengthens the fractured leg to prevent severing of blood vessels
    c. Provides rigid immobilization of the fractured site
    d. Provides comforts by reducing muscles spasms and provide fracture immobilization

76. The client with skeletal leg traction with an overbed frame is instructed to limit his movement from side to side. Which action by the nurse would be most useful in trying to provide good skin care to the client?

    a. Have another nurse turn the client anyway
    b. Ask the client to pull up on the trapeze to lift the hips off the bed
    c. Ask the client to lift up by digging into the mattress with the unaffected leg
    d. Push down on the mattress of the bed while administering care

77. The nurse is monitoring the pin sites of a client in skeletal traction. The nurse would be least concerned with which of the following findings?

    a. Serous drainage
    b. Purulent drainage
    c. Pain at the pin site
    d. Inflammation

78. A male client is immobilized in skeletal leg traction for almost 20 days. No visitor for almost a week and no books to read and no one to talk to. The client complains of being bored and restless. The nurse would be formulating which of the following nursing diagnoses for this client?

    a. Powerlessness
    b. Self care deficit
    c. Deficient diversional activity
    d. Impaired physical mobility

79. The right leg of the client is applied with Buck's extension traction. The nurse is assigned to care for the client. The nurse would plan which of the following interventions to prevent complications of the device?

    a. Massage the skin of the right leg with lotion every 8 hours
    b. Inspects the skin on the right leg at least once every 8 hours
    c. Release the weights on the right leg for range of motion exercises daily
    d. Give pin care once a shift

80. The nurse is caring for a client who had skeletal traction applied to the left leg. The client asks the nurse how long he will stay in that condition. While talking to the nurse, the client complains of severe left leg pain. Which of the following actions should the nurse take first?

    a. Call the physician
    b. Provide pin care
    c. Medicate the client with an analgesic
    d. Check the client's alignment in bed

81. The nurse is to care for the client with casted extremity. In completing the assessment for any sing infection to the casted extremity, the nurse would assess for which of the following signs and symptoms indicative of infection?

    a. Coolness and pallor of the extremity
    b. Diminishes distal pulse
    c. Presence of a "hot spot" on the cast
    d. Dependent Edema

82. The client has sustained a closed fracture and has just had a cast applied to the affected arm. The client is complaining of intense pain. The nurse has done all the measures of care to alleviate pain. The nurse would interpret that this pain may be due to:

    a. Infection under the cast
    b. The newness of the fracture
    c. The anxiety of the client
    d. Impaired tissue perfusion

83. A client with multiple trauma is admitted to the nursing unit. The client has a leg fracture and had a plaster cast applied. The nurse is assigned to position the client. In positioning the casted leg, the nurse should:

    a. Keep the leg in a level position
    b. Elevate the leg for 3 hours and put it flat for 1 hour
    c. Elevate the leg on pillows continuously for 24 to 48 hours
    d. Keep the leg in a level position

84. The client is complaining of itchiness for the edges of a cast applied the last two days. The nurse checks the site and notes skin irritation. The nurse should take which of the following actions?

    a. Massage the skin at the rim of the cast
    b. Apply lotion to the skin a the rim at the rim of the cast
    c. Petal the cast edges with adhesive tape.
    d. Use a rough file to smooth the cast

85. The nurse is conducting a lecture session regarding cast care to a client that will be discharged in the next two hour. The nurse would evaluate that the client understands proper care of the cast if the client states that he or she should:

    a. Use the padded coat hanger end to scratch under the cast
    b. Use the fingertips to lift and move the leg
    c. Cover the casted leg with warm blanket
    d. Avoid getting the cast wet

86. The client will be using crutches and it is measured correctly for the client. The client asks the nurse why the crutches cannot rest up underneath the arm for extra support. The nurse best response is base on the understanding that this could results in:

    a. Impaired range of motion while the client ambulates
    b. Injury to the brachial plexus nerves
    c. A fall and further injury
    d. Skin breakdown in the area of the axillas

87. The nurse is assigned to teach and help the client how to stand and use the crutches. The nurse plans to incorporate into written instruction that the client should be told to place the crutches:

    a. 8 inches to the front and side of the client's toes
    b. 20 inches to the front and side of the client's toes
    c. 3 inches to the front and side of the client's toes
    d. 15 inches to the front and side of the client's toes

88. The nurse is providing information to the client about crutch safety. The nurse has completely discussed all the possible safety measures to the client. The nurse determines that the client needs additional information if the client states:

    a. That crutch tips will not slip even when wet
    b. The need to have spare crutches and tips available
    c. That crutch tips should be inspected periodically for wear
    d. Not to use someone else's crutches

89. A male client with right-sided weakness will be using a cane. The nurse provides instruction to the client on how to use the cane. The nurse instructed the client to position the cane by holding it with the:

    a. Left hand and placing the cane in front of the left foot
    b. Left hand and 6 inches lateral to the left foot
    c. Right hand and 6 inches lateral to the right foot
    d. Right hand and placing the cane in front of the right foot

90. The client has a left-sided weakness and using a cane. The nurse observes the client walking using a cane. The nurse would intervene and correct the client if the nurse observed that the client:

    a. Keeps the cane 6 inches out to the side of the right foot
    b. Moves the cane when the right leg is moved
    c. Leans on the cane when the right leg swings through
    d. Hold the cane on the right side

91. A client with a fractured femur experiences dyspnea. A set of arterial blood gas tests reveal the following: pH, 7.35; PaCO2 43; PaO2 58; HCO3 23. A nurse interprets that the client probably has experienced fat embolus because of the result of the:

    a. PaCO2
    b. PaO2
    c. HCO3
    d. pH

92. A client with fat embolus is complaining of difficulty of breathing. Based on the assessment, the nurse plans to assists with which of the following therapies?

    a. Administration of corticosteroids, intubation, mechanical ventilation with positive-end expiratory pressure
    b. Administration of bronchodilators, intubation, mechanical ventilation
    c. Administration of antihypertensive, high flow oxygen, continuous positive airway pressure mask
    d. Administration of plasma expanders, low-flow oxygen and suctioning

93. The client is being treated for fat embolus after multiple fractures. Which of the following significant data would the nurse evaluate as the most favorable indication of resolution of the fat embolus?

    a. Minimal dyspnea
    b. Arterial oxygen level of 78 mmHg
    c. Oxygen saturation of 85%
    d. Clear chest radiograph

94. The client with severe fractured arm is complaining of numbness and tingling sensation on the casted arm. The client asks the nurse how this can happen. The nurse's response is based on the understanding that:

    a. The fascia expands with injury, causing pressure on underlying nerves and muscles
    b. An injured artery cause impaired arterial perfusion through the compartment
    c. Bleeding and swelling cause increased pressure in an area that cannot expand
    d. A bone fragment has injured the nerve supply in the area

95. The nurse is providing information to the client in an arm cast about signs and symptoms of compartment syndrome. The nurse determines that the client understands the information if the client stated that he/she should report which of the following early symptoms of compartment syndrome?

    a. Numbness and tingling in the fingers
    b. Pain that is relieved only by oxycodone and aspirin
    c. Cold, bluish-colored fingers
    d. Pain that increases when the arm is dependent

96. The client with right hip fracture has returned to the nursing care unit. Following internal fixation on the fractured hip, the nurse is assigned to monitor and reposition the client. In repositioning the client, the nurse should use:

    a. Pillow to keep the right leg adducted during turning
    b. Pillow to keep the right leg abducted during turning
    c. Trochanter rolls to prevent abduction while turning
    d. Trochanter roll to prevent external rotation while turning

97. The surgeon instructed the nurse to get the client out of bed to a chair on the first postoperative day after the total knee replacement. The nurse would plan to do which of the following to protect the knee joint of the client?

    a. Obtain a walker to minimize weight bearing by the client on the affected leg.
    b. Lift the client to the bedside chair, leaving the continuous passive motion machine in place.
    c. Apply an Ace wrap around the dressing and put ice on the knee while sitting.
    d. Apply a knee immobilizer before getting the client up and elevate the client's surgical leg while sitting.

98. The nurse completed a discharge instruction to the client who had a total knee replacement. The nurse evaluates the understanding of the client to the given instruction. The nurse determines that the instruction is not clear to the client if the client states that she/he should:

    a. Ignore changes in the shape of the knees.
    b. Report bleeding gums or tarry stools.
    c. tell future caregivers about the metal implants.
    d. Report fever, redness, or increase pain.

99. A client with diabetes mellitus has had a right below-the-knee amputation. The nurse would assess specifically for which of the following signs and symptoms because of the history of diabetes?

    a. Edema of the stump
    b. Separation of wound edges
    c. Slight redness of the incision
    d. Hemorrhage

100. After a vehicle accident, client is scheduled for below-the-knee amputation. Following the surgery, the client tells the nurse, "I think I'm going to be crazy. I can feel my left foot itching." The nurse interprets the client's statement to be:

    a. an abnormal response that indicates the client is in denial about the limb loss
    b. a normal response that indicates the presence of phantom limb sensation
    c. a normal response that indicates that the client needs more psychological support
    d. an abnormal response that indicates the presence of phantom limb pain

**Test V - Psychiatric Nursing**

1. A nurse is caring to a client with a diagnosis of major depression. The client attempted suicide for three times, and tells the nurse, “I should have died, I am a failure”. I don’t have everything to live for”. The most therapeutic response to the client is

    a. “You’ve been feeling like a failure for a while?”
    b. “I don’t see you a failure”
    c. “Feeling like this is all part of being ill”
    d. “You have everything to live for

2. The nurse is assigned to visit a client at home. He asks the client about the effectiveness of the therapy. The client states, “I don’t know if the therapy is really working”, I haven’t slept at all the last couple of nights.” Which response by the nurse illustrates the most therapeutic communication technique for this client?

    a. “Go on….’
    b. “Sleeping?”
    c. “The last couple of nights?”
    d. “You’re having difficulty sleeping?”

3. A client who has just been sexually assaulted is admitted. The nurse is observing the behavior of the client which is quiet and calm. The nurse analyzes this behavior as indicating which defense mechanism?

    a. intellectualization
    b. projection
    c. denial
    d. rationalization

4. A client who is admitted to a mental health unit for treatment of psychotic behavior is shouting in front of the locked exit door. The client states, “I don’t belong here”. “There is nothing wrong with me”. The nurse interprets this behavior of the client as

    a. regression
    b. rationalization
    c. projection
    d. denial

5. A nurse is making rounds; he enters a client’s room. The client is begging to the nurse to be released from the hospital. The nurse checks the client’s records and found out that the client was voluntarily admitted two days ago with a diagnosis of an anxiety disorder. Which of the following will the nurse take?

    a. call the client’s family
    b. tell the client that discharge is not possible at this time
    c. contact the physician
    d. persuade the client to stay a few more days

6. After a group therapy session. A client with anxiety disorder asks a nurse and verbalizes a need for seclusion because of uncontrollable feelings. The most appropriate nursing action would be

    a. inform the client’s family
    b. inform the client that seclusion has not been prescribed
    c. place the client in seclusion immediately

d. obtain an informed consent

7. A nurse caring for a client experiencing delirium needs to convince the client to participate on laboratory work prescribed by the physician. When the nurse is about to obtain specimen to the client's blood, the client begins to shout, "You are all vampires. Let me out of here!" The most appropriate nursing response is which of the following?

    a. "I am not going to hurt you, I am going to help you!"
    b. "What makes you think that I am a vampire?"
    c. "It must be frightful to think others want to hurt you"
    d. "I'll leave and come back later for your blood"

8. The nurse employed in a mental health unit is assigned to care for a client who has sought counseling. After trying to rescue a neighbor involved in a house fire. In spite of the client's efforts, the neighbor died. Which action does the nurse engage in with the client during the working phase of the nurse-client relationship?

    a. exploring the client's potential for self-harm
    b. exploring the client's ability to function
    c. inquiring about and examining the client's feelings that may block adaptive coping
    d. inquiring about the client's perception or appraisal of the neighbor's death

9. A client with major depression is considering cognitive therapy. The client asks the nurse if the treatment will work and if it will be effective to treat his major depression. The nurse response to the client

    a. "This type of treatment helps you examine how your thoughts and feelings contribute to your difficulties.
    b. " This type of treatment will help you relax and develop new coping skills"
    c. "This type of treatment helps you confront your fears by gradually exposing you to them"
    d. " This type of treatment helps you examine how your past life has contributed to your problems"

10. The nurse is assigned to care for client with phobia. The nurse exposes the client to a short period of time to the phobic object while in a calm state. The nurse understands that this form of behavior modification can best described as

    a. a form of behavior modification therapy
    b. a cognitive approach to changing behavior
    c. a living, learning or working environment
    d. a behavioral approach to changing behavior

11. The nurse organized a psychotherapy group. Several clients are eager to attend the session. Several clients are eager to attend the session. The nurse creates a group knowing that the maximum number of group members to include in the group is

    a. 10
    b. 14
    c. 16
    d. 12

12. The client has bipolar disorder with aggressive social behavior. The nurse caring for this client is making a plan of activities for the day. Which of the following activities would the most appropriate for this client?

a. basketball
b. ping pong
c. writing
d. chess

13. The nurse is planning activities for a depressed client during the early stage of hospitalization. Which of the following plans is best for a depressed client?

    a. offer the client a menu of daily activities and insist the client participate in all of them
    b. provide a structured daily program of activities and encourage the client to participate
    c. provide an activity that is quiet and solitary to avoid increased fatigue, such as working on a puzzle or reading a book
    d. Plan nothing until the client asks to participate in milieu

14. The client verbalizes feeling of low self-esteem and tells the nurse, "I am a failure, I can't do anything right. "The appropriate nursing response to the client would be

    a. to remain with the client and sit in silence; this will encourage the client to verbalize feelings
    b. to tell the client that this is not true; that we all have a purpose in life
    c. to identify recent behaviors or accomplishment that demonstrate skill ability
    d. to reassure the client that you know how the client is feeling and that things will get better

15. A client is admitted in the mental health unit and diagnosed with major depression recurrent with psychotic features. What would be the most important plan of care that would create a safe environment for the client?

    a. Imbalanced Nutrition
    b. Disturbed Thought Processes
    c. Deficient Knowledge
    d. Self-Care Deficit

16. A depressed client is ready for discharge. The nurse caring for this client feels better that the client clearly understand the disease process and can fully recovered from depression by stating that

    a. " It's important for me to eat well, exercise, and to take my medication, If I begin to lose my appetite or not sleep well, I've got to get in to see my doctor"
    b. "I don't know what happened to me. I've always been able to make decisions for myself and for my business. I don't ever want to feel so weak or vulnerable again"
    c. "I'll never let this happen to me again. I won't let my boss or my job or my family get to me"
    d. "I've learned I am a good person and that I am worthy of giving and receiving love. I don't need anyone. I have myself to rely on!"

17. The nurse is planning activities for the day on a client with manic problem. The nurse plans which activity suitable for manic client?

    a. tetherball
    b. deep breathing and progressive relaxation group
    c. paint-by-number-activity

d. brown-bag luncheon and a book review

18. A client who is delusional tells the nurse, “The federal guards were set to kill us”. The nurse’s best response would be

    a. “I don’t believe this is true”
    b. “What makes you think the guards were sent to hurt you?”
    c. “The guards are not out to kill you”
    d. “I don’t know anything about the guards. Do you feel afraid that people are trying to hurt you?”

19. A female client, after the car accident, comes into the emergency room in very nervous state. The nurse initial nursing intervention is to

    a. put the client in a quiet room
    b. teach the client deep breathing
    c. remain with the client
    d. encourage the client to talk about their feelings and concerns

20. A nurse in night shift is making rounds. The nurse enters the client’s room and found out that the client becomes disoriented and confused. The best initial nursing intervention is to:

    a. keep the television and a soft light on during the night
    b. use a night light and turn off the television
    c. play soft music during the night, and maintain a well-lit room
    d. move the client net to the nurse’s station

21. A male client is being considered for electroconvulsive therapy. The client is calm, but the family is anxious about the procedure. The mother of the client begins to cry and says, “My son’s brain will be destroyed.” How can the doctor do this to him?” The nurse’s best response is

    a. “Your son has decided to have this treatment. You should be supportive to him.”
    b. “It sounds as though you need to speak to the psychiatrist.”
    c. “Perhaps you’d like to see the electroconvulsive therapy room and speak to the staff.”
    d. “It sounds as though you have some concerns about the electroconvulsive therapy procedure. Why don’t we sit down together and discuss any concerns you may have.”

22. The nurse completes the assessment on a client with dementia. Which data gathered during the assessment would indicate a manifestation associated with this disease?

    a. improvement in sleeping
    b. absence of sundown syndrome
    c. presence of personal hygienic care
    d. confabulation

23. The community health nurse visits a client at home. The client just recently retired and states’ “Lately I’m getting forgetful about things. Do you think I’m getting Alzheimer’s disease?” Which response by the nurse would be most therapeutic?

    a. “ Now, I’m not going to discuss this with you because I think you are just normal”
    b. “I am so forgetful too. I have to make out lists now to go shopping.”

c. “Tell me more about your forgetfulness. It isn’t unusual for forgetfulness to occur if memory is not exercised. Are you staying socially active?”
d. “Oh, I’m certain it’s not Alzheimer’s disease because there is no family history of it”

24. The nurse is caring for a male client and observes that the client is pacing, agitated, and presenting aggressive gesture. The client’s speech pattern is rapid and affect is belligerent. Based on the behavior of the client, the nurse’s immediate priority of care is to

a. provide the clients on the unit with a sense of comfort and safety
b. provide safety for the client and other clients on the unit
c. offer the client a less stimulated area to calm down and gain control
d. assist the staff in caring for the client in a controlled environment

25. The nurse is discharging a client with chronic anxiety. The nurse wants to ensure a safe environment for the client. The most appropriate maintenance goal should focus on which of the following?

a. ignoring feeling of anxiety
b. continued contact with a crisis counselor
c. eliminating all anxiety form daily situations
d. identifying anxiety-producing situations

26. The client is afraid to go out of the house and states, “I’m afraid to do something crazy in public.” Because of this fear the client would choose to stay home except when accompanied outside by the spouse. Based on this data, the nurse determines that the client is experiencing

a. agoraphobia
b. socialphobia
c. claustrophobia
d. hypochondriasis

27. A nurse is conducting a therapy session, while the session is on-going one of the clients in the group with mania consistently talks and dominates the group session and his behavior is interrupting the group interaction. The nurse would initially

a. Tell the client that he needs to allow other client’s in the group time to talk.
b. Ask the client to leave the group session.
c. Tell the client that he will not be able to attend any future group sessions.
d. Ask another nurse to escort the client out of the group session.

28. A client is admitted to a medical nursing unit with a diagnosis of acute blindness. Several tests were done and there seems to be no medical reasons why the client cannot see. Based on the assessment of the nurse, he found out that the client became blind after witnessing a hit-and –run car accident. Three family members died in the accident. The nurse suspects that the client maybe experiencing a:

a. conversion disorder
b. psychosis
c. repression
d. dissociative disorder

29. Inside the day room, the manic client announces that a stripper is coming to perform in the evening. The nurse strongly states. “This is not possible to happen”, the manic client

becomes verbally abusive and threatens physical violence to the nurse. Based on the situation, the nurse determines that the most appropriate actions would be to

a. Tell the client that smoking privileges are revoked for 24 hours
b. With assistance, escort the manic client to her room and administer haloperidol (HALDOL) as prescribed if needed
c. Tell the client that the behavior is not appropriate
d. Orient the client to time, person and place

30. A nurse is assigned to a female client who is newly admitted to the mental health unit for anorexia nervosa. The nurse visits the client in her room and found out that the client is engaged in rigorous push-ups. Which nursing action is most appropriate?

a. Interrupt the client and offer to take her for a walk.
b. Allow the client to complete her exercise program.
c. Tell the client that she is not allowed to exercise rigorously.
d. Interrupt the client and weigh her immediately.

31. The nurse is monitoring the behavior of the client with anorexia nervosa. The nurse understands that the client with anorexia nervosa manages anxiety by:

a. Engaging in immoral acts.
b. Having the need always to make the right decision
c. Always reinforcing self-approval
d. Observing rigid rules and regulations

32. A nursing student formulated a nursing plan of care for a hospitalized client with Bulimia nervosa. As the nurse reviews the list of plan, the nurse would question which intervention listed in the plan?

a. monitoring electrolyte levels
b. monitoring intake and output
c. observing for excessive exercise
d. checking for the presence of laxatives and diuretics in the client's room

33. The nurse is assigned to monitor a client for signs of alcohol withdrawal. Which of the following signs would be alarming and would lead to the potential for delirium tremors?

a. Hypertension, changes in level of consciousness, hallucinations
b. Hypotension, coarse hand tremors, agitation
c. Hypotension, ataxia, hunger
d. Stupor, agitation, muscular rigidity

34. The female client voluntarily admitted herself to the mental health unit for alcohol withdrawal. The client says, "I should get out of this bad situation" The most helpful response by the nurse would be

a. "Why don't you tell your husband about this?"
b. " I agree with you. You should get out of this situation"
c. "This is not the best time to make that decision"
d. "What do you find difficult about this situation?"

35. The home health nurse is scheduled to visit a client at home and found out that the client is dependent on drugs. Which of the following assessment questions would assist the nurse to provide appropriate nursing care?

a. "Why did you get started on these drugs?"

b. The nurse does not ask any questions in fear that the client is in denial and will throw the nurse out of the home.
c. "How long did you think you could take these drugs without someone finding out""
d. "How much do you use and what effect does it have on you"

36. An anxious client is walking in the hallway back and forth. In walking three steps forward and two steps backward, the client is almost blocking the hallway and other clients are agitated trying to get past. The nurse observes this situation and would intervene by:

    a. Walking alongside the client and saying "You're not going anywhere very fast doing this."
    b. Stopping the behavior and saying "You're going to get exhausted"
    c. Standing alongside the client and saying, "You're very anxious today."
    d. Taking the client to the TV lounge and saying, "Relax and watch television no."

37. A nurse is caring for a newly admitted client with alcohol withdrawal. The nurse is monitoring a client for signs of alcohol withdrawal. Which assessment data would indicates early signs of withdrawal?

    a. dizziness, vomiting, headache
    b. clouding of consciousness, tiredness, fatigue
    c. anxiety, tremor, irritability
    d. disorientation, and sleepiness

38. A 3 year-old child was hospitalized because of severe diarrhea. The mother observes that, since her child was brought to the hospital, he has begun to wet the bed. The mother is concerned about the changes of her child and asks the nurse what to do. The appropriate nursing response is which of the following?

    a. " We will need to discuss this behavior with the physician
    b. "You need to discipline the child"
    c. "The child probably has developed a urinary tract infection"
    d. "This is normal occurrence following hospitalization"

39. A 6 year-old child is admitted to the hospital. The nurse is assigned to assess the condition of the child. On her assessment, she found out that the child was sexually abused. The child is withdrawn and just staying at the corner of the room. Which of the following describes the best plan for the initial encounter to convey concern and support?

    a. Introduce self and tell the child that the nurse would like to sit with her for a talk.
    b. Introduce self and explain to the child that she is safe and now she is in the hospital
    c. Introduce self, explain role and ask the child to act out the sexual encounter with the abuser using art therapy
    d. Introduce self, ask the child to express how she feel about the events leading up to hospital admission

40. A charge nurse assigned a nursing assistant to care to a client with delirium. While the nurse is on her way to the other client's room, she happens to hear the nursing assistant talking in an unusually loud voice to the client. The charge nurse takes which appropriate action?

    a. Explains to the nursing assistant that yelling in the client's room is tolerated only If the client is talking loudly

b. Informs the client that everything is all right
c. Ascertains the client's safety, calmly asks the nursing assistant to join the nurse outside the room, and informs the nursing assistant that her voice was unusually loud
d. Speaks to the nursing assistant immediately while in the client's room to solve the problem

41. A 9 year-old child is hospitalized for 8 weeks after having a traumatic car accident. The nurse caring for the child is formulating a plan of care and the best way to promote psychosocial development of this child is to plan for:

    a. A portable radio and tape player with headphones
    b. A phone to call family and friends
    c. Tutoring to keep the child up with school work
    d. Computer games, TV and videos at the bedside

42. A client diagnosed with a major depression says to the nurse, "I'm such a loser. "It would be better for me to die. "The nurse makes which therapeutic statements to the clients?

    a. "I see a lot of positive things in you"
    b. "You still have a great deal to live for"
    c. "Everything will get better, you are not a loser"
    d. "You've been feeling like a loser for some time now?"

43. A nurse is assigned to care to a client with schizophrenia. The nurse observes the behavior of the client while in the mental health center. Based on her observation, the client is unable to speak, although there is no known pathological dysfunction in the organ of communication of the client. The nurse notes that the client is experiencing"

    a. mutism
    b. verbigeration'
    c. pressured speech
    d. poverty of speech

44. A nurse is caring to a client with a diagnosis of panic disorder. The client displays difficulty of breathing and sweating and shaky. The nurse anticipates that the physician will prescribe a benzodiazepine and checks the physician's order sheet for which medication order?

    a. Imipramine (Tofranil)
    b. Alprazolam (Xanax)
    c. Buproprion (Wellbutrin)
    d. Doxepin ( Sinequan)

45. A nurse enters the female client room to administer medication. Inside the room, the client is in manic state. She is naked and making sexual remarks and gestures toward the nurse. The best initial nursing action is to:

    a. ask the other nurse to calm the client
    b. approach the client and insist that she has to put on her clothes
    c. quietly approach the client and assist her in getting dressed
    d. confront the client on the inappropriateness of her behavior and offer her a time-out

46. A client is scheduled to an electroconvulsive therapy for a major depressive disorder. The nurse caring for this client wants to identify which unexpected side effect of ECT.

    a. Memory loss
    b. Hypertension
    c. Disorientation
    d. Confusion

47. A nurse is assigned to care for a client in delirium state. During nursing assessment the client states, “Look at the scorpion in the floor “. The nurse makes which response to the client?”

    a. “I know that you are frightened, but I do not see scorpion on the floor”
    b. “You’re having a hallucination; there are no scorpion in this room at all”
    c. “I can see the scorpion on the floor but they are not going to hurt you”
    d. “Would you like me to kill the spider for you?”

48. A hospitalized 22 year old famous singer went to other client’s room and taking their possession. On her way going back to her room she is singing to herself, giggling for no apparent reasons. The nurse assigned in the unit recognizes the severe regression of the client and the difficulty with limit setting. The nurse would implement which of the following action?

    a. taking the client to seclusion until she cooperates with unit rules
    b. putting arms around the client saying “you’re okay. You just need a hug”
    c. Saying, “I can see you are very anxious today. Let’s go and sing”
    d. Taking the client to the lounge and saying, “sit here and behave yourself”

49. A nurse caring for a client with a diagnosis of schizophrenia is monitoring the client’s condition. The nurse checks the doctor’s order and Risperidone (Risperdal) is prescribed for the treatment of the client’s disorder. The nurse anticipates which laboratory study to be done before administering the medication therapy?

    a. blood clotting studies
    b. platelet count
    c. complete blood count
    d. liver function studies

50. The nurse in-charge placed the manic client in a seclusion room following an outburst of violent behavior that involved a physical assault on another client. As the client is in the seclusion room, the nurse in charge would:

    a. informs the client that he is being secluded to help regain self-control
    b. asks the client if she understands why the seclusion is necessary
    c. remains silent because verbal interaction would be too stimulating
    d. tells the client that she will be allowed to rejoin the others when she can behave

51. The client with history of alcohol abuse is hospitalized for 3days. The nurse in charge informed the client that he will be scheduled for an important diagnostic test. The client tells the nurse, “I am leaving now. I have to go. I don’t’ want anymore treatment. I have things that I must do.” The client dresses and begins to walk out of the hospital room. The most appropriate nursing action it to:

    a. call the nursing supervisor
    b. call security to block all exit areas
    c. tell the client that he cannot return to this hospital again if the client leaves now

d. restrain the client until the physician can be reached

52. The nurse is completing an admission assessment on a client with a diagnosis of bulimia nervosa. The nursing students will be observing the nurse in the admission. The nurse ask the student about the expected assessment findings and determines that the student needs to know more about the disorder if the student states that which of the following is a characteristics findings:

    a. body weight well below ideal range
    b. dental decay
    c. loss of tooth enamel
    d. electrolyte imbalance

53. A nurse formulating a plan of care for a client in crisis. In formulating a plan, the nurse must consider which of the following?

    a. A client's response to a crisis is individual and what constitutes a crisis for one person may not constitute a crisis to another person
    b. A crisis state indicates that the individual is suffering from emotional illness
    c. Presenting symptoms in a crisis situation are similar for all individuals experiencing crisis.
    d. A crisis state indicates that the individual is suffering from mental illness

54. The nurse is developing a discharge plan for the client who attempted suicide. The nurse should focus the plan in which of the following?

    a. Encouraging the family always to be with the client
    b. Providing the hospital telephone numbers
    c. Follow-up appointments
    d. Contracts and immediate available crisis resources

55. A client is admitted in the mental health unit complaining of loose, watery stool, and difficulty walking. The nurse would expect the serum lithium level to be which of the following?

    a. 1.3 mEq/L
    b. 0.7 mEq/L
    c. 1.8 mEq/L
    d. 1.0 mEq/L

56. A nurse is performing a health teaching to a client who is being started on Imipramine hydrochloride (Tofranil). The nurse informs the client that maximum desired effects of the drug may:

    a. not occur until after 2 months of administration
    b. start during the 2nd week of administration
    c. start during the 1st week of administration
    d. not occur for 2-3 weeks of administration

57. A client complains of feeling "faint" when trying to get out of bed in the morning. The nurse reviews the physician's order and found out that the client is receiving Thioridazine hydrochloride (Mellaril) and recognizes the complaints of the client as a symptoms of:

    a. respiratory insufficiency

b. postural hypotension
c. psychosomatic disorder
d. cardiac dysrhythmias

58. A depressed client taking tricyclic antidepressant arrives at the mental health clinic. Which observation would indicate that the client is following the medication plan correctly?

a. client arrives at the clinic neat and appropriate in appearance
b. client complains of not being able to do anything anymore
c. client reports sleeping 12 hours per night and 3 to 4 hours during the day
d. client reports not going to work for this past week

59. The physician prescribed Thioridazine hydrochloride (Mellaril) to a client with depression. The nurse will administer the drug in oral concentration form. The nurse prepares this medication by mixing it in which of the following just before giving it to the client?

a. fruit juices
b. applesauce
c. tea
d. pudding

60. The nurse is performing a follow-up assessment with a client that was discharged a month ago. The client is taking Flouxetine (Prozac). What would be the important information that the nurse need to obtain regarding the side effects related to the medication?

a. gastrointestinal dysfunctions
b. problems with excessive sweating
c. cardiovascular symptoms
d. problems with mouth dryness

61. A client under treatment of alcohol withdrawal returns to the clinic for follow-up check up. The client has been taking Buspirone hydrochloride (BuSpan) for 1 month. The nurse determines that the medication is effective if the absence of which manifestation(s) has occurred?

a. rapid heartbeat or anxiety
b. paranoid thought process
c. alcohol withdrawal symptoms
d. thought broadcasting or delusions

62. The client taking lithium carbonate (Eskalith) is complaining vomiting, abdominal pain, diarrhea, blurred vision, tinnitus and tremors. The nurse interprets that the lithium level of 2.5 mEq/L is:

a. toxic
b. normal
c. slightly above normal
d. excessively below normal

63. A hospitalized client is prescribed with Chloral hydrate (Noctec). The nurse is in charge to monitor the client for drug side effects. The nurse includes which action in the plan of care?

a. monitor blood pressure every 4 hour
b. monitor apical heart rate every 2 hour
c. clear path to the bathroom at bedtime
d. instruct the client to call for ambulation assistance

64. A nurse is scheduled to visits the client at home. The nurse checks the medication of the client. The client gives the nurse a bottle of clomipramine hydrochloride (Anafranil). The nurse notes that the medication has not been taken by the client in 2 months. What observation made by the nurse to validate uncompliance of the client with this medication?

a. Complaints of insomnia
b. frequent hand washing with hot, soapy water
c. complaints of hunger and fatigue
d. a pulse rate fewer than 60 beats per minute

65. A client is taking Amitriptyline hydrochloride (Elavil). The nurse evaluates that the medication is most effective for this client if the client reports which of the following?

a. decrease in appetite
b. sleeping 14-16 hours a day
c. ability to get to work on time each day
d. having difficulty concentrating on an activity

66. The client with schizophrenia is receiving medication therapy with Haldol. The nurse determines that the medication is effective if the client manifest behavior(s) in which of the following?

a. presence of a fixed rate
b. absence of delusional statement
c. taking sips of water for dry mouth
d. decrease appetite and food intake

67. During a group therapy session, one of the clients asks a male client with a diagnosis of antisocial personality disorder why he is in the hospital. The nurse might expect to response and considers the client type of personality disorder;

a. “I decided that it’s time I own up to my problems”
b. “I need a lot of help with my trouble”
c. “society makes people react in odd ways”
d. “my life needs straightening out and this might help”

68. A client is scheduled for discharge and will be receiving Phenobarbital sodium (Luminal) for an extended period of time. The nurse would give priority teaching in the client. Which of the following points that directly relates to client safety?

a. Take medications only with meals
b. Avoid drinking alcohol while taking this medication
c. Take the medication at the same time each day
d. Use a dose container to help prevent missed dose

69. The client with schizophrenia is admitted in the mental health unit and will be starting on medication therapy with Clozapine (Clozaril). The nurse assesses the results of which laboratory study to monitor for adverse effects from this medication.

a. white blood cell count

b. blood glucose
c. platelet count
d. liver function studies

70. Female client with schizophrenia has been prescribed Chlorpromazine ( Thorazine). The client was alarmed with the color of her urine that becomes dark. The client has no other urinary symptoms. The nurse tells the client:

a. That this medication indicates toxicity
b. To increase intake of acid-ash foods and liquids
c. To seek treatment for urinary tract infection
d. That this is an expected side effect of the medication

71. A client is taking Fluphenazine hydrochloride (Prolixin) daily. To lessen the common side effects of this medication, the nurse would instruct the client to do which of the following?

a. have the blood pressure checked once a week
b. monitor the temperature daily
c. eat snacks at midmorning and at bedtime
d. use hard sour candy or sugarless gum

72. The nurse is teaching the client about the medication side effects. The client is receiving Oxazepan (Serax). The nurse incorporates in discussion with the client the need to:

a. rest if the heart begins to beat rapidly
b. take antidiarrheal agents if diarrhea occurs
c. increase fluids and bulk in the diet
d. consume a low-fiber diet

73. The client is on medication therapy with Alprazolam (Xanax). The nurse give priority teaching to the client about the medication, Alprazolam should not be discontinued abruptly. The client asks the nurse the reason. The nurse incorporates which of the following response?

a. abruptly stopping the medication will make the medication much less effective if it must be restarted
b. rebound central nervous system excitation could occur
c. the client is likely to become resistant to medication effects
d. the client is likely to suffer irreversible damage to the kidneys

74. The nurse checks the medication sheet of the client. The order states that client will be starting with the Sertraline hydrochloride (Zoloft). To ensure safe administration of the drug, the nurse would give the dose:

a. at the same time each evening
b. evenly spaced around the clock
c. on empty stomach
d. as needed when the client complains of depression

75. The client is displaying an aggressive behavior in the mental health unit. The nurse is visit the unit and observes that the client aggressive behavior is escalating. Which nursing intervention is least helpful to this client at this time?

a. initiate confinement measures
b. acknowledge the client's behavior

c. assist the client to an area that is quiet
d. maintain a safe distance with the client

76. A nurse is in charge to care to a newly admitted client in the mental health unit. The nurse is reviewing the assessment data of a client and notes the client is experiencing anxiety as a result of a situational crisis. The nurse determines that this type of crisis is caused by:

a. the death of a loved one
b. a fire that destroyed the client's home
c. a recent rape episode experienced by the client
d. witnessing a murder

77. The nurse is performing a first assessment on a client in crisis state. The nurse wants to know the precipitating event that causes the client to experience crisis. What would be the most appropriate question to ask to the client?
a. "What leads you to seek help now?"
b. "What do you usually do to feel better?"
c. "Who is available to help you?"
d. "With whom do you live?"

78. A nurse has a conversation with a depressant client on an inpatient unit. During that particular period, the client tells the nurse, "My family would be better off without me". The nurse's best response is:

a. "Have you talked to your family about this?"
b. "Everyone feels this way when they are depressed."
c. "You will feel better once your medication begins to work."
d. "You sound very upset. Are you thinking of hurting yourself?"

79. A client arrives at the emergency room escorted by a police officer. The client has seriously lacerated both wrists and keep on saying, "I want to die. I am useless." The initial nursing action is to:

a. secure and record the detail history
b. examine and treat the wound sites
c. encourage and assist the client to ventilate feelings
d. administer an antianxiety drug

80. A nurse receives a telephone call from a female client who states that she wants to kill herself and holding a bottle of a poisonous substance. The best nursing action is to:

a. use therapeutic communication techniques, especially the reflection of feelings
b. insist that the client give you her name and address so that you can get the police there immediately
c. keep the client talking and allow the client to ventilate feelings
d. keep the client talking and signal another staff member to trace the call so that appropriate help can be sent

81. A nurse is evaluating the client's response to the treatment. Based on the observation of the nurse, the client with nursing diagnosis of dysfunctional grieving related to loss of spouse is progressing. Which of the following is an appropriate outcome for this nursing diagnosis?

a. The client verbalizes stages of grief and plans to attend a community grief group
b. The client reports three additional coping strategies

c. The client verbalizes decreased desire for self-harm and discusses two alternatives to suicide
d. The client verbalizes connections between significant losses and low self-esteem

82. The nurse is checking the client who is in seclusion and ensures that the client is safe. The client is asking the nurse to let her out of the unit. The nurse determines that the client is safe to come out of seclusion when the client states:

a. "I am no longer a threat to myself or others"
b. "I need to go to the bathroom"
c. "I want to be alone for a while in my own room"
d. "I can't breathe in here. The walls are closing in on me"

83. The nurse is developing a plan of care for a client being admitted to the nursing unit. The client attempted suicide several times. Which of the following priority nursing intervention will the nurse include in developing a care plan?

a. Ask the client to report suicidal thoughts immediately
b. Check whereabouts of the client every 15 minutes
c. One-to-one suicide precaution
d. Suicide precautions with 30 minutes check

84. A 60 year old female client comes to the emergency room and voluntarily admitted herself. According to the nurse's assessment, the client is a victim of family violence. Which priority instruction would be included?

a. Instruction regarding calling the police
b. Information regarding family members and shelters
c. Explaining the importance of leaving the violent situation
d. Instruction regarding self-defense classes

85. A nurse is in charge to care for a young female client, a victim of sexual assault. The nurse completed the physical assessment and important evidence was gathered. The nurse notes that the client is withdrawn, confused, and at times physically immobile. This behavior are interpreted by the nurse as:

a. signs of depression
b. evidence that the client is a high suicide risk
c. normal reaction to a devastating event
d. indicative of the need for hospital admission

86. A 12-year old female client, a rape victim, is hospitalized. A nurse is caring for a client for almost a month. Which of the following is unrealistic as a short-term initial goal?

a. physical wounds will heal
b. the client will resolve feelings of fear and anxiety
c. the client will verbalizes feelings about the event
d. the client will participate in the treatment plan

87. A home health nurse visits a client at home. With the observation of the nurse, she determines that the client is dependent on drugs. Which of the following assessment questions would assist the nurse to provide appropriate nursing care?

a. The nurse does not ask any question in feat that the client is in denial and will throw the nurse out

b. “How long did you think you could take these drugs without someone finding out?”
c. “Why did you get stated on these drugs?”
d. “How much do you use and what is the effect it has on you?”

88. A female client comes into the emergency room after an assault. The nurse start an assessment to the client and notes that the client exhibits hyperventilation, pacing, rapid speech and headache. The nurse assesses the level of anxiety of the client to be:

a. Moderate
b. Panic
c. Severe
d. Psychotic

89. The nurse is preparing a plan of care for the client who is suffering from anxiety disorder after the loss of a job. The client is expressing concerns regarding the ability to meet role expectations and financial obligations. The most appropriate nursing diagnosis for this client is

a. Risk for anxiety
b. Dysfunctional Family Process
c. Disturbed Thought process
d. Ineffective coping

90. A nurse is caring for a 12 year old female client who is a victim of physical and sexual abuse. The client is newly admitted in the hospital and the nurse performs assessment about the case of the client. Following assessment, the nurse found out that the child’s father is the abuser. That time, the father arrives and angrily approaches the nurse and says, “I’m taking my daughter home. She’s told me what you people are up to and we’re out of here!” The nurse makes which therapeutic response to the child’s father?

a. ”Your daughter is sick and needs to be here.”
b. “Over my dead body you will! She’s here and here she stays until the doctor says different”
c. “Listen to me. If you attempt to take your daughter from this unit, the police will bring her back.”
d. “You seem very upset. Let’s talk at the nurse’s station. I want to help you. It would be best if you agree to let you daughter stay here for now.”

91. A nurse plans to start an assessment to a client for vegetative signs of depression. The nurse assess for these signs by determining the client’s:

a. appetite, weight, sleep pattern, and psychomotor activity
b. ability to think,concentrate,and make decisions
c. level of self-esteem
d. level of suicidal ideation

92. A young adolescent is admitted and diagnosed as having an anorexia nervosa. The nurse can determine that anorexia nervosa is usually precipitated by:

a. an unconscious with to punish a parent who tries to dominate the adolescent’s life
b. the acting out of aggressive impulses, which results in feelings of hopelessness
c. an inaccurate perception of hunger stimuli and a struggle between dependence and independence

d. the inability to deal with being the center of attention in the family and a desire for independence

93. There are many clients diagnosed with schizophrenia experience opposing emotions simultaneously. The nurse understands this phenomenon as:

a. double bind
b. ambivalence
c. loose association
d. inappropriate affect

94. A female client has been admitted to the psychiatric unit with the diagnosis of bipolar I disorder, manic episode. Her physician has prescribed Tiagabine hydrochloride (Gabatril). The nurse is aware that the client will experience the side effects of this medication such as:

a. dizziness, lethargy, and generalized weakness
b. sensitivity to the sun, agitation, and restlessness
c. weight gain, drowsiness, and decreased concentration
d. abdominal cramps, tremors, and muscular weakness

95. The nurse is planning an intervention to help a client with bipolar I disorder, manic episode meet needs for rest and sleep, the nurse must remember that the manic client:

a. requires less sleep than the average person
b. needs to expend energy to be tired enough to sleep
c. is easily stimulated by the environment
d. experiences few sleep pattern disturbances

96. A newly admitted client is diagnosed with Schizophrenia, undifferentiated type and is under observation by the nurse. The nurse should be aware that the defense mechanism of a client with this kind of disorder, would most probably exhibit is:

a. repression
b. regression
c. projection
d. rationalization

97. The nurse is developing a plan of activities to a client who is withdrawn and hallucinatory. The nurse should know that which activity would be most therapeutic for this kind of client:

a. watch a movie with other clients
b. play cards with a group of clients
c. play solitaire alone in the dayroom
d. go for a walk with the nurse

98. A child client is admitted and refuse appears to be scared to the nurse. The nurse is aware that a 4-year old child's greatest fear related to hospitalization usually is the fear of:

a. Bodily harm
b. Loss of control
c. Loss of independence
d. Separation from the mother

99. A nurse is caring for a client diagnosed with obsessive-compulsive disorder. The client tells the nurse that his roommates get upset because it would take him 30 minutes to take a bath six times a day. The client says, 'This prevents me from getting nervous." The nurse's most appropriate response would be:

    a. "Tell me more about what you do in the bathroom during those 30-minute periods."
    b. "That is not a problem now because you have your own bathroom here."
    c. "We can compromise. Let's start by cutting down the time you spend in the bathroom to 20minutes three times a day."
    d. "Explain how spending time in the bathroom helps you avoid becoming nervous."

100. A severely depressed client is admitted in the mental health unit for 8 weeks. The nurse observes that the client has not responded to any of the antidepressant medication, the physician decides to try electroconvulsive therapy (ECT). Before the treatment the nurse should:

    a. Give the client a detailed explanation of the entire procedure
    b. Have the client speak with other clients receiving ECT
    c. Limit the client's intake to a light breakfast on the day of the treatment
    d. Provide a simple explanation of the procedure and continue to reassure the client

**Test I - Foundation of Nursing, Nursing Research, Professional Adjustment, Leadership and Management**

**ANSWERS AND RATIONALE**

1. **ANSWER: C**
   **RATIONALE:** The nurse should immediately return the unit of blood to the blood bank. The presence of gas bubbles in the bag indicates possible bacterial growth and unit is considered contaminated

2. **ANSWER: C**
   **RATIONALE:** The first layer of the chest tube dressing is petrolatum gauze which allowed for an occlusive seal at the chest tube insertion site. Additional layers of gauze cover this layer, and the dressing is secured with a strong adhesive tape or Elastoplast tape.

3. **ANSWER: C**
   **RATIONALE:** FORMULA

   $$\text{DROP/MIN} = \frac{\text{TOTAL VOLUME IN CC x DROP FACTOR}}{\text{NO. OF HOURS X 60 MINS}}$$

   $$= \frac{1000\text{ml} \times 15\text{gtts}}{8\text{ HRS.(60 MINS)}}$$

   $$= \frac{15000}{480} =$$ 31.2 or **31gtts/ minuteee**

4. **ANSWER: B**
   **RATIONALE:** **Pharyngeal reflex (gag reflex**) is tested by touching the back of the throat with an object, such as a tongue depressor. It is considered normal if there is a positive response to these reflexes.

5. **ANSWER: D**
   **RATIONALE:** The **normal serum amylase is 25 to 151 IU/L**. In client with chronic pancreatitis, the increase in serum amylase does not exceed 3 times the normal value.

6. **ANSWER: C**
   **RATIONALE:** The nurse should ask the client to perform Valsalva's maneuver during tubing change this maneuver would help the client to avoid air embolism during the procedure

7. **ANSWER: C**
   **RATIONALE:** If client developed uncontrolled atrial fibrillation with a ventricular rate over 100 beats per minute, the client may experience low cardiac output caused by loss of atrial kick. The nurse assesses the client for palpitation, chest pain, or discomfort, hypotension, pulse deficit, fatigue, weakness, dizziness, shortness of breath and distended neck veins.

8. **ANSWER: A**
   **RATIONALE:** The solution containing the highest amount of glucose should be hung until the new TPN becomes available. The 10% water solution is the best because it minimizes the risk of hypoglycemia

9. **ANSWER: A**

**RATIONALE:** A dry sterile dressing such as 2x2 gauze is used to apply pressure to the discontinued IV site. This material is absorbent, sterile and non-irritating.

10. **ANSWER: A**
    **RATIONALE:**
    Desire
    Available x ml = 30mEq/ 40mEq x 20ml = 15ml

11. **ANSWER: C**
    **RATIONALE:** After liver biopsy, the client is assisted to assume right side-lying position with a small pillow or folded towel because it compresses the liver against the chest wall at the biopsy site.

12. **ANSWER: C**
    **RATIONALE:** The lung is collapsed; therefore, there are no breath sounds during auscultation

13. **ANSWER: A**
    **RATIONALE:** If the balloon is positioned in the urethra, inflating the balloon could produce trauma, and pain will occur. If pain occurs, the fluid should be aspirated and the catheter inserted a little further in order to provide sufficient space to inflate the balloon.

14. **ANSWER: C**
    **RATIONALE:** All IV solutions should be free of particles or precipitates. The nurse must check the solution before the procedure.

15. **ANSWER: D**
    **RATIONALE:** The most accurate means of confirming the diagnosis of Tuberculosis is by sputum culture

16. **ANSWER:C**
    **RATIONALE:** The Miller-Abbott tube is a nasogasenteric tube that is used to decompresses the intestine and to correct a bowel obstruction

17. **ANSWER: D**
    **RATIONALE:** The nurse asks the client to void at the beginning of the collection period and discard the unit sample

18. **ANSWER: C**
    **RATIONALE:** A pneumothorax is characterized by distended neck veins, displaced point of maximal impulse (PMI), and subcutaneous emphysema, tracheal deviation to the unaffected side, decreased fremitus, and worsening cyanosis.

19. **ANSWER: C**
    **RATIONALE:** Typical assessment findings in the client with a pleural effusion include Dyspnea, which usually occurs with exertion, and a dry nonproductive cough. The cough is caused by bronchial irritation and possible mediastinal shift.

20. **ANSWER: A**
    **RATIONALE:** Apmhotericin B is a toxic medication, which can produce symptoms during administration such as chills, fever, headache, vomiting, and impaired renal function. The medication is very irritating to the IV site, commonly causing thrombophlebitis. The nurse administering this medication monitors for these complications.

21. **ANSWER: A**

**RATIONALE:** Rapid emptying of a large volume of urine may cause engorgement of pelvic blood vessels and hypovolemic shock. Clamping the tubing for 30minutes allows for equilibration to prevent complication.

22. **ANSWER: A**
    **RATIONALE:** To prevent a tension pneumothorax, the nurse avoids clamping the chest tube, unless specifically ordered. Clamping the chest tube is contraindicated by agency policy

23. **ANSWER: C**
    **RATIONALE:** If a chest tube accidentally disconnects from the tubing of the drainage apparatus, the nurse should first reestablish an underwater seal to prevent tension pneumothorax and mediastinal shift. This can be accomplished by reconnecting the chest tube, or in this case, immersing the end of the chest tube in a bottle of sterile normal saline or water. The physician should be notified after taking the corrective action.

24. **ANSWER: A**
    **RATIONALE:** Any condition in which gastrointestinal motility is slowed or esophageal reflux is possible places a client at risk for aspiration.

25. **ANSWER: C**
    **RATIONALE:** Indirect laryngoscopy is done to assess the function of the vocal cords or to obtain tissue for biopsy. Observations are made during rest and phonation by using a laryngeal mirror. The client is placed in an upright position to facilitate passage of the laryngeal mirror into the mouth and is instructed to breathe normally. The tongue cannot be moved back because it would occlude the airway. Swallowing can not be done with the mirror in place. The procedure takes longer that the time the client would be able to hold the breath, and this action is ineffective.

26. **ANSWER:B**
    **RATIONALE:** The bell of the stethoscope is not use to auscultate the breath sounds. The client ideally should sit up and breathe slowly and deeply through the mouth. The diaphragm of the stethoscope which is warmed before use, is placed directly on the client's skin, not over a gown or clothing.

27. **ANSWER: A**
    **RATIONALE:** The dropper is not allowed to touch any object or any part of the client's skin. The solution is warmed before use. The client is placed on the side with the affected ear upward. The nurse pulls the auricle backward and upward to adult client and instills the medication by holding the dropper about 1cm above the ear canal

28. **ANSWER: C**
    **RATIONALE:** Following pneumonectomy, the fluid status of the client is monitored closely to prevent fluid overload, because the size of the pulmonary vascular bed has been reduced as a result of pneumothorax. Complete lateral turning and positioning is avoided. The client should remain on bed rest and the head of the bed should be elevated to promote lung expansion.
29. **ANSWER: A**
    **RATIONALE:** Restraint should be applied securely not tightly because it could impair circulation

30. **ANSWER: D**
    **RATIONALE:** Pulmonary angiography involves minimal exposure to radiation. The procedure is painless although the client may feel discomfort with insertion of the needle for the catheter that is used for dye injection.

31. **ANSWER: A**
**RATIONALE:** Staying with the client has a two-fold benefit. First, it relieves the anxiety of the dyspneic client. In addition, the nurse must stay with the client to observe respiratory status after application of the occlusive dressing.

32. **ANSWER: B**
**RATIONALE:** The Allen test is performed to assess collateral circulation in the hand before drawing a radial artery blood specimen. The therapeutic response provides information to the client.

33. **ANSWER: A**
**RATIONALE:** The procedure involves the injection of radiopaque dye into the blood vessel. If the client has allergy to iodine the procedure will not be advised to prevent complications of the client's reaction to the dye.

34. **ANSWER: B**
**RATIONALE:** Furosemide is a potassium-losing diuretic, so there is no need to avoid high-potassium product such as a salt substitute. Orthostatic hypotension is a risk. And the client must caution with changing position and with exposure to warm weather. The client needs to discuss the use of alcohol with the physician.

35. **ANSWER: B**
**RATIONALE:** A client in shock is placed in a modified Trendelenburg position that includes elevating the legs, leaving the trunk flat and elevated head and shoulders. This position promotes increase venous return from the lower extremities without compressing the abdominal organ against the diaphragm.

36. **ANSWER: A**
**RATIONALE:** The order of priority in the event of fire is to rescue the clients who are in immediate danger. The next step is to activate the alarm. The fire then is confided by closing the door and last the fire is extinguished

37. **ANSWER: D**
**RATIONALE:** After suctioning, client either with or without artificial airway, the breath sounds are auscultated to determine the extent to which the airways have been cleared of respiratory secretions. The other assessment items are not as precise as breath sounds.

38. **ANSWER: A**
**RATIONALE:** The water seal chamber should be filled to the 2cm mark to provide an adequate water seal between the external environment and the client's pleural cavity. The water seal prevents air from reentering the pleural cavity. Because evaporation of water can occur, the nurse should solve this problem by adding water until the level is gain at the 2cm mark

39. **ANSWER: C**
**RATIONALE:** Serous drainage is an expected finding at a surgical site. The other options indicate sign of wound infection.

40. **ANSWER: A**
**RATIONALE:** When the post operative client arrives from the post anesthesia care unit, the nurse performs an initial assessment. Common time frames for continuing postoperative assessment activities are every 15 minutes for the first hour, every 30 minutes for the second hour, and then every hour for four hours and every four hour as needed.

41. **ANSWER: B**

**RATIONALE:** The nurse should petal the edges of the cast with tape to minimize skin irritation. A hair dryer is used on a cool low setting if a non plaster cast becomes wet. Massaging the skin will not help. Powder should not be shaken under the cast, because it could clump, becomes moist, and cause skin breakdown.

**42. ANSWER: B**
**RATIONALE:** The indirect coombs' test detects circulating antibodies against red blood cells and is the "screening" component to type and screen the client's blood. This test is used in addition to ABO typing, which is normally done to determine blood type.

**43. ANSWER: B**
**RATIONALE:** The client needs to lie still for ERCP, which takes about an hour to perform. An informed consent must be signed. Intravenous sedation (NOT ORALLY) is given to relax the client. The anesthetic spray is used to help keep the client from gaggling as the endoscope is passed.

**44. ANSWER: A**
**RATIONALE:** The most common post operative respiratory problems are atelectasis, pneumonia and pulmonary emboli. Pneumonia is inflammation of lung tissue that causes productive cough, dyspnea and crackles.

**45. ANSWER: C**
**RATIONALE:** There should be enough room for two fingers to slide comfortably under the tracheostomy holder. This ensures that the holder is tight enough to present tracheostomy dislocation, while preventing excessive constriction around the neck.

**46. ANSWER: A**
**RATIONALE:** The first step to client education is establishing what client already knows. This allow the nurse to not only connect any misinformation but also to determine the starting point for teaching and to implement the education of the client's level.

**47. ANSWER:A**
**RATIONALE:** Every effort must be done to obtain permission from a responsible family member to perform surgery if the client is unable to sign the consent form. Telephone consent must be witnessed by two persons who hear the family oral consent. The two witnessed sign the consent noting that an oral consent was obtained.

**48. ANSWER: C**
**RATIONALE:** To elicit Homan's sign, the nurse would dorsiflex the client's foot and assesses the client for pain in the calf area. If pain is present, a positive Homan's sign is present.

**49. ANSWER: A**
**RATIONALE:** The nurse would assist the client to void immediately before surgery so that the bladder will be empty. Any trauma or accidental puncture to the bladder is avoided.

**50. ANSWER: A**
**RATIONALE:** The nurse must remain with the client for the first 15 minutes of transfusion which is the most frequent period of danger of transfusion reaction. This enables the nurse to detect reactions and intervene quickly.

**51. ANSWER: A**
**RATIONALE:** An assault occurs when a person puts another person in fear of a harmful of offensive contact.

52. **ANSWER: D**
**RATIONALE:** If the physician writes an order that requires confirmation, the nurse' responsibility is to contact the physician for clarification. If there is no resolution regarding the order because the physician cannot be located and because the order remains as it was written after talking to the physician, the nurse then should contact the nurse manager or supervisor for further clarification as to what the next step should be.

53. **ANSWER: D**
**RATIONALE:** Floating is an acceptable legal practice used by hospitals to solve their understaffing problems. Legally, a nurse cannot refuse to float unless a union contract guarantees that nurses can work only in a specified area or can prove the lack of knowledge for the performance of assigned task.

54. **ANSWER: B**
**RATIONALE:** Documentation of unusual occurrence, incident, accidents and the nursing actions taken as a result of the occurrence allows the nurse to review the quality of care and determine any potential risks present.

55. **ANSWER: D**
**RATIONALE:** Nurse Practice acts require reporting impaired nurses. This incident needs to be reported to the nursing supervisor, who will then report to the board of nursing and authorities.

56. **ANSWER: C**
**RATIONALE:** Living will are required to be in writing and signed to the client. The client's signature either must be witnessed by specified individuals or notarized. Many states prohibit any employee even a nurse of a facility where the client is receiving care from being a witness.

57. **ANSWER: D**
**RATIONALE:** If the nurse makes an error in documenting in the client's record, the nurse should follow agency policies to correct the error in the documentation. This includes drawing one line and then documenting the correct information.

58. **ANSWER: D**
**RATIONALE:** Sexual harassment in the workplace is prohibited by state and federal law. Sexually suggestive jokes, touching, pressuring a co-worker for a date and open displays of sexually oriented photograph are examples of conduct that could be considered sexual harassment. If the nurse believes that he/she is being subject to unwelcome sexual conduct, these concerns should be reported to the nursing supervisor immediately.

59. **ANSWER: D**
**RATIONALE:** Invasion of privacy takes place with unreasonable intrusion into an individual's private affairs.

60. **ANSWER: A**
**RATIONALE:** Performing a procedure without consent of the client is a form of battery. Threatening the client to give medication is an example of assault. Threatening the client cannot leave the hospital constitute false imprisonment and sharing the client's data is a form of invasion of privacy.

61. **ANSWER: B**
**RATIONALE:** Slander or Defamation takes place when something untrue is said about a person resulting injury to that person's good name and reputation.

62. **ANSWER: D**
**RATIONALE:** The report should contain a factual description of the incident, any injuries experienced by those involved and the outcome of the situation

63. **ANSWER: C**
**RATIONALE:** Generally, in only two instances is the informed consent of an adult client not needed. First, is when emergency is present and delaying treatment for the purpose of obtaining informed consent would result in injury of death to the client. Second, is when the client waives the right to give informed consent.

64. **ANSWER: C**
**RATIONALE:** An assault occurs when person puts another person in fear of a harmful or offensive contact. For this intentional tort to be actionable, the client must be aware of the threat.

65. **ANSWER: C**
**RATIONALE:** If the nurse determines that a physician's order is unclear, or if the nurse has a question about an order, the nurse should contact the physician, before implementing the order. Under no circumstances should the nurse carry out the order unless the physician has clarified the order.

66. **ANSWER: A**
**RATIONALE:** Slander/Defamation takes place when something untrue is said (slander) or written (libel) about a person resulting in injury to that person's good name or reputation

67. **ANSWER: C**
**RATIONALE:** The client has the right to donate her or his organs for transplantation. Any person 18years or older may become an organ donor by written consent. In the absence of appropriate documentation, a family member or legal guardian may authorize donation of the decedent's organs

68. **ANSWER: A**
**RATIONALE:** Tort is a wrongful act intentionally or unintentionally committed against a person or his or her property. The nurse's inaction in the situation described is consistent with the definition of a tort offense.

69. **ANSWER: B**
**RATIONALE:** Discussing a client's condition without client permission violates a client's right and places the nurse on legal jeopardy. This action by the nurse is both an invasion of privacy and affects the confidentiality issue with the client rights.

70. **ANSWER: B**
**RATIONALE:** A nurse must uphold the client's rights and does not give any information regarding a client's care needs to anyone who is not directly involved in the client's care. To request that the friend come for teaching is a direct violation of the client's right to privacy. There is no information in the question to indicate that the family desires assistance form the friend. To refer the call to the nurse manager and social worker again assumes that the friend's assistance and involvement is desired by the family. Informing the friend that the nurse is visiting daily is providing information that is considered confidential.

71. **ANSWER: A**
**RATIONALE:** The nurse has a duty to provide care to all clients in a nondiscriminatory manner. Personal autonomy does not apply if it interferes with the rights of the clients. There is no legal obligation to inform the client of the nurse's personal objections to the

client. Refusal to provide care may be acceptable if that refusal does not put ht e client's safety at risk and the refusal is primarily associated with religious objections, not personal objection to lifestyle or medical diagnosis. The nurse also has an obligation to observe the principle of nonmaleficence.

**72. ANSWER: C**
**RATIONALE:** A living will addresses the withdrawal or withholding of life sustaining intervention that unnaturally prolong life. It identifies the person who will make care decisions if the client is unable to take action. It is witnessed and signed by two people who are unrelated to the client. Nurses or employees of a facility in which the client is receiving care and beneficiaries of the client should not serve as a witness. There is no reason to call the physician.

**73. ANSWER: D**
**RATIONALE:** The client should discuss the request for a living will with the physician. The client should also discuss this desire with the family. Wills should be prepared with legal counsel and should identify the executor of the state, address distribution and use of property, and the specific plans for burial. Although the other options may be helpful, their contact would not be the initial step. The lawyer will be contacted following discussion with physician and family.

**74. ANSWER: C**
**RATIONALE:** The client should discuss the living will with the physician, and it should be reviewed annually to ensure that it contains the client's present wishes and desires. Although a lawyer needs to be consulted if the living will be need to be changed.

**75. ANSWER: C**
**RATIONALE:** Clients who cannot write may sign an informed consent with an X. This is witnessed by two nurses. Nurses serve as a witness to the client's signature and not to the fact that the client is informed. It is the physician's responsibility to inform the client about a procedure. The nurse clarifies facts presented by the physician. There is no useful reason to contact the physician at this time. A client is not send to a procedure without a signed informed consent

**76. ANSWER: C**
**RATIONALE:** Nurses need their own liability insurance for protection against malpractice lawsuits. Nurses erroneously assume that they are protected by an agency's professional liability policies.

**77. ANSWER: B**
**RATIONALE:** For negligence to be proven, there must be a duty, and then a breach of duty; the breach of duty must cause the injury and damages or injury must be experienced.

**78. ASNWER: C**
**RATIONALE:** The Nurse Practice Acts requires reporting the suspicion of the impaired nurses. The Board of Nursing has jurisdiction over the practice of nursing and may develop plans for treatment and supervision. This suspicion needs to be reported to the nursing supervisor, who will then report to the Board of Nursing. Confronting the colleague may cause conflict. Asking the colleague to go to the nurses' lounge to sleep for a while does not safeguard clients.

**79. ANSWER: C**
**RATIONALE:** Invasion of privacy takes place when an individual's private affairs are unreasonably intruded into.

**80. ANSWER: B**
**RATIONALE:** External Cardiac Massage is a life-saving treatment that a client can refuse. The most appropriate initial nursing action is to notify the physician, because written do not Resuscitate (DNR) order from the physician is needed. The DNR order must be reviewed or renewed on a regular basis per agency policy.

**81. ANSWER: D**
**RATIONALE:** In team nursing, nursing personnel are led by a registered nurse leader in providing care to a group of clients.

**82. ANSWER: D**
**RATIONALE:** Confrontation is an important strategy to meet resistance head-on. Face-to-face meetings to confront the issue at hand will allow verbalization of feelings, identifications of problems and issues.

**83. ANSWER: D**
**RATIONALE:** The nurse must determine the most appropriate assignment based n the skills of the staff member and the needs of the client. In this case, the most appropriate assignment for a nursing assistant would be to care for the client who requires urine specimen collection. The nursing assistant is skilled in this procedure.

**84. ANSWER: D**
**RATIONALE:** When delegating nursing assignment, the nurse needs to consider the skills and educational level of the nursing staff. The bed bath, fleet enema and assisting the client in ambulation can be done by the nursing assistant. Licensed Practical Nurse is skilled in wound irrigation and care.

**85. ANSWER: D**
**RATIONALE:** A nurse would plan to care first a client who had a fever and restless because the client's needs are the priority. Waiting for pain medication to take effect before providing care to the post operative client is best.

**86. ANSWER: C**
**RATIONALE:** An airway is always a high priority, and the nurse would attend to the client who has been experiencing an airway problem first

**87. ANSWER: A**
**RATIONALE:** The nurse is responsible for the care provided to the assigned clients. The most appropriate action is to provide safety to the client who is receiving the bed bath and prepare to administer the pain medication.

**88. ANSWER : B**
**RATIONALE:** The nurse would plan to see the client requiring twice daily dressing changes first because the dressing changes should be spaced as far apart as possible. The nurse next plan would be the client being visited by the home health aide and provide instructions and direction to the aide regarding health care to the client. The nurse then would to see the client regarding supervision of the dressing change and would perform the admission last because that may take more time than the other clients. The nurse then would return to the client regarding second twice daily dressing

**89. ANSWER: B**
**RATIONALE:** In an emergency department, triage is classifying clients according to priorities of care. The kind of illness, severity of the problem, and the resources available govern the process. Clients with trauma, chest pain, severe respiratory distress or cardiac arrest, limb amputation, acute neurological deficits, and those who sustained

chemical splashes to the eyes are classified as emergent and are the number one priority.

**90. ANSWER: C**
**RATIONALE:** Airway is always a high priority and the nurse would assess the client who has a tracheostomy and is on a mechanical ventilator first. The nurse next step of care would assess the client scheduled for cardiac catheterization, followed by the client scheduled for discharge.

**91. ANSWER: B**
**RATIONALE:** Work that is delegated to others must be done consistent with the individual's level of expertise and licensure. Based on the options provided, the LEAST appropriate activity for a nursing assistant would be assisting a post cardiac catheterization client who needs to lie flat to eat lunch. Because the client needs to eat lying flat, the client is at risk for aspiration.

**92. ANSWER: D**
**RATIONALE:** The nurse would most appropriately assign the client with emphysema to the LPN. This client has an airway problem and has the highest priority needs from the other clients presented in the options. The clients described in option A,B,C can be cared for by the nursing assistant.

**93. ANSWER: D**
**RATIONALE:** Participative leadership suggests a compromise between the authoritarian and the democratic style. In participative leadership, the manager presents his or her own analysis of problems and proposals for actions to team members, inviting critique and comments. The participative leader then analyzes the comments and makes the final decision.

**94. ANSWER: C**
**RATIONALE:** The RN must remember that even though a task may be delegated to someone, the nurse who delegates maintains accountability for the overall nursing care of the client. Only the tasks, not the ultimate accountability, may be delegated to another. The RN is responsible for ensuring that competent and accurate care is delivered to the client. Because this is a new procedure to the LPN, the RN should accompany the LPN and provide guidance in performing the procedure.

**95. ANSWER: C**
**RATIONALE:** Primary nursing is concerned with keeping the nurse at the bedside actively involved in direct care while planning goal-directed, individualized client care.

**96. ANSWER: B**
**RATIONALE:** Case management represents an interdisciplinary health care delivery system to promote appropriate use of hospital personnel and material resources to maximize hospital revenues while providing for optimal outcome of care. It manages client care by managing the client care environment.

**97. ANSWER:C**
**RATIONALE:** The functional model of care involves an assembly line approach to client care, with major tasks being delegated by the charge nurse to individual staff members. Team nursing is characterized by a high degree of communication and collaboration between members. The team is generally led by a registered nurse, who is responsible for assessing, developing nursing diagnosis, planning, and evaluating each client's plan of care

**98. ANSWER: C**

**RATIONALE:** Confrontation is an important strategy to meet resistance head on. Face-to-face meeting to confront the issue at hand will allow verbalization of feelings, identification of problems and issues, and the development of strategies to solve the problem.

**99. ANSWER: D**

**RATIONALE:** When beginning the change process, the nurse should identify and defines the problems that needs improvement or correction. This important first step can prevent many future problems, because if the problem is not correctly identified, a plan for change may be aimed at the wrong problem. This is followed by goal setting, prioritizing, and identifying potential solutions and strategies to implement the change or new system.

**100. ANSWER: C**

**RATIONALE:** Option c empowers the charge nurse to assist the staff nurse while trying to identify and reduce the behaviors that make it difficult for the staff nurse to function.

**Test II - Maternal and Child Health, Community Health Nursing, Communicable Diseases, Integrated Management of Childhood Illness**

**ANSWERS AND RATIONALE**

1. **ANSWER: A**
   **RATIONALE:** The second stage of labor begins when the cervix is dilated completely and ends with birth of the neonate.

2. **ANSWER: C**
   **RATIONALE:** Late decelerations are due to uteroplacental insufficiency as the result of decreased blood flow and oxygen to the fetus during the uterine contractions. This causes hypoxemia therefore oxygen is necessary.

3. **ANSWER: B**
   **RATIONALE:** A normal fetal heart rate is 120 to 160 beats per minute. A count of 180 beats per minute could indicate fetal distress and would warrant physician notification. White blood cells count in a normal pregnancy begin to rise in the second trimester and peak in the third trimester with a normal range of 11,000-15,000 cells/mm, up to 18,000 cells/mm.

4. **ANSWER: D**
   **RATIONALE:** Vena cava and descending aorta compression by the pregnant uterus impedes blood return from the lower trunk and extremities. This leads to decreasing cardiac return, cardiac output and blood flow to the uterus and subsequently the fetus. The best position to prevent this would be side-lying with the uterus displaces off the abdominal vessels.

5. **ANSWER: D**
   **RATIONALE:** Abdominal exercises should not start immediately following abdominal surgery, and the client should wait at least 3 to 4 weeks postoperatively to allow for healing of the incision.

6. **ANSWER: C**
   **RATIONALE:** The nurse simultaneously should palpate the maternal radial or carotid pulse and auscultate the fetal heart rate to differentiate the two. If the fetal and maternal heart rates are similar, the nurse may mistake the maternal heart rate for the FHR. Noting if the heart rate is greater than 140 beats per minute or placing the diaphragm of the Doppler on the mother's abdomen will not ensure accuracy in obtaining the FHR.

7. **ANSWER: A**
   **RATIONALE:** A normal fetal heart rate is 120-160 beats per minute. Bradycardia or late or variable decelerations indicate fetal distress and the need to discontinue the oxytocin.

8. **ANSWER: C**
   **RATIONALE:** Continuous electronic fetal monitoring should be implemented during an intravenous infusion of oxytocin.

9. **ANSWER: A**
   **RATIONALE:** A normal fetal heart rate is 120-160 beats per minute. Fetal Bradycardia between contractions may indicate the need for immediate medical management, and the physician or nurse midwife needs to be notified.

10. **ANSWER: A**

**RATIONALE:** Acceleration are transient increase in the fetal heart rate that often accompany contractions or are caused by fetal movement. Episodic accelerations are thought to be a sign of fetal well being and adequate oxygen reserve.

**11. ANSWER: C**
**RATIONALE:** Signs of a fetal or maternal compromise include a persistent no reassuring fetal heart rate, fetal acidosis, and the passage of meconium. Maternal exhaustion and infection can occur if the labor is prolonged but do not indicate fetal or maternal compromise.

**12. ANSWER: B**
**RATIONALE:** Therapeutic management for hypotonic uterine dysfunction includes oxytocin augmentation and amniotomy to stimulate a labor that slows. A cesarean birth will be performed in no progress in labor occurs.

**13. ANSWER: A**
**RATIONALE:** Management of hypertonic labor depends on the cause. Relief of pain is the primary intervention to promote a normal labor pattern. An amniotomy and an oxytocin infusion are not treatment may be used in clients with hypotonic dysfunction.

**14. ANSWER: B**
**RATIONALE:** The mother is anxious and frightened, and the most appropriate nursing diagnosis for the client at this time is fear. No date in the question support a nursing diagnosis of powerlessness, ineffective coping or fatigue, although these nursing diagnoses may be considered for this client at some point during the hospitalization experience.

**15. ANSWER: B**
**RATIONALE:** The priority is to monitor the fetal heart rate. Although providing comfort measures changing the client's position frequently, and keeping the significant others informed of the progress of the labor are components of the plan of care, the fetal status would be the priority

**16. ANSWER: C**
**RATIONALE:** In a client with a multifetal pregnancy, each fetal heart rate is monitored separately.

**17. ANSWER: C**
**RATIONALE:** The most appropriate initial intervention in planning to meet the emotional needs of the client and her spouse is to assess their perception of the event.

**18. ANSWER: B**
**RATIONALE:** Because the placenta is implanted in the lower uterine segment, which does not contain the same intertwining musculature as the fundus of the uterus, this site is more prone to bleeding.

**19. ANSWER: B**
**RATIONALE:** Signs of placental separation include lengthening of the umbilical cord, a sudden gush of dark blood from the introitus, a firmly contracted uterus, and the uterus, and the uterus changing from a discoid to a globular shape. The client may experience vaginal fullness, but not severe uterine cramping.

**20. ANSWER: A**
**RATIONALE:** When cord prolapse occurs, prompt actions are taken to relieve cord compression and increase fetal oxygenation. The mother should be positioned with the hips higher than the head to shift the fetal presenting part toward the diaphragm. The

nurse should push the call light to summon help, and the others staff members should call the physician and notify the delivery room.

**21. ANSWER: A**
**RATIONALE:** During the immediate postpartum period, the nurse takes the vital signs every 15 minutes in the first hour after birth, every 30 minutes for the next 2 hours, and every hour for the next 2-6 hours. The nurse monitors vital signs there after every 4 hours for 24 hours and every 8 hour to 12 hours for the remainder of the hospital stay.

**22. ANSWER: D**
**RATIONALE:** The mother's temperature may be taken every 4 hours while she is awake. Temperatures up to 100.4 degrees Fahrenheit in the first 24 hours after birth often are related to the dehydrating effects of labor. The most appropriate action is to increase hydration by encouraging oral fluids, which should bring the temperature to a normal reading.

**23. ANSWER: B**
**RATIONALE:** Orthostatic hypotension may be evident during the first 8 hours after birth. Feeling of faintness or dizziness is signs that caution the nurse to beware for the client's safety. The nurse should advise the mother to get help the first few times the mother gets out of bed.

**24. ANSWER: A**
**RATIONALE:** Before starting the fundal assessment, the nurse should ask the mother to empty her bladder so that an accurate assessment can be done. When the nurse is performing fundal assessment, the nurse asks the woman to lie flat on her back with the knees flexed. Massaging the fundus is not appropriate unless the fundus is boggy or soft and then it should be massaged gently until firm.

**25. ANSWER: A**
**RATIONALE:** Lochia, the discharge present after birth, is not for the first 1 to 3 days and gradually decreases in amount. Normal lochia has a fleshy odor. Foul smelling or purulent lochia indicates infection and these findings are not normal.

**26. ANSWER: A**
**RATIONALE:** Normally one may find a few small clots in the first 1-2 days after birth from pooling of the blood in the vagina. Clots larger than 1 cm are considered abnormal. The cause of these clots such as uterine atony, retained placental fragments, needs to be determined and treated to prevent further blood loss

**27. ANSWER: B**
**RATIONALE:** The normal amount of lochia may vary with the individual but should never exceed 4-8 peripads a day. The average number of peripads used is 6 per day.

**28. ANSWER: A**
**RATIONALE:** For the breast-feeding woman, the nurse should note the presence of an erectile nipple that the infant can latch on to easily. The nurse also should observe and palpate for nipple soreness, breast tenderness, engorgement, mastitis, the presence of colostrums, and the presence of leaking milk.

**29. ANSWER: A**
**RATIONALE:** After birth, the nurse should auscultate the woman's abdomen in all four quadrants to determine the return of bowel sounds. Normal bowel elimination usually returns 2-3 days postpartum. Surgery, anesthesia, and the use of narcotics and pain control agents also contribute to the longer period of altered bowel function

30. **ANSWER: C**
**RATIONALE:** To elicit homan's sign, the nurse asks the woman to extend her legs on the bed. The nurse grasps the foot and dorsiflexes it forward. If this cause any discomfort or resistance, the nurse should notify the physician or midwife that Homan's sign is present.

31. **ANSWER: A**
**RATIONALE:** Because the woman has had epidural anesthesia and is anesthetized, she cannot feel pain, pressure or a tearing sensation. Changes in vital signs indicate hypovolemia in the anesthetized postpartum woman with vulvar hematoma.

32. **ANSWER: C**
**RATIONALE:** Application of ice will reduce swelling caused by hematoma formation in the vulvar area.

33. **ANSWER: C**
**RATIONALE:** The use of an epidural, prolonged second- stage labor and forceps delivery are predisposing factor for hematoma formation and a collection of up to 500 ml of blood can occur in the vaginal area.

34. **ANSWER: A**
**RATIONALE:** The post operative client will need an antibiotic because she is at increased risk for infection as a result of the break in skin integrity and collection of blood at the hematoma site.

35. **ANSWER: D**
**RATIONALE:** During the fourth stage of labor, the maternal blood pressure, pulse and respiration should be checked every 15 minutes during the first hour. A rising pulse is an early sign of excessive blood loss because the heart pumps faster to compensate for reduced blood volume. The blood pressure will fall as the blood volume diminishes but a decreased in blood pressure would not be the earliest sign of hemorrhage.

36. **ANSWER: B**
**RATIONALE:** If the uterus is not contracted firmly, the first intervention is to massage the fundus until it is firm and to express clots that may have accumulated in the uterus. Pushing on an uncontracted uterus can invert the uterus and cause massive hemorrhage. Elevating the client's leg and encouraging the client to void will not assist in managing uterine atony. If the uterus does not remain contracted as a result of the uterine massage, the problem may be a distended bladder and the nurse should assist the mother to urinate, but this would not be the initial action.

37. **ANSWER: D**
**RATIONALE:** Thrombosis of superficial veins usually is accompanied by signs and symptoms of inflammation. These include swelling of the involved extremity and redness, tenderness and warmth.

38. **ANSWER: A**
**RATIONALE:** Thrombosis that is limited to the superficial veins of the saphenous system is treated with Analgesics, rest and elastic support stockings. Elevation of the affected lower extremity to improve venous return also may be recommended.

39. **ANSWER: D**
**RATIONALE:** If pulmonary embolism is suspected, oxygen should be administered at 8-10 L/min by face mask. Oxygen is used to decrease hypoxia. The woman also is kept on bedrest with the head of the bed slightly elevated to reduce dyspnea.

40. **ANSWER: A**
**RATIONALE:** In most cases, the mother can continue to breast-feed with both breast. If the affected breast is too sore, the mother can pump the breast gently. Regular emptying of the breast is important to prevent abscess formation. Antibiotic therapy assists in resolving the mastitis within 24 – 48 hours. Additional supporting measures include ice packs, breast supports, and analgesics.

41. **ANSWER: C**
**RATIONALE:** In the first 24 hours after birth, the uterus will feel like a firmly contracted ball roughly the size of a large grape fruit. One easily can locate the uterus at the level of the umbilicus. Lochia should be dark red and moderate in amount.

42. **ANSWER: B**
**RATIONALE:** Stasis is believed to be a predisposing factor in the development of thrombophlebitis. Because cesarean delivery is also a risk for thrombophlebitis, new mother should ambulate early and frequently to promote circulation and prevent stasis.

43. **ANSWER: B**
**RATIONALE:** The treatment for deep venous thrombophlebitis is anticoagulant therapy. The nurse assess for bleeding, which is an adverse effect for anticoagulants. This includes hematuria, ecchymosis and epistaxis.

44. **ANSWER: D**
**RATIONALE:** Because pulmonary circulation is compromise in the presence of embolus, cardio-respiratory support is initiated by oxygen administration.

45. **ANSWER: D**
**RATIONALE:** Symptoms of hypovolemia include cool clammy pale skin, sensation of anxiety or impending doom, restlessness and thirst. When these symptoms are present, the nurse should further assess for hypovolemia and notify the healthcare provider.

46. **ANSWER: A**
**RATIONALE:** If bleeding is excessive, the cause maybe the laceration of the cervix or birth canal. Massaging the fundus if it is firm will not assist in controlling the bleeding. Trendelenburg position is to be avoided because it may interfere with cardiac function. Although the nurse would record the findings, the initial nursing action would be to contact the physician.

47. **ANSWER: C**
**RATIONALE:** Mastitis is an infection of the lactating breasts and occurs most often during the second and third week after birth, although it may be develop at any time during breast feeding. Mastitis is most common in mothers nursing for the first time and usually affects one breast. A supportive bra will not cause mastitis; however, constriction of the breast from a bra that is too tight may interfere with emptying of all the ducts and may lead to infection.

48. **ANSWER: D**
**RATIONALE:** Mastitis generally is caused by an organism that enters through an injured area of the nipples such as a crack or blister. Measures to prevent the development of mastitis include changing nursing pad when they are wet and avoiding continuous pressure on the breast. Soap is drying and could lead to cracking of the nipples, and the mother should be instructed to avoid the use of soap on the nipples during breast feeding.

49. **ANSWER: D**

**RATIONALE:** Broad – spectrum antibiotics will be prescribed for the mother, and the mother should be instructed to take the antibiotics as prescribed. Analgesics are often necessary, and warm compresses or sitz baths maybe used to provide comfort in the area. The infant is not isolated routinely from the mother with a wound infection, but the mother must be taught how to protect the infant from contact with contaminated articles.

**50. ANSWER: D**
**RATIONALE:** Anticoagulation therapy maybe used to prevent the extension of thrombus by delaying the clotting time of the blood. Activated partial thromboplastin time should be monitored, and the heparin dose should be adjusted to maintain a therapeutic level of 1.5 – 2.5 times the control. The prothrombin time and the international normalized ratio are used to monitor coagulation time when warfarin (coumadin) is used. The platelet count cannot be used to determine an adequate dosage for the heparin infusion

**51. ANSWER: C**
**RATIONALE:** The nurse may suspect strabismus in a child when a child complains of frequent headaches, squints, or tilts the head to see.

**52. ANSWER: B**
**RATIONALE:** In a child diagnosed with strabismus, surgery may be indicated to realign the weakened muscles. Surgery most often is indicated when amblyopia (decreased vision in the deviated eye) is present. The surgery should be performed before the child is 2 years old.

**53. ANSWER: B**
**RATIONALE:** A diagnosis of chlamydial conjunctivitis in a child who is not sexually active should signal the health care provider to assess the child for possible sexual abuse. Allergy, infection, and trauma can cause conjunctivitis, but the causative organism is not likely to be Chlamydia.

**54. ANSWER: B**
**RATIONALE:** Bacterial conjunctivitis is highly contagious, and the nurse should teach infection control measures, these include good handwashing, and not sharing towel and washcloth.

**55. ANSWER: B**
**RATIONALE:** The size and appearance of the tympanostomy tube should be described to the parents after surgery. They should be reassured that if the tube fall out, it is not an emergency, but the physician should be notified

**56. ANSWER: D**
**RATIONALE:** The nurse must instruct the parents regarding the administration of the antibiotic. Antibiotic need to be taken as prescribed, and the full course needs to be completed

**57. ANSWER: D**
**RATIONALE:** After myringotomy with insertion of tympanostomy tubes, the client may experience some discomfort. Tylenol can be given to relieve the discomfort. A narcotic is not necessary, and aspirin should be administered to a child.

**58. ANSWER: B**
**RATIONALE:** Parents need to be instructed that the child should not blow his or her nose for 7-10 days. Bath and lake water are potential sources of bacterial contamination. Diving and swimming in deep water are prohibited. The child's ears need to be kept dry.

**59. ANSWER: C**

**RATIONALE:** Because the tonsillar area is so vascular, post operative bleeding is a concern. The prothrombin time, partial thromboplastin time, platelet count, hemoglobin and hematocrit, white blood cells count, and urinalysis are performed pre operatively. The prothrombin time results would identify a potential for bleeding

**60. ANSWER: D**
**RATIONALE:** In the preoperative period, the child should be observed for the presence of loose teeth to decrease the risk of aspiration during surgery.

**61. ANSWER: B**
**RATIONALE:** Respiratory syncytial virus is a highly communicable disorder and is not transmitted via the air borne route. The virus usually is transferred by the hands, and meticulous handwashing is necessary to decrease the spread of organisms. The infant with RSV is isolated in a single room or placed in a room with another child with RSV.

**62. ANSWER: B**
**RATIONALE:** Ribavirin (virazole) is an antiviral respiratory medication used mainly in hospitalized children with severe RSV. Administration is via hood, facemask, or oxygen tent.

**63. ANSWER: D**
**RATIONALE:** Decrease wheezing in a child with asthma may be interpreted incorrectly as a positive sign when in fact it may signal an inability to move air.

**64. ANSWER: B**
**RATIONALE:** Splinting of the affected side by lying on that side may decrease discomfort

**65. ANSWER: D**
**RATIONALE:** Sudden infant death syndrome usually occurs during sleep and during the winter months and most frequently occurs between the second and the forth month of life. The syndrome is more common in boys.

**66. ANSWER: D**
**RATIONALE:** Nurse should encourage parents to place the infant on the back for sleep. The infant may have the ability to turn to a prone position from the side lying position. Infants in the prone position maybe an able to move their heads to the side thus increasing the risk of suffocation and lethal rebreathing.

**67. ANSWER: A**
**RATIONALE:** In a sweat test sweating stimulate on the child's forearm with pilocarpine, the sample is collected on absorbent material, and the amount of sodium and chloride are measured. A sample of at least 50 mg of sweat is required for accurate result. A chloride level greater than 60 mEq/L is considered to be a positive test result.

**68. ANSWER: B**
**RATIONALE:** Adequately protecting children with cystic fibrosis from communicable diseases by immunization is essential. In addition to the basic series of immunization, a yearly influenza and possibly a pneumococcus vaccine also a recommended for children with cystic fribrosis.

**69. ANSWER: A**
**RATIONALE:** In duration measuring 10mm or greater is considered to be a positive result in children younger than 4 years of age and in those with chronic illness or at high risks for environmental exposure to TB.

70. **ANSWER: D**
**RATIONALE:** For children with human immunodeficiency virus infection, a minimum of 12 months of treatment with isoniazid is recommended.

71. **ANSWER: A**
**RATIONALE:** An early sign of congestive heart failure include tachycardia, tachypnea, profuse scalp sweating, fatigue and irritability, sudden weight gain and respiratory distress

72. **ANSWER: D**
**RATIONALE:** Crying exhausts the limited energy supply. Increases the workload of the heart and increases the oxygen demand.

73. **ANSWER: A**
**RATIONALE:** The most appropriate method for assessing urine output in an infant receiving diuretic therapy is to weigh the diaper.

74. **ANSWER: A**
**RATIONALE:** A weight gain of 1 lb in a day is due to the accumulation of fluid. The nurse should assess urine output, assess for evidence facial edema, auscultate lung sounds and report the weight gain to the physician

75. **ANSWER: A**
**RATIONALE:** The parents need to be instructed that if the child vomits after the digoxin is administered they are not to repeat the dose.

76. **ANSWER: D**
**RATIONALE:** In tricuspid atresia no communication exist from the right atrium to the right ventricle.

77. **ANSWER: A**
**RATIONALE:** A child with transposition of the great arteries may receive prostaglandin E temporarily to increase blood mixing if systemic and pulmonary mixing is inadequate to maintain adequate cardiac output

78. **ANSWER: C**
**RATIONALE:** The child with aortic stenosis shows signs of exercise intolerance, chest pain, and dizziness when standing for long period of time

79. **ANSWER: A**
**RATIONALE:** The mother should be instructed that lotions and powder should not be applied to the incision site.

80. **ANSWER: B**
**RATIONALE:** Rheumatic fever characteristically presents 2-6 weeks after an untreated or partially treated group A beta hemolytic streptococcal infections of the upper respiratory tract. Initially the nurse determines whether the child has a sore throat or an unexplained fever within the past 2 months.

81. **ANSWER: C**
**RATIONALE:** Anti inflammatory agents including aspirin may be prescribed for the child with rheumatic fever. Aspirin should not be given to a child who has chicken pox or other viral infections such as flu.

82. **ANSWER: D**

**RATIONALE:** A diagnosis of rheumatic fever is confirmed by the presence of 2 manifestations or 1 major and 2 minor manifestation from Jones Criteria in addition, the evidence recent streptococcal is confirmed by a positive ASO titer.

**83. ANSWER: C**
**RATIONALE:** Kawasaki disease is also called mucocutaneous lymph node syndrome, is a febrile generalized vasculitis of unknown origin.

**84. ANSWER: B**
**RATIONALE:** In the acute stage the child has a fever conjunctival hyperemia, a red throat, swollen hands, a rash and enlargement of the cervical lymph nodes

**85. ANSWER: A**
**RATIONALE:** Immune globulin is administered intravenously to the child with Kawasaki Disease to decrease the incidence of coronary artery lesions and aneurysms and to decrease fever and inflammation.

**86. ANSWER: B**
**RATIONALE:** Vomiting will cause the loss of hydrochloric acid and subsequent metabolic alkalosis.

**87. ANSWER: D**
**RATIONALE:** Rectal temperature measurements should be avoided if diarrhea is present. Use of rectal thermometer can stimulate peristalsis and cause more diarrhea.

**88. ANSWER: C**
**RATIONALE:** The mother is taught the ESSR methods of feeding the child with cleft palate: enlarge the nipple stimulate the sucking reflex. Swallow and rest to allow the infant to finish swallowing what has been placed in the mouth.

**89. ANSWER: B**
**RATIONALE:** After cleft lip repair the infant should be positioned supine or on the side lateral to the repair to prevent the contact of the suture lines with the bed linens. Placing the infant on the left side is best to prevent the risk of aspiration if the infant vomits.

**90. ANSWER: D**
**RATIONALE:** Any child who exhibits the 3 C – coughing and choking with feedings and unexplained cyanosis- should be suspected of tracheoesopahgeal fistula

**91. ANSWER: D**
**RATIONALE:** The infant should be placed in head elevated prone position following feedings at night.

**92. ANSWER: D**
**RATIONALE:** Feedings thickened with rice cereal may reduce the episode of emesis.

**93. ANSWER: B**
**RATIONALE:** Clinical manifestation of pyloric stenosis include projectile vomiting, irritability, hunger and crying, constipation, dehydration and decrease in urine output.

**94. ANSWER: A**
**RATIONALE:** Lactose intolerance is the inability to tolerate lactose, the sugar found in the dairy products, additional dietary changes may be required to provide adequate sources of calcium.

**95. ANSWER: A**

**RATIONALE:** Dietary management is the mainstay of treatment in celiac disease. All wheat, rye, barley, oats should be eliminated from the diet.

**96. ANSWER: B**
**RATIONALE:** Chronic constipation beginning in the first month of life and resulting in pellet like or ribbon stools that are foul smelling is a manifestation of this disorder

**97. ANSWER: D**
**RATIONALE:** During the newborn assessment, this defect should be identified easily on sight. Tube may be necessary to determine patency if meconium is not passed in the first 24 hours after birth.

**98. ANSWER: D**
**RATIONALE:** The child with intussusceptions classically has severe abdominal pain that is crampy and intermittent causing the child to draw in the knees to the chest. Bright red blood and mucus are passed through the rectum and commonly described currant jelly like stool.

**99. ANSWER: A**
**RATIONALE:** Renal function is monitored closely during the administration of chelation therapy because the medication secreted via the kidney.

**100. ANSWER: C**
**RATIONALE:** Initial treatment of salicylate overdose includes inducing vomiting with syrup of ipecac.

**Test III - Medical and Surgical Nursing**

**ANSWER AND RATIONALE**

1. **ANSWER: A**
   **RATIONALE:** The testicular self examination is recommended monthly after a warm bath or shower when the scrotal skin is relaxed. The client should stand to examine the testicles. Using both hands, with fingers under the scrotum and thumbs on top, the client should gently roll the testicles, feeling for any lumps

2. **ANSWER: B**
   **RATIONALE:** Viruses may be one of multiple agents acting to initiate carcinogenesis and have been associated with several types of cancer. Increased stress has been associated with causing the growth and proliferation of cancer cells. Two forms of radiation, ultraviolet and ionizing, can lead to cancer. A diet high in fat may be a factor in the development of breast, colon, and prostate cancer. High-fiber diets may reduce the risk of colon cancer.

3. **ANSWER: B**
   **RATIONALE:** Thrombocytopenia indicates a decrease in the number of platelets in the circulating blood. A major concern is monitoring for and preventing bleeding.

4. **ANSWER: B**
   **RATIONALE:** The normal white blood cell count ranges from 5000 – 10,000 cells/$mm^3$.

5. **ANSWER: A**
   **RATIONALE:** The breast self-examination should be performed monthly seven days after the menstruation period.

6. **ANSWER: C**
   **RATIONALE:** The client is at risk of deep vein thrombosis or thrombophlebitis after the surgery, as for any other major surgery.

7. **ANSWER: D**
   **RATIONALE:** A pelvic ultrasound requires the ingestion of large volume of water just before the procedure.

8. **ANSWER: D**
   **RATIONALE:** A biopsy is done to determine whether a tumor is malignant or benign. Magnetic resonance imaging, computed tomography scan and ultrasound will visualize the presence of a mass but will not confirm a diagnosis of malignancy.

9. **ANSWER: C**
   **RATIONALE:** Multiple myeloma is a B cell neoplaststic condition characterized by abnormal malignant proliferation of plasma cells and the accumulation of mature plasma cells in the bone marrow.

10. **ANSWER: B**
    **RATIONALE:** Findings indicates of multiple myeloma are an increased number of plasma cells in the bone marrow, anemia, hypercalcemia caused by the released of calcium from the deteriorating bone tissue and an elevated blood urea nitrogen level.

11. **ANSWER: A**
    **RATIONALE:** Hypercalcemia caused by bone destruction is a priority concern in the client with multiple myeloma. The nurse should administer fluids in adequate amount to

maintain an output of 1.5 to 2 L/day. The fluid is needed not only to dilute the calcium overload but also to prevent protein form precipitating in the renal tubules.

12. **ANSWER: D**
    **RATIONALE:** Hodgkin's disease is a disorder of young adults. The other options are characteristics of the disease

13. **ANSWER: A**
    **RATIONALE:** Alopecia is not an assessment finding in testicular cancer. Alopecia may occur, however, as a result of radiation or chemotherapy.

14. **ANSWER: D**
    **RATIONALE:** In general, only the area in the treatment field is affected by the radiation. Skin reaction, fatigue, nausea and anorexia may occur with radiation to any site, whereas other side effects occur only when specific areas are involved. A client receiving radiation to the larynx is most likely to experience sore throat.

15. **ANSWER: C**
    **RATIONALE:** The time that the nurse spends in a room of a client with an internal radiation implant is 30 minutes per 8-hour shift. The dosimeter badge must be worn when in the client's room. Children younger than 16 years of age and pregnant women are not allowed in the client's room.

16. **ANSWER: A**
    **RATIONALE:** The client with a cervical radiation implant should be maintained on bed rest in the dorsal position to prevent movement of the radiation source. The head of the bed is elevated to a maximum of 10 to 15 degrees for comfort. The nurse avoids turning the client on the side. If turning is absolutely necessary, a pillow is placed between the knees and , with the body in straight alignment, the client is
    log rolled.

17. **ANSWER: D**
    **RATIONALE:** A lead container and long-handled forceps should be kept in the client's room at all times during internal radiation therapy. If the implant becomes dislodged, the nurse should pick up the implant with long-handled forceps and place it in the lead container.

18. **ANSWER: D**
    **RATIONALE:** In the Immunocompromised client, a low-bacteria diet is implemented. This includes avoiding fresh fruits and vegetables and thorough cooking of all foods. Not all visitors are restricted, but the client is protected form persons with known infections. Fluids should be encouraged. Invasive measures such as an indwelling urinary catheter should be avoided to prevent infection.

19. **ANSWER: B**
    **RATIONALE:** A high risk of hemorrhage exists when the platelet count is fewer than 20,000 cells/$mm^3$. Fatal central nervous system hemorrhage or massive gastrointestinal hemorrhage can occur when the platelet count is fewer than 10,000 cells/mm. The client should be assessed for changes in level of consciousness, which may be an early indication of an intracranial hemorrhage.

20. **ANSWER: A**
    **RATIONALE:** The client's self report is a critical component of pain assessment. The nurse should ask the client about the description of the pain and listen carefully to the client's words used to describe the pain. The nurse's impression of the client's pain is not

appropriate in determining the client's level of pain. Nonverbal cues from the client are important but are not the most appropriate pain assessment measures.

21. **ANSWER: B**
    **RATIONALE:** Hypovolemia occurs with decreased cardiac output and the resulting decrease arterial pressure is reflected in weak, thready peripheral pulse

22. **ANSWER: C**
    **RATIONALE:** Oxygen is necessary for the production of fire

23. **ANSWER: A**
    **RATIONALE:** This is an early typical finding after a myocardial infarction because of the altered contractility of the heart

24. **ANSWER: D**
    **RATIONALE:** Activity may encourage the dislodgement of more microemboli

25. **ANSWER: C**

    **RATIONALE:** The supine position prevents hip flexion limiting injury and promoting healing of the catheter insertion site; if the head of the bed is elevated, it should not exceed 20 degrees

26. **ANSWER: B**
    **RATIONALE:** An apical pulse is taken to detect dysrhythmias related to cardiac irritability; blood pressure is monitored to detect hypotension, which may indicate bleeding or shock

27. **ANSWER: A**
    **RATIONALE:** A warm flushing sensation that last approximately 30 seconds will occur when the contrast medium is injected

28. **ANSWER: D**
    **RATIONALE:** This is a elastic reaction because it dilates coronary arteries, which increase oxygen to he myocardium thus decreasing pain

29. **ANSWER: D**
    **RATIONALE:** Morphine is a specific central nervous system depressant used to relieve the pain associated with myocardial infarction, it also decreases apprehension and prevents cardiac shock

30. **ANSWER: D**
    **RATIONALE:** This response provide information and reduces anxiety. The nurse should understand that the greater saphenous vein in the leg is used to bypass the diseased coronary artery because the surgical team can obtain the vein while the other team perform the chest surgery, this shortens the surgical time and risk of surgery

31. **ANSWER: D**
    **RATIONALE:** These are classic symptoms of a myocardial infarction; further medical evaluation is needed immediately

32. **ANSWER: C**
    **RATIONALE:** The fiber component of complex carbohydrates helps bind and eliminate dietary cholesterol and fosters growth of intestinal microorganisms to break down bile salts and release the cholesterol component for excretion

33. **ANSWER: B**
**RATIONALE:** Tingling indicates decreased arterial circulation to the extremity, it may be caused by an embolus

34. **ANSWER: B**
**RATIONALE:** Of all basic food groups, fresh fruits and juices are the lowest in sodium

35. **ANSWER: B**
**RATIONALE:** Inactivity causes venous stasis hyper coagulability, and arterial pressure against the vein, all of which lead to thrombus formation, early ambulation in exercise of the lower extremities reduce the occurrence of this phenomenon

36. **ANSWER: D**
**RATIONALE:** The original myocardial infarction may be extending the client's symptoms require immediate medical intervention and relief of pain

37. **ANSWER: D**
**RATIONALE:** A sustained diastolic pressure exceeding 90 mmHg reflects pathology and indicates hypertension

38. **ANSWER: C**
**RATIONALE:** If a closed chest drainage tube becomes obstructed there is increased intrathoracic pressure which pushes the heart to the opposite side, thereby, reducing venous return and cardiac output

39. **ANSWER: C**
**RATIONALE:** Troponin I and Troponin T are proteins in the striated cells of cardiac tissue and therefore unique marks for cardiac damage, elevation occur within one hour of a myocardial infarction and persist for 7-15 days

40. **ANSWER: C**
**RATIONALE:** At least ½ of all deaths occur from the life-threatening dysrhythmias of ventricular tachycardia

41. **ANSWER: C**
**RATIONALE:** Both type are compatible. A- is the same as the client's blood type and preferred; in an emergency, type O- blood may be given also.

42. **ANSWER: B**
**RATIONALE:** Blood replacement is needed to increase the oxygen-carrying capacity of the blood, the expected hematocrit for women is 37-47%.

43. **ANSWER: D**
**RATIONALE:** The blood must be stopped and the normal saline should be infused to keep the line patent and maintain blood volume

44. **ANSWER: B**
**RATIONALE:** Slow rate provides time to recognize a reaction that is developing before too much blood is administered.

45. **ANSWER: D**
**RATIONALE:** With shock the heart rate accelerates to increase blood flow and oxygen to body tissue

46. **ANSWER: C**

**RATIONALE:** Thrombocytes are involved in the clotting mechanism; thrombocytopenia is a reduced number of Thrombocytes in the blood: hematuria is blood in the urine

47. **ANSWER: B**
**RATIONALE:** A definite confirmation of multiple myeloma can only be made through a bone marrow biopsy, this is a plasma cell malignancy with wide spread bone destruction.

48. **ANSWER: C**
**RATIONALE:** Brief pressure is generally enough to prevent bleeding

49. **ANSWER: D**
**RATIONALE:** Pernicious Anemia is caused by the inability to absorb vitamin B12 resulting from a lack of intrinsic factor in gastric juices

50. **ANSWER: B**
**RATIONALE:** Blood products (packed RBC or platelet) are administered when warranted.

51. **ANSWER: A**
**RATIONALE:** The inflammatory response and trauma of surgery may cause edema, compressing the trachea and compromising the airway.

52. **ANSWER: D**
**RATIONALE:** Maintaining airway patency is always the priority

53. **ANSWER: B**
**RATIONALE:** These symptoms could indicate impending hypocalcemic tetany, a complication after removal of parathyroid tissue during a thyroidectomy

54. **ANSWER: A**
**RATIONALE:** Bleeding may occur, and blood will pool in the back of the neck because the blood will flow via gravity

55. **ANSWER: D**
**RATIONALE:** Dry, sparse hair and cold intolerance are characteristics adaptations to low serum thyroxine

56. **ANSWER: A**
**RATIONALE:** Thyrotoxic crisis is severe hyperthyroidism; excessive amounts of thyroxine increase the metabolic rate, thereby raising the pulse and temperature

57. **ANSWER: D**
**RATIONALE:** Physiological needs must be prioritized. Anxiety is a psychosocial problem hence, deemed least priority among the given options.

58. **ANSWER: C**
**RATIONALE:** Increased basal metabolic rate, increase circulation and vasodilation result in warm moist skin

59. **ANSWER: A**
**RATIONALE:** This thyroid tissue is left because it may provide enough hormone for normal function

60. **ANSWER: A**
**RATIONALE:** An Aldosteronoma is an aldosterone secreting adrenal cortex

61. **ANSWER: B**
**RATIONALE:** Excessive thirst, hunger, and frequent urination are caused by the body inability to correctly metabolize glucose

62. **ANSWER: C**
**RATIONALE:** Proteins and lipid metabolic occur because carbohydrate cannot be used by the cells, this results in weight loss and muscle wasting

63. **ANSWER: C**
**RATIONALE:** Insulin facilitates transport of glucose across the cell membrane to meet metabolic needs and prevents fatigue

64. **ANSWER: C**
**RATIONALE:** Exercise improves glucose metabolism. With exercise, the client is at risk of becoming hypoglycemia not hyperglycemia

65. **ANSWER: B**
**RATIONALE:** A blood glucose testing is a one direct accurate measure.

66. **ANSWER: C**
**RATIONALE:** Controlling the diabetes decreases the risk of infection. This is the best prevention

67. **ANSWER: B**
**RATIONALE:** Renal and cardiac complication will occur if hypertension is not corrected

68. **ANSWER: B**
**RATIONALE:** These are the classic sign of hypokalemia that occur when potassium levels are reduced as potassium enters cells with glucose

69. **ANSWER: C**
**RATIONALE:** Knowledge of the signs and treatment for hypoglycemia and hyperglycemia is critical to client health and well-being and essential for survival

70. **ANSWER: B**
**RATIONALE:** When the head of the pancreas is removed, the client has a greatly reduced number of insulin-producing cells and hyperglycemia will occur. Immediate attention is necessary

71. **ANSWER: B**
**RATIONALE:** These beverages contain caffeine which may increase thyroid activity

72. **ANSWER: C**
**RATIONALE:** Assays of catecholamine are performed on single-voided urine specimens, 2-4 hour specimens and 24 hour urine specimens. The normal range of urinary catecholamine is up to 14 mcg/100 mL of urine, with higher level occurring in pheochromocytoma

73. **ANSWER: A**
**RATIONALE:** Calcitonin can lower plasma calcium levels in clients with hypercalcemia caused by hyperparathyroidism. The therapeutic effect in this client situation would be a reduction in serum calcium level

74. **ANSWER: B**

**RATIONALE:** The most likely medication to be prescribed in hypertensive crisis is Regitine. This medication is a short-acting a-adrenergic blocker and would be given by IV bolus or drip for hypertensive crisis.

**75. ANSWER: A**
**RATIONALE:** A high-complex carbohydrate and high protein diet will be prescribed for the client with Addison's disease. To prevent excess fluid and sodium loss, the client will be taught to maintain a normal salt intake daily (3g) and to increase salt intake during hot weather, before strenuous exercise, and in response to fever, vomiting or diarrhea

**76. ANSWER: A**
**RATIONALE:** Shakiness is a sign of hypoglycemia and would indicate the need for food or glucose. A fruity breath odor blurred vision and Polyuria are signs of hyperglycemia

**77. ANSWER: C**
**RATIONALE:** Because of the hypermetabolic state, the client with hyperthyroidism needs to be provide with an environment that is restful physically and mentally. Six full meals a day that are well balanced and high in calories are required because of the accelerated metabolic rate.

**78. ANSWER: A**
**RATIONALE:** Desmopressin is a synthetic form of antidiuretic hormone that causes increased reabsorption of water with a resultant decrease in urine output.

**79. ANSWER: D**
**RATIONALE:** Decreased blood glucose levels produce autonomic nervous system symptoms, which are manifested classically as nervousness, irritability, and tremors.

**80. ANSWER: C**
**RATIONALE:** The client with pheochromocytoma needs to be provided with a diet high in vitamins, minerals and calories. Beverages that contain caffeine, tea, cola, cocoa, are prohibited because they can precipitate hypertensive crisis.

**81. ANSWER: C**
**RATIONALE:** Hemodilution has occurred because the 1500ml of IV fluid has lowered the serum sodium level.

**82. ANSWER: B**
**RATIONALE:** With the client's history and the large weight gain, this is the most likely cause of the increase in weight

**83. ANSWER: A**
**RATIONALE:** Blood glucose that exceeds the renal threshold for glucose reabsorption in the kidney tubules will cause cellular osmotic diuresis resulting in dehydration

**84. ANSWER: B**
**RATIONALE:** Osmosis is the movement of fluid from an area of lesser solute concentration to an area of greater solute concentration

**85. ANSWER: C**
**RATIONALE:** A rate of 30ml/hr is considered adequate perfusion of the kidney, heart and brain.

**86. ANSWER: D**

**RATIONALE:** Prolonged exposure to the sun, unusual cold, or other conditions can damage the skin. The outdoor construction worker would fit into a high-risk category for the development of an Integumentary disorder.

**87. ANSWER: B**
**RATIONALE:** Depending on the size and location of the lesion, a biopsy is usually a quick and almost painless procedure. The most common source of pain is the initial local anesthetic, which can produce a burning or stinging sensation.

**88. ANSWER: A**
**RATIONALE:** Following a skin biopsy, the nurse instructs the client to keep the dressing dry and in place for a minimum of 8 hours. After the dressing is removed, the site is cleaned once a day with tap water or saline to remove any dry blood or crusts.

**89. ANSWER: A**
**RATIONALE:** Examination of the skin under a Wood's Light is always carried out in a darkened room. This is a noninvasive examination; therefore consent is not required. The skin does not need to be shaved and a local anesthetic is not necessary.

**90. ANSWER: D**
**RATIONALE:** Client preparation for a scratch skin test includes informing the client to discontinue the administration of systemic corticosteroids or antihistamines for at least 5days before the test. This medication must be discontinues to prevent suppression of the inflammatory response to the allergen.

**91. ANSWER: A**
**RATIONALE:** If the client reapplies patches that come loose, this can interfere with an accurate interpretation of the allergic reaction. The nurse reinforces the necessity of removing loose or nonadherent test patches for reapplication at a later date. The initial reading is performed 2 days after application, and the final reading is performed 2-5days later.

**92. ANSWER: D**
**RATIONALE:** The client should avoid using a dehumidifier because this will dry room air further. Instead, the client should use a room humidifier during the winter months or whenever the furnace is in use.

**93. ANSWER: C**
**RATIONALE:** Lyme disease is a multisystem infection that results from a bite by a tick carried by several species of deep.

**94. ANSWER: B**
**RATIONALE:** The hallmark of stage I is the development of a skin rash within 2-30 days of infection, generally at the site of the tick bite. The rash develops into a concentric ring, giving it a bull's eye appearance. The lesion enlarges up to 50-60 cm.

**95. ANSWER: C**
**RATIONALE:** A blood test is available to detect Lyme disease however the test is not reliable if performed before 4-6 weeks following the tick bite.

**96. ANSWER: A**
**RATIONALE:** Prevention, public education and early diagnosis are vital to the control and treatment of Lyme disease.

**97. ANSWER: C**

**RATIONALE:** In the prevention of Lyme disease, individuals need to be instructed to use an insect repellent on the skin and clothes when in an area where the ticks are likely to be found.

**98. ANSWER: D**

**RATIONALE:** When an individual comes in contact with a poison ivy plant, the sap form the plant forms an invisible film on the human skin. The client should be instructed to shower immediately and to lather the skin several times and rinse each time in running water.

**99. ANSWER: C**

**RATIONALE:** If an inhalation injury is suspected, administration of 100% oxygen via a tight-fitting non-rebreather face mask is prescribed until carboxyhemoglobin levels fall below 15%. In inhalation injuries the oropharynx is inspected for evidence of erythema, blisters, or ulcerations.

**100. ANSWER: C**

**RATIONALE:** Autograft placed over joints or on the lower extremities often are elevated and immobilized following surgery for 3-7 days. This period immobilization allows the autograft time to adhere and attach to the wound bed.

**Test IV - Medical and Surgical Nursing**

**ANSWERS AND RATIONALE**

1. **ANSWER: C**
   **RATIONALE:** Common risk factors for colorectal cancer include age over 40 years old, first degree relative with colorectal cancer, high fat, low fiber diet and history of bowel problems.

2. **ANSWER: D**
   **RATIONALE:** The discomfort of reflux is aggreviated by positions that compress the abdomen and the stomach. These include lying flat on the back or on the stomach after meal. The left side lying position with the head elevated 30 degrees is most likely to give relief to the client.

3. **ANSWER: C**
   **RATIONALE:** Foods that increase the lower esophageal sphincter pressure will decrease reflux and lessen the symptoms of gastro esophageal reflux disease. The food substance that will increase LES pressure is non fat milk.

4. **ANSWER: B**
   **RATIONALE:** These assessment addresses the client's airway. The nurse places highest priority on assessing for the return of the gag reflex.

5. **ANSWER: A**
   **RATIONALE:** The client doest not have to lie still for ERCP, which takes about an hour to perform

6. **ANSWER: B**
   **RATIONALE:** A barium swallow is an x-ray study that uses a substance called barium for contrast to highlight abnormalities in the gastrointestinal tract. The client should fast 8-12 hours before the test.

7. **ANSWER: B**
   **RATIONALE:** The client should not drive for several hours because the client would have received sedative medication during the procedure.

8. **ANSWER: C**
   **RATIONALE:** The appropriate sequence for abdominal examination is inspection, auscultation, percussion and palpation.

9. **ANSWER: D**
   **RATIONALE:** The solution golytely is a bowel evacuant used to prepare a client for colonoscopy by cleansing the bowel. The solution is expected to cause a mild diarrhea and will clear the bowel in 4-5 hours.

10. **ANSWER: D**
    **RATIONALE:** Chronic gastritis causes deterioration and atrophy of the lining of the stomach, leading to the loss of function of the parietal cells. The source of the intrinsic factor is lost which results inability to absorb vitamin B12.

11. **ANSWER: D**
    **RATIONALE:** Indomethacin is a NSAID drug and can cause ulceration to the esophagus, stomach, duodenum and small intestine. This drug is contraindicated in a client with gastrointestinal disorder.

12. **ANSWER: A**
    **RATIONALE:** Following cholecystectomy, drainage from the T tube is initially bloody and then turns to green brown. The amount of expected drainage will range from 500-1000 L/day. The nurse would document the output.

13. **ANSWER: B**
    **RATIONALE:** Perforation is a surgical emergency and is characterized by sudden, sharp, intolerable severe pain beginning in the mid epigastric area and spreading over the abdomen, which becomes rigid and board like.

14. **ANSWER: B**
    **RATIONALE:** The cimetidine will decrease the secretion of gastric acid.

15. **ANSWER: C**
    **RATIONALE:** Option c describes the procedure for a pyloroplasty.

16. **ANSWER: A**
    **RATIONALE:** Propantheline bromide is an antimuscarnic anticholinergic medication that decreases gastrointestinal secretions. This drug should be administered 30 minutes before meal.

17. **ANSWER: B**
    **RATIONALE:** Docusate sodium is a stool softener that promotes absorption of water in to the stool, producing a softer consistency of stool. The intended effect is prevention of constipation.

18. **ANSWER: B**
    **RATIONALE:** Cascara sagrada is a laxative that causes nausea and abdominal cramps as the most frequent side effects.

19. **ANSWER: A**
    **RATIONALE:** Most rapid results from bisacodyl occur when it is taken on an empty stomach.

20. **ANSWER: D**
    **RATIONALE:** Senna works by changing the transport of water in the large intestine which causes accumulation of water in the mass of stool and increase peristalsis.

21. **ANSWER: C**
    **RATIONALE:** Respiratory failure is described as a $PaO_2$ of 50 mmHg or less and a $PaCO_2$ of 50 mmHg or greater in a client with no history of respiratory disease.

22. **ANSWER: C**
    **RATIONALE:** Instruction for using a metered dose inhaler include shake the canister, hold it right side up, inhale slowly and evenly through the mouth, deliver 1 spray per breath and hold the breath after inhalation.

23. **ANSWER: B**
    **RATIONALE:** The earliest detectable sign of acute respiratory distress syndrome is an increased respiratory rate, which can begin anywhere from 1-96 hours after the initial insult to the body.

24. **ANSWER: C**
    **RATIONALE:** The normal pulmonary capillary wedge pressure is 8-13 mmHg

25. **ANSWER: C**
**RATIONALE:** The client with emphysema has hyper inflation of the alveoli and flattening of the diaphragm. This lead to increased anteropoasterior diameter referred to as barrel chest.

26. **ANSWER: D**
**RATIONALE:** Albuterol is a bronchodilator of the adrenergic type. The nurse assess of the respiratory pattern, lung sounds, pulse, and BP before and during therapy.

27. **ANSWER: D**
**RATIONALE:** The client taking adrenergic bronchodilators may experience paradoxical bronchospasm, which is evidenced by client's wheezing. These can occur with excessive use of inhalers.

28. **ANSWER: D**
**RATIONALE:** Metaproterenol sulfate is an adrenergic type of bronchodilator.

29. **ANSWER: B**
**RATIONALE:** Theophylline is a xanthine bronchodilator. Before drawing of a serum level of the medication, the client should avoid taking in food or beverages that contain xanthine such as coffee, cola or chocolate.

30. **ANSWER: A**
**RATIONALE:** Oxtriphylline is a xanthine bronchodilator. The nurse teaches the client to limit the intake of xanthine containing food when taking this medication.

31. **ANSWER: B**
**RATIONALE:** Following renal biopsy, the nurse ensures that the client remains in bed for atleast 24 hours.

32. **ANSWER: A**
**RATIONALE:** Struvite stones common are referred to as infection stones because the form in urine that is alkaline and reach in ammonia, such as with a urinary tract infection.

33. **ANSWER: A**
**RATIONALE:** The client with uric acid stone should avoid food containing high amounts of purines. These include limiting or avoiding organ meats such as liver, brain, heart, kidney and sweetbread.

34. **ANSWER: D**
**RATIONALE:** A Nephrostomy tube is put in place after percutaneous ultrasonic lithotripsy to treat calculuses in the renal pelvis.

35. **ANSWER: D**
**RATIONALE:** Bladder trauma or injury should be considered or suspected in the client with low abdominal pain and hematuria.

36. **ANSWER: B**
**RATIONALE:** Bladder trauma or injury is characterized by lower abdominal pain that may radiate to one of the shoulders.

37. **ANSWER: A**
**RATIONALE:** The presence of blood of the urinary meatus may indicate urethral trauma or disruption. The nurse notifies the physician, knowing that the client should not be catheterized until the cause of the bleeding Is determined by the diagnostic testing.

38. **ANSWER: A**
**RATIONALE:** The nurse assess the patency of the fistula by palpating for the presence of a thrill or aucultating for a bruit. The presence of the thrill and bruit indicate patency of the fistula.

39. **ANSWER: C**
**RATIONALE:** Urethritis in the male client often results from chlamydial infection and is characterized by dysuria which is accompanied by a clear to mucopurulent discharge.

40. **ANSWER: B**
**RATIONALE:** The most serious complication of the chlamydial infection is sterility. The infection can be prevented by the use of latex condoms.

41. **ANSWER: B**
**RATIONALE:** Trimethoprim-sulfamethoxazole (Bactrim) maybe administered by intravenous infusion but should not be mixed with any other medication or solutions. This drug is infused over 60-90 minutes, and bolus infusion or rapid infusion must be avoided.

42. **ANSWER: D**
**RATIONALE:** Nalidixic acid can intensify the effects of oral anti coagulants by displacing this agents from binding sites on plasma protein. When an oral anticoagulant is combined with a Nalidixic acid, a decrease in the anticoagulant dosage may be needed.

43. **ANSWER: A**
**RATIONALE:** Each dose of sulfisoxazole (Gantricin) should be administered with a full glass of water, and the client should maintain a high fluid intake.

44. **ANSWER: D**
**RATIONALE:** Sulfonamides can intensify the effects of warfarin sodium (Coumadin), phenytoin (Dilantin), and orally administered hypoglycemic such as Tolbutamide (Orinase). When combine with sulfonamides, this medication may require a reduction in dosage.

45. **ANSWER: B**
**RATIONALE:** Client's taking Trimethoprim-sulfamethoxazole should be informed about early signs of blood disorder that can occur from this medication.

46. **ANSWER: D**
**RATIONALE:** Cranial nerve II is the optic nerve, which governs vision. The nurse ca provides safety for the visual impaired client by clearing the path of obstacle when ambulating.

47. **ANSWER: A**
**RATIONALE:** The limbic system is responsible for feelings and emotions, calculation ability and knowledge of current events relates to function to function of the frontal lobe. The cerebral hemispheres with specific regional functions, control orientation. Recall of recent events is controlled by the hippocampus.

48. **ANSWER: D**
**RATIONALE:** The trigeminal nerve has a motor and sensory division. The motor division innervates the muscle for chewing (mastication). The sensory division innervates the entire face, scalp, and cornea, nasal and oral cavity.

49. **ANSWER: B**

**RATIONALE:** Cranial nerves III (oculomotor), IV trochlear, and VI abducens have only motor component and control, in a coordinated manner, the six cardinal field of gaze.

**50. ANSWER: A**
**RATIONALE:** Motor testing of the unconscious client can be done only by testing response to painful stimuli. Nail bed pressure tests a basic peripheral response. Cerebral responses to pain are tested using sternal rub, placing upward pressure on the orbital rim, or squeezing the clavicle or sternocleidomastoid muscle.

**51. ANSWER: C**
**RATIONALE:** The client having an MRI scan has all metallic objects removed because of the magnetic field generated by the device. A careful history is done to determine any metal objects are inside the client, such as orthopedic hardware, pacemakers, artificial heart valves, aneurysm clips, or intrauterine devices.

**52. ANSWER: D**
**RATIONALE:** The client undergoing lumbar puncture is positioned lying on the side, with the legs pulled up to the abdomen, and with the head bent down onto the chest.

**53. ANSWER: A**
**RATIONALE:** After CT scan the client may resume all usual activities. The client should be encourage to consume extra fluids to replace those loss with the diuresis from the contrast dye.

**54. ANSWER: D**
**RATIONALE:** Caloric testing provides information about differentiating between cerebellar and brain stimulation. After determining patency of the ear canal, cork or warm water is injected into the auditory canal. A normal response that indicates intact function of cranial nerve III, VI, VIII is conjugate eye movements toward the side being irrigated, followed by rapidly nystagmus to the opposite side. Absent or dysconjugate eye movements indicate brainstem damage.

**55. ANSWER: C**
**RATIONALE:** Following a myelogram, the client is placed on bedrest for 6-8 hours after the procedure. When a water based contrast medium is used, the client is position with the head of bed elevated 15-30 degrees.

**56. ANSWER: D**
**RATIONALE:** A change in vital signs may be a late sign of increased intracranial pressure. Trends include, increasing temperature and blood pressure and decreasing pulse and respiratory. Respiratory irregularities also may arise.

**57. ANSWER: A**
**RATIONALE:** The head of the client with increased intracranial pressure should be positioned so the head is in a neutral, mid-line position. The nurse should avoid flexing or extending the neck or turning the head side to side.

**58. ANSWER: D**
**RATIONALE:** Activities that increase intrathoracic and intra abdominal pressures caused an indirect elevation of the intracranial pressure. Some of these activities include isometric exercises, valsalva's maneuver, coughing, sneezing, and blowing the nose. Exhaling during activities such as repositioning or pulling up in bed, opens the glottis, which prevents intrathoracic pressure from rising.

**59. ANSWER: A**

**RATIONALE:** Leakage of CSF from the ears or nose may accompany basilar skull fracture. CSF can be distinguished from other body fluids because the drainage will separate into bloody and yellow concentric rings on dressing material, called halo's sing.

**60. ANSWER: B**
**RATIONALE:** A complication of head injury is diabetes insipidus, which can occur with insult to the hypothalamus, the antidiuretic hormone storage vesicles, or the posterior pituitary gland. Urine output that exceeds 9L per day generally requires treatment with Desmopressin.

**61. ANSWER: B**
**RATIONALE:** Soft tissue injuries such as sprains are treated by RICE (rest, ice, compression and elevation) for the first 24 hours after the injury. Heat is not use in the first 24 hours because it could increase venous congestion which would increase edema and pain.

**62. ANSWER: D**
**RATIONALE:** A client at risk for osteoporosis needs to increase intake of calcium. Yogurt is one of the major dietary source of calcium.

**63. ANSWER: C**
**RATIONALE:** Risk factor for osteoporosis include being a female, post menopausal, low calcium diet, being sedentary and smoking cigarettes.

**64. ANSWER: C**
**RATIONALE:** Home modification includes use of railings on all staircase, ample lighting, removal of scattered rags, and placement of handrails in the bathroom. Removal of wall to wall carpeting is not necessary.

**65. ANSWER: D**
**RATIONALE:** After biopsy the client usually requires mild analgesic.

**66. ANSWER: C**
**RATIONALE:** Fever or any sign and symptoms of infection should be reported to the physician.

**67. ANSWER: A**
**RATIONALE:** Because of the risk to allergy to the contrast dye, the nurse must assess if the client has an allergy to iodine or shellfish.

**68. ANSWER: A**
**RATIONALE:** A radiograph is a photographic image of a part of the body on a special film which is used to diagnose a wide variety of condition. Any radiopaque objects such as jewelry or any other metal must be removed

**69. ANSWER: D**
**RATIONALE:** No special restriction are necessary after a bone scan. The client is encourage to drink large amount of water for 24-48 hours to flush the radio isotope from the system.

**70. ANSWER: D**
**RATIONALE:** Typical sign and symptoms of fracture include pain, loss of function in the area, deformity, shortening of the extremity, crepitus, swelling and ecchymosis.

**71. ANSWER: B**

**RATIONALE:** With the suspected fracture, the client is not moved unless it is dangerous to remain in that spot.

**72. ANSWER: B**
**RATIONALE:** Immobility and the weight of a casted arm may cause the shoulder above an arm fracture to become stiff. The shoulder of a casted arm should be lifted over the head periodically as a preventive measure.

**73. ANSWER: D**
**RATIONALE:** A fiber glass cast is made of water activated polyurethane materials that are dry to the touch within minutes and reach full rigid strength in about 20 minutes.

**74. ANSWER: B**
**RATIONALE:** Surface soil on a cast can be remove with a damp cloth. If the cast gets wet, it can be dried with a hair dryer set to a cool setting to prevent skin breakdown.

**75. ANSWER: D**
**RATIONALE:** Traction reduces muscle spasms and helps to immobilize the fracture

**76. ANSWER: B**
**RATIONALE:** If the client in the skeletal traction may not turn from side to side, the nurse should have the client pull up on a trapeze and try to lift the hips off the bed for skin care, bedpan use, and linen changes.

**77. ANSWER: A**
**RATIONALE:** Small amount of serous oozing is expected at the pin insertion site

**78. ANSWER: C**
**RATIONALE:** Major defining characteristics of deficient diversional activity is expression of boredom of a client

**79. ANSWER: B**
**RATIONALE:** The nurse inspect the skin of the limb in traction at least once every 8 hours for irritation or inflammation

**80. ANSWER: D**
**RATIONALE:** The nurse realigns the client and if that is ineffective then calls the physician.

**81. ANSWER: C**
**RATIONALE:** Sign and symptoms of infection under a casted area include odor, purulent drainage or the presence of hot spots.

**82. ANSWER: D**
**RATIONALE:** Pain that is not relieved by analgesic or elevation, application of cold and rest should be reported to the physician because the pain may result from impaired tissue perfusion.

**83. ANSWER: C**
**RATIONALE:** A casted extremity is elevated continuously for 24-48 hours to minimize swelling and promote venous drainage.

**84. ANSWER: C**
**RATIONALE:** The nurse petals the edges of the cast with tape to minimize the skin irritation.

**85. ANSWER: D**
**RATIONALE:** A plaster cast must remain dry to keep its strength.

**86. ANSWER: B**
**RATIONALE:** Crutches are measured so that the tops are 2-3 finger breadths from the axillas to prevent injury to the brachial plexus.

**87. ANSWER: A**
**RATIONALE:** The crutches are placed anywhere from 6-10 inches in front and to the side of the client, to provide a wide base of support to the client and improves balance.

**88. ANSWER: A**
**RATIONALE:** Crutch tip should remain dry. Water could cause slipping by decreasing the surface friction of the rubber tip on the floor.

**89. ANSWER: B**
**RATIONALE:** The cane is placed 4-6 inches lateral to the fifth toe, the reason is that with normal walking the opposite arm and leg move together.

**90. ANSWER: B**
**RATIONALE:** The cane is held on the stronger side to minimize stress on the affected extremity and provide a wide base of support and move forward with the affected leg.

**91. ANSWER: B**
**RATIONALE:** Key feature of fat embolism is a significant degree of hypoxemia with a PaO2 often less than 60 mmHg

**92. ANSWER: A**
**RATIONALE:** Respiratory failure is the most common cause of death after fat embolus. The client may be intubated and mechanically ventilated with positive and expiratory pressure to treat hypoxemia and pulmonary edema. Corticosteroids are given to treat inflammation of the lungs.

**93. ANSWER: D**
**RATIONALE:** The clear chest radiograph is a good indicator that fat embolus is resolving when fat embolism occurs, the chest radiograph has a “snow storm” appearance.

**94. ANSWER: C**
**RATIONALE:** Compartment syndrome is caused by bleeding and swelling within a compartment, which is lined by fascia and does not expand.

**95. ANSWER: A**
**RATIONALE:** The earliest symptoms of compartment syndrome is paresthesia (numbness and tingling)

**96. ANSWER: B**
**RATIONALE:** Following internal fixation of a hip fracture the client is turned to the affected side or the unaffected side as prescribed by the surgeon. Before moving the client the nurse places a pillow between the client’s leg to keep the affected leg in abduction.

**97. ANSWER: D**
**RATIONALE:** The nurse assist the client to get out of bed after putting a knee immobilizer on the affected joint for stability.

**98. ANSWER: A**

**RATIONALE:** After the total knee replacement, the client should report signs and symptoms of infection and any changes on the shape of the knee.

**99. ANSWER: B**

**RATIONALE:** Client with DM are more prone to wound infection and delayed wound healing because of the disease.

**100. ANSWER: B**

**RATIONALE:** Phantom limb sensation are felt in the area of the amputated limb. These sensations can include itching, warmth and cold. The sensations are due to intact peripheral nerves in the area amputated.

**Test V - Psychiatric Nursing**

**ANSWERS AND RATIONALE**

1. **ANSWER: A**
   **RATIONALE:** Responding to the feelings expressed by a client is an effective therapeutic communication technique. The correct option is an example of the use of restating.

2. **ANSWER: D**
   **RATIONALE:** Option D uses the therapeutic communication technique of restatement. Although restatement is a technique that has a prompting component to it, it repeats the client's major theme, which assists the nurse to obtain a more specific perception of the problem from the client.

3. **ANSWER: C**

   **RATIONALE:** Denial is refusal to admit to a painful reality and may be a response by a victim of sexual abuse.

4. **ANSWER: D**
   **RATIONALE:** Denial is refusal to admit to painful reality which is treated as if it does not exist.

5. **ANSWER: C**
   **RATIONALE:** Generally, the client seeks voluntary admission. Voluntary clients have the right to demand and obtain release. If the client is a minor, the release may be contingent on the consent of the parents or guardian. The nurse needs to be familiar with the state and facility policies and procedures. Many states requires that the client submit a written release notice to the facility staff, who reevaluates the client's condition for possible conversion to involuntary status, according to criteria established by law

6. **ANSWER: D**
   **RATIONALE:** A client may request to be scheduled or restrained. Federal law require the consent of the client, unless an emergency situation exists in which an immediate risk to the client or others can be documented. The use of seclusion is permitted only on the written order of a physician which must be reviewed and renewed every 24 hours and which also must specify the type of restraint to be used.

7. **ANSWER: C**
   **RATIONALE:** Option C helps the client to focus on the emotion underlying the delusion but does not argue with it.

8. **ANSWER: C**
   **RATIONALE:** The client must first deal with feeling s and negative responses before the client is able to work through the meaning of the crisis. Option C pertains directly to the client's feelings.

9. **ANSWER: A**
   **RATIONALE:** Cognitive therapy frequently is used with clients who have depression. This type of therapy is based on exploring the client's subjective experience. Cognitive therapy includes examining the client's thoughts and feelings about situations and how these thoughts and feelings contribute to and persuade the client's difficulties and mood.

10. **ANSWER: A**

**RATIONALE:** Systematic desensitization is a form of therapy used when the client is introduced to short periods of exposure to the phobic object while in a relaxed state. Gradually exposure is increased until the anxiety about or fear of the objects or situation has ceased.

**11. ANSWER: A**
**RATIONALE:** The ideal number of clients in a psychotherapy group ranges from 7 to 10. Having more than 10 members is not recommended because the group will subdivide, which his counterproductive. Too large a group also can create more opportunities for acting out as opposed to working through issues.

**12. ANSWER: C**
**RATIONALE:** Solitary activities that require a short attention span with mild physical exertion are the most appropriate activities for a client who is exhibiting aggressive behavior. Writing, walks with staff, and finger painting are activities that minimize stimuli and provide a constructive release for tension.

**13. ANSWER: B**
**RATIONALE:** A depressed client experiences a depressed mood and client is withdrawn. The person also experiences difficulty concentrating loss of interest or pleasure, low energy, fatigue, and feeling s of worthlessness and poor self-esteem. The plan of care needs to provide successful experiences in a stimulating yet structured environment.

**14. ANSWER: C**
**RATIONALE:** Feelings of low self=esteem and worthlessness are common symptoms of the depressed client. An effective plan of care to enhance the client's personal self-esteem is to provide experiences for the client that are challenging but will not be met with failure. Reminders of the client's past accomplishments or personal success are ways to interrupt the client's negative self-talk and distorted cognitive view of self.

**15. ANSWER: B**
**RATIONALE:** Major depression, recurrent, with psychotic features alerts the nurse that in addition to the criteria that designates the diagnosis of major depression, one also must deal with the client's psychosis. Psychosis is defined as a state in which a person's mental capacity to recognize reality and to communicate and relate to others is impaired, thus interfering with the person's capacity to deal with the demand of life.

**16. ANSWER: A**
**RATIONALE:** The exact cause of depression is not known but is believed to be related to a biochemical disruption of neurotransmitters in the brain. Diet, exercise, and medication are recognized treatment for the disease process.

**17. ANSWER: D**
**RATIONALE:** Safety to the client and other clients is the priority. Option D is the only option that addresses the client and other client's safety needs.

**18. ANSWER: D**
**RATIONALE:** For the nurse to empathize with the client's experience is most therapeutic. Disagreeing with delusions may make the client more defensive and the client may cling to the delusions even more.

**19. ANSWER: C**
**RATIONALE:** If a client with severe anxiety is left alone the client may feel abandoned and become overwhelmed. Placing the client in a quiet room is also important, but the nurse must stay with the client.

20. **ANSWER: B**
**RATIONALE:** Provision of a consistent daily routine and a low stimulating environment is important when the client is oriented Noise, including radio and television, may add to the confusion and disorientation.

21. **ANSWER: D**
**RATIONALE:** In option D the nurse encourages the client and the family to verbalize fears and concerns. Other options avoid dealing with concerns and are blocks to communication.

22. **ANSWER: D**
**RATIONALE:** The clinical picture of dementia varies from the development of mild cognitive defects to severe. Life-threatening alterations in neurological functioning. For the client to use confabulation or the fabrication of events or experiences to fill in memory gaps is not unusual. Often lack of inhibitions on the part of the client may constitute the first indication of anything being "wrong' to the client's significant others.

23. **ANSWER: C**
**RATIONALE:** The most effective communication technique is the one in which the nurse is giving information. Regarding memory functioning, the normal older adult who ages will find that the time required for memory scanning is longer for recent and remote memory recall. Dementia of the Alzheimer's type involves a disorder that is characterized by a syndrome of symptomatology the onset of which is slow and insidious with a generally progressive and deteriorating course.

24. **ANSWER: B**
**RATIONALE:** Safety to the client and other clients is the priority. Option B is the only option that addresses the client and other client's safety needs.

25. **ANSWER: D**
**RATIONALE:** Recognizing situations that produce anxiety allows the client to prepare to cope with anxiety or avoid a specific stimulus. Counselors will not be available for all anxiety producing situations, and this option does not encourage the development of internal strength. Ignoring feelings will not resolve anxiety.

26. **ANSWER: A**
**RATIONALE:** Agoraphobia is a fear of open spaces and the fear of being trapped in a situation form which there may not be an escape. Agoraphobia includes the possibility of experiencing a sense of helplessness or embarrassment if an attack occurs.

27. **ANSWER: A**
**RATIONALE:** Manic clients may be talkative and can dominate group meetings or therapy session by their excessive talking. If this occurs, the nurse initially would set limits on the client's behavior. Initially, asking the client out of the session is inappropriate. This may agitate the client and further escalate the client's behavior.

28. **ANSWER: A**
**RATIONALE:** A conversion disorder is the alteration or loss of a physical function that cannot be explained by any known pathophysiological mechanism. A conversion disorder is thought to be an expression of a psychological need or conflict. In this situation the client witnessed an accident that was so psychologically painful that the client became blind.

29. **ANSWER: B**

**RATIONALE:** The client is at risk for injury to self and others and therefore should be escorted out of the dayroom. Antipsychotic medications are useful to manage the manic client. Hyperactive and agitated behavior usually responds to haloperidol (Haldol)

**30. ANSWER: A**
**RATIONALE:** Clients with anorexia nervosa frequently are preoccupied with rigorous exercise and push themselves beyond normal limits to work off caloric intake. The nurse must provide for appropriate exercise and place limits to rigorous activities.

**31. ANSWER: D**
**RATIONALE:** Clients with anorexia nervosa have the desire to please others. Their need to be correct or perfect interferes with rational decision-making processes. These clients are moralistic. Rules and rituals help the clients manage their anxiety.

**32. ANSWER: C**
**RATIONALE:** Excessive exercise is a characteristic of anorexia nervosa, not a characteristic of clients with bulimia. Frequent vomiting, in addition to laxative and diuretic abuse, may lead to dehydration and electrolyte imbalance.

**33. ANSWER: A**
**RATIONALE:** Some of the symptoms associated with delirium tremors typically are anxiety, insomnia, anorexia, hypertension, disorientation, hallucinations, changes in level of consciousness, agitation, fever and delusions

**34. ANSWER: D**
**RATIONALE:** The most helpful response is one that encourages the client to problem solve. Giving advice implies that the nurse knows what is best and also can foster dependency. The nurse should not agree with the client, nor should the nurse request that the client provide explanations.

**35. ANSWER: D**
**RATIONALE:** Whenever the nurse employs an assessment for a client who is dependent on drugs, it is best for the nurse to attempt to elicit information by being judgmental and direct.

**36. ANSWER: C**
**RATIONALE:** An important consideration in alleviating the anxiety is to assist the client to recognize their behavior.

**37. ANSWER: C**
**RATIONALE:** The signs of alcohol withdrawal develop within a few hours after cessation or reduction of alcohol and peak after 24 to 48 hours. The early signs include anxiety, anorexia, insomnia, tremor, irritability, an elevation in pulse and blood pressure, nausea, vomiting and poorly formed hallucinations or illusions

**38. ANSWER: D**
**RATIONALE:** Regression can occur in a preschooler and is most often a result of the stress of the hospitalization. It is best to accept the regression if it occurs. Parents may be overly concerned about the regressive behavior and should be told that regression is normal following hospitalization.

**39. ANSWER: A**
**RATIONALE:** Victims of sexual abuse may exhibit fear and anxiety over what has just occurred. In addition, they may fear that the abuse could be repeated. On initiating contact with a child victim of sexual abuse who demonstrates fear of others, it is best to convey a willingness to spend time, and move slowly to initiate activities that may be

perceived as threatening. Once rapport is established, the nurse may explore the child's feelings or use various therapeutic modalities to encourage recounting the sexual encounter. Option A conveys a plan for an initial encounter that establishes trust by sitting with the child in a nonthreatening atmosphere.

**40. ANSWER: C**
**RATIONALE:** The nurse must ascertain the client is safe, and then discuss the matter with the nursing assistant in an area away from the hearing of the client. If the client heard the conversation, the client may become more confused or agitated.

**41. ANSWER: C**
**RATIONALE:** The developmental task of the school-aged child is industry versus inferiority. The child achieves success by mastering skills and knowledge. Maintaining school work provides for accomplishment and prevents feeling s of inferiority from lagging behind the class. The other options provide diversion and are of lesser importance for a child of this age.

**42. ANSWER: D**
**RATIONALE:** Responding to the feelings expressed by a client is an effective therapeutic communication technique. Restating what the client has said would give a chance to the client to verbalize the feelings.

**43. ANSWER: A**
**RATIONALE:** Mutism is the absence of verbal speech. The client does not communicate verbally, despite an intact physical structural ability to speak. Pressured speech refers to rapidity of speech reflecting the client's racing thoughts. Verbigeration is the purposeless repetition of words or phrases. Poverty of speech means diminished amount of speech or monotonic replies.

**44. ANSWER: B**
**RATIONALE:** Options A, C and D are classified as antidepressants and act by stimulating the central nervous system to elevate mood. Alprazolam (Xanax ), a benzodiazepine antianxiety agent, depresses the CNS and induces relaxation in panic disorders.

**45. ANSWER: C**
**RATIONALE:** A person who is experiencing mania lacks insight and judgment, has poor impulse control and is highly excitable. The nurse must take control without creating increased stress or anxiety to the client.

**46. ANSWER: B**
**RATIONALE:** The major side effects of ECT are confusion, disorientation, and memory loss. A change in blood pressure would not be an anticipated side effect and would be a cause for concern. If hypertension occurred after ECT, the physician should be notified

**47. ANSWER: A**
**RATIONALE:** When hallucination are present, the nurse should reinforce reality with the client. Option A, the nurse addresses the client's feelings and reinforces reality.

**48. ANSWER: C**
**RATIONALE:** The use of defense mechanism allows a person to avoid the painful experience of anxiety or to transform it into a more tolerable symptom, such as regression. Regression allows the threatened client to move backward developmentally to a stage in which more security is felt. The recognition of regression is a signal that the client is anxious. Option C will help the client feel less anxious.

**49. ANSWER: D**
**RATIONALE:** Risperidone (Risperdal) is an antipsychotic medication that suppresses behavioral responses in psychosis. Baseline assessment includes renal and liver function tests, and these studies should be done before the initiation of treatment. This medication is used with caution in clients with renal or hepatic impairment with underlying cardiovascular disorders, and in older or debilitative clients.

**50. ANSWER: A**
**RATIONALE:** The client is removed to a nonstimulating environment as a result of behavior. It is best to inform the client the purpose of the seclusion.

**51. ANSWER: A**
**RATIONALE:** A nurse can be charge with false imprisonment if a client is made to believe wrongfully that the client cannot leave the hospital. Most health care facilities have documents that the client is asked to sign that relate to the client's responsibilities when the client leaves against medical advice. The client should be asked to sign this document before leaving. The nurse should request that the client wait to speak to the physician before leaving, but if the client refuses to do so, the nurse can't hold the client against the client's will. Restraining the client and calling security to block exits constitute false imprisonment. Any client has a right to healthcare ad cannot be told otherwise.

**52. ANSWER: A**
**RATIONALE:** A client with Bulimia Nervosa initially may not appears to be physically or emotionally ill. They are often at the slightly below ideal body weight. On further inspection the client demonstrates dental decay and loss of tooth enamel if the client has been inducing vomiting. Electrolyte imbalances are present.

**53. ANSWER: A**
**RATIONALE:** Although each crisis response can be described in similar terms as far as presenting symptoms are concerned, what constitutes a crisis for one person may not constitute a crisis for another person because each is a unique individual. Being in the crisis state does not mean that the client is suffering form emotional or mental illness.

**54. ANSWER: D**
**RATIONALE:** Crisis times may occur between appointments. A contract facilitates the client feeling a responsibility for keeping a promise.

**55. ANSWER: C**
**RATIONALE:** The therapeutic serum level of lithium is 0.6 to 1.2 mEq/L. A serum lithium level of 1.8 mEq/L indicates moderate toxicity. Serum lithium concentration of 1.5 – 2.5 mEq/L may produce vomiting, diarrhea, ataxia, incoordination, muscle twitching, and slurred speech

**56. ANSWER: D**
**RATIONALE:** The maximum therapeutic effects of Imipramine hydrochloride (Tofranil) may not occur for 2-3 weeks after the antidepressant therapy has been initiated.

**57. ANSWER: B**
**RATIONALE:** Thioridazine hydrochloride (Mellaril), an antipsychotic, can cause postural hypotension. The client needs to be taught to get out of bed slowly and to rise from sitting position slowly because of this untoward effect related to the medication.

**58. ANSWER: A**
**RATIONALE:** Depressed individual will sleep for long periods are not able to go to work and feel as if they cannot "do anything". Once they have had some therapeutic effect for

the medication, they will report resolution of many of these complaints and demonstrate an improvement in their appearance.

**59. ANSWER: A**
**RATIONALE:** The oral concentrate form of Thioridazine hydrochloride (Mellaril) should be diluted in water or fruit juice just before administration into the client.

**60. ANSWER: A**
**RATIONALE:** The most common side effects related to the medication includes central nervous system and gastrointestinal system by causing nausea, vomiting, cramping and diarrhea.

**61. ANSWER: A**
**RATIONALE:** BuSpan is not recommended for the treatment of drug or alcohol withdrawal, thought disorders or schizophrenia. Buscopirone hydrochloride (BuSpan) is mostly indicated for the treatment of anxiety

**62. ANSWER: A**
**RATIONALE:** Maintenance serum level of lithium are 0.6 to 1.2 mEq/L. Symptoms of toxicity begin to appear at levels of 1.5 mEq/L. Lithium toxicity requires immediate medical attention with lavage and possible peritoneal dialysis or hemodialysis.

**63. ANSWER: D**
**RATIONALE:** Chloral hydrate is a sedative. This medication does not affect cardiac functions. Blood pressure is not significant with the use of this medication. The client should call for assistance to the bathroom at night. Additional, the client may experience residual daytime sedation, therefore the nurse also instructs the client to call for ambulation assistance during the daytime hours.

**64. ANSWER: B**
**RATIONALE:** Clomipramine hydrochloride is a tricyclic antidepressant used to treat obsessive compulsive disorder. Weight gain and tachycardia are side effects of this medication. Sedation sometimes occur and insomnia is a seldom side effect.

**65. ANSWER: C**
**RATIONALE:** Amitriptyline is a tricyclic antidepressant. Depressed individuals sleep for extended periods, have a change in appetite, unable to go to work, and have difficulty concentrating. They also may experience increased fatigue, feeling of guilt, worthlessness, loss of interest in activities and possible suicidal tendencies.

**66. ANSWER: B**
**RATIONALE:** Haloperidol (Haldol) is an antipsychotic drug used to manage psychotic disorder. Hallucination, delusions, and altered thought processes are characteristics of a psychotic disorder and should decrease with effective treatment.

**67. ANSWER: C**
**RATIONALE:** The client is incapable of accepting responsibility for self-created problems and blames society for the behavior.

**68. ANSWER: B**
**RATIONALE:** Phenobarbital sodium is an anticonvulsant and hypnotic agent. The client should avoid taking any other central nervous depressant such as alcohol while taking this medication.

**69. ANSWER: A**

**RATIONALE:** The client taking Clozapine may experience agranulocytosis, which is monitored by reviewing the results of the white blood cell counts. Treatment is interrupted if the white blood cells count drops below 3000 cells/mm³. Agranulocytosis could be fatal if undetected and untreated.

**70. ANSWER: D**
**RATIONALE:** Chlorpromazine is an antipsychotic medication. A side effect of this medication is that the color of the urine may darken. The client should be aware that this effect is harmless.

**71. ANSWER: D**
**RATIONALE:** Dry mouth is a common side effect. Frequent mouth rinsing with water, sucking on hard candy, and chewing sugarless gum will alleviate this common side effect.

**72. ANSWER: C**
**RATIONALE:** Oxazepam causes constipation, and the client is instructed to increase fluid intake and bulk in the diet. If the heart begins to beat fast, the physician is notified because this could indicate overdose.

**73. ANSWER: B**
**RATIONALE:** The abrupt withdrawal of Alprazolam could result in seizure activity from rebound central nervous system excitation. All clients receiving this medication should be warned of this danger.

**74. ANSWER: A**
**RATIONALE:** Sertraline (Zoloft) is classified as an antidepressant. This drug is administered once every 24 hours. It may be administered in the morning or evening, but evening administration would be preferable because drowsiness is a side effect. The medication can be administered without food or with food if gastrointestinal distress occurs. This drug is not ordered for use as needed.

**75. ANSWER: A**
**RATIONALE:** During the escalation period, the client's behavior is moving toward loss of control. Nursing actions include taking control, maintaining safe distance, acknowledging behavior, moving the client to a quiet area, and medicating the client if appropriate. To initiate confinement measures during this period is not appropriate.

**76. ANSWER: A**
**RATIONALE:** A situational crisis arises from external rather that internal sources. External situations that could precipitates crisis include loss of or change of job, the death of the loved one, abortion, a change in financial status, divorce, addition of new family members, pregnancy and severe illness.

**77. ANSWER: A**
**RATIONALE:** The nurse's initial assessment task when assessing a client in crisis is to assess the individual or family and the problem. The more clearly the problem can be defined, the better the chance a solution can be found. Option A will assist in determining data relate to the precipitating event that led to the crisis.

**78. ANSWER: D**
**RATIONALE:** Clients who are depressed may be at risk for suicide. For the nurse to assess suicidal ideation and plan is critical. Ask the client directly with the client's feelings.

**79. ANSWER: B**

**RATIONALE:** The initial nursing action is to assess and treat the self-inflicted injuries. Injuries from lacerated wrists can lead to a life threatening situation.

**80. ANSWER: D**
**RATIONALE:** In a crisis the nurse must take an authoritative, active role to promote the client's safety. A bottle of poisonous substance that will be used to kill her is the "crisis". The client's safety is the prime concern. Keeping the client on the phone and getting help to the client is the best intervention.

**81. ANSWER: A**
**RATIONALE:** The question is focused on the nursing diagnosis of dysfunctional grieving. The only option that deals with grief is option A.

**82. ANSWER: A**
**RATIONALE:** The client in seclusion must be assessed at regular intervals (usually every 15-39 minutes) for physical needs, safety and comfort. Option B indicates a physical need that could be met with a urinal or bedpan. If necessary, it does not indicate that the client has calmed down enough to leave the seclusion room. Option C could be an attempt to manipulate the nurse. Option D indicates the need for supportive communication or possibly medication as needed.

**83. ANSWER: C**
**RATIONALE:** One-to-one suicide precautions are required for the client who has attempted suicide. The best intervention is constant supervision so that the nurse may intervene as needed if the client attempts to cause harm to self.

**84. ANSWER: B**
**RATIONALE:** Tertiary prevention of family violence includes assisting the victim once the abuse has already occurred. The nurse should provide the client with information regarding where to obtain help. This includes a specific plan for removing self from the abuser, information as to escaping, hotlines, and the location of shelters. An abused client is usually reluctant to call the police. Teaching the client to fight back is not the appropriate action for the victim when dealing with a violent person.

**85. ANSWER: C**
**RATIONALE:** During the acute phase of the rape crisis, the client can display a wide range of emotional and somatic responses. The symptoms noted indicate a normal reaction to an intensely difficult crisis event.

**86. ANSWER: B**
**RATIONALE:** Short term goals include the beginning stages of dealing with the rape trauma. Clients will be expected initially to keep appointments, participate in care, begin to explore feelings, and begin to heal any physical wounds that were inflicted at the time of the rape.

**87. ANSWER: D**
**RATIONALE:** Whenever the nurse employs an assessment for a client who is dependent on drugs,, it is best for the nurse to attempt to elicit information by being nonjudgmental and direct.

**88. ANSWER: C**
**RATIONALE:** The client who has severe anxiety may be hyperventilating, complaining of a headache, has loud or rapid speech and purposeless activity.

**89. ANSWER: D**

**RATIONALE:** Ineffective coping maybe evidenced by inability to meet basic needs, inability to meet role expectations, alteration in social participation, use of inappropriate defense mechanism or impairment of usual patterns of communication.

**90. ANSWER: D**
**RATIONALE:** When a suspected abused child is admitted to the hospital for further evaluation and protection, the physician will usually work with the parents so they will agree to the admission. If the parents refuse to agree to the admission, the hospital can request an immediate court order to retain the child for a specific length of time.

**91. ANSWER: A**
**RATIONALE:** The vegetative signs of depression are changes in physiological functioning during depression. These include appetite, weight, sleep patterns and psychomotor activity.

**92. ANSWER: C**
**RATIONALE:** This is a theoretical explanation for the development of anorexia nervosa

**93. ANSWER: B**
**RATIONALE:** Ambivalence describes the existence of two conflicting emotions, impulses or desires

**94. ANSWER: A**
**RATIONALE:** These are side effects during initial therapy. Gabatril causes the typical symptoms of CNS depression

**95. ANSWER: C**
**RATIONALE:** These individuals readily respond to environmental cues; increased stimulation increases activity; decreased stimulation decreases activity.

**96. ANSWER: B**
**RATIONALE:** Regression is the defense mechanism commonly used by clients with schizophrenia to reduce anxiety by returning to earlier behavior

**97. ANSWER: D**
**RATIONALE:** This activity would facilitate a one-to-one interaction and the development of a trusting relationship

**98. ANSWER: A**
**RATIONALE:** The psychosexual development of a preschooler focuses on the fear of invasive procedures.

**99. ANSWER: D**
**RATIONALE:** This response encourages the client to explore the defenses employed to cope with anxiety.

**100. ANSWER: D**
**RATIONALE:** The nurse should offer support and use clear, simple terms to allay the client's anxiety.

# How to Study for the NLE and NCLEX Examination

1. **Know the test.** Become familiar with content, format, and topics covered on the exam so you know how to focus your studies and have no surprises on test day.

2. **Study area.** Have a dedicated study area where you can keep your study aids and have a focus for your daily studies. Make sure it is properly lit and away from distractions such as TV.

3. **Practice schedule**. Set up a reasonable practice schedule that you can complete each day. Feeling guilty over not being able to keep up with your studies will not help you with the test.

4. "**Near-test" conditions**. Practice taking the test under "near-test" conditions with no distractions, and timed sessions as closely resembling the real test as possible.

5**. Focus.** Studying for extended periods of time with short, scheduled breaks will keep you focused and improve your ability to concentrate on test day.

6. **Read the answers**. When taking practice tests, read all the correct answer descriptions, whether you got them right or not. This will help you learn the ones you missed and ensure you understood the ones you answered correctly.

7. **Use mnemonics.** If you have a list of information to memorize, rely on mnemonics to help you remember the information.

8. **Study partners.** If you can find some study partners, not only will you have fresh motivation when you hit a lull, but you can collaborate on study techniques.

9**. Flashcards.** Make or buy a set of flashcards and keep them with you always. While you stand in line you can take out your flashcards and do a little studying.

10. **Concept over memorization**. The point of the ***NLE and NCLEX*** is to prove you understand how to apply knowledge in the real world, so focus on learning the concepts over memorizing book knowledge.

11. **Do other things, too**. Don't spend every bit of your free time studying. You need to make time for other activities you enjoy such as going to the gym or having dinner with a friend so you don't burn out on studying.

12. **Stay positive**. A positive attitude will carry over in your practice and test taking. Keeping an upbeat outlook will take you the extra mile.

13. Take advantage of these **free resources** to help you study for your ***NLE and NCLEX. (http://nursingcrib.com and http://nclexreviewers.com)***

14. **Nursing Review Centers**
Ranging from practice tests to study guides to a full study programs, these services and products cost a little but will give you a boost in the right direction for the ***NLE and NCLEX*** Examination.

**Note**: For a comprehensive list of NLE and NCLEX Review Centers visit **http://nursingcrib.com/review-centers/**

## How to Stay Focus on Studying – Studying for long stretches over several weeks can become challenging.

1. **Be unavailable.** Let friends and family know what your study hours are and that you will absolutely be unavailable during those times for phone calls, visits, or any other social time.

2. **Choose the right time of day.** Find out what time of day you are most focused and choose that time for your study time. If your energy starts flagging around 7:30 in the evening, then evening study sessions will not be productive for you.

3**. Set a timer.** Not only can you use a timer for those timed practice sessions, but you can also set a timer for your study session. That way you don't have to keep checking the clock and can just work straight through until the timer goes off.

4**. Set daily goals.** Before you start each study session, set specific goals that you want to accomplish during that session.

5. **Incentives.** Give yourself incentives for successful study time such as a movie or time with friends after you finish your studying.

6. **Change topics.** Don't stay on the same topic for the whole study session. Changing every few hours will help keep your focus steady.

7. **SQ3R Reading Method.** If you have a lot of reading and memorizing to do, try using the SQ3R technique to help process the information more efficiently.

8. **Take stretch breaks.** Give yourself 10 minutes every few hours to get up and move around and get your blood flowing again.

9**. Eat.** Don't get so involved in your studying that you forget to eat. Have easy and nutritious snacks on hand so you can nibble as you study.

10. **Leave your space tidy.** After each study session, clean up your work space so that it is inviting when you return the next day.

# The Night before the Examination

You've invested so much time and energy into preparing for your test. Follow this advice to make sure you get off to a good start on test day.

1. **Organize**. Make sure you have everything you need for the next day such as any necessary forms, your photo ID, the address for the exam location, and the correct time.

2. **No studying.** If you've spent your prep time wisely, spending those extra few hours right before the test studying is not necessary. Instead, take the time to take care of yourself.

3. **Eat well.** Eat a nutritious dinner, but not too close to bed time as it may prevent a good night's sleep.

4. **Light exercise.** Take part in some light exercise early in the evening. This will serve to clear your mind and get your body ready for sleep in a few hours.

5. **Put the test in perspective.** Realize that while the ***NLE or NCLEX*** is an important step in starting your career, it is not a life or death situation. Most people pass this exam on the first try. If you don't pass, you can retake the exam.

6. **Relax.** Don't spend the last few hours before the exam worrying or cramming. Do something relaxing to set the stage for a great test tomorrow.

7. **Meditate.** Enjoy relaxing meditation or deep breathing exercises before bed. This will help you clear your mind of anxiety and prepare for much-needed sleep.

8. **Sleep**. Go to bed early and get a good night's rest. Wake up feeling refreshed so you can do your best on the exam.

9. **No alcohol.** Drinking alcohol can interfere with your sleep and too much can make you feel miserable the next morning.

10. **Back up plan**. Have a back up plan in place to cover any unexpected events such as car trouble or oversleeping. Set an extra alarm and put friends on notice for any help you might need in case of an emergency.

## Examination Day

These tips will help you do your best while taking the test.

1. **Breakfast.** Before heading out the door for your test, make sure you eat a healthy breakfast with plenty of protein.

2. **Energy food.** On testing day, bring snacks that are healthy and give you energy such as almonds, bananas, apples, and granola. Keeping your energy up and blood sugar level will help you concentrate better.

3. **Be comfortable.** Wear comfortable clothing and consider dressing in layers in case the temperature at the testing site is too warm or cold. If you are normally cold in the air conditioning, consider bringing a sweater.

4. **Arrive early.** There is nothing worse than getting lost and realizing you are running late for your appointment. Avoid this possibility by arriving early to your testing site.

5. **Don't rush.** Don't feel that you need to apply an unrealistic pressure on yourself to finish as quickly as possible. Don't rush and spend the appropriate amount of time to answer each question to the best of your ability.

6. **Make an educated Guess.** If you don't know an answer or are unsure, just guess. There is no penalty for guessing and you might guess it correctly. Your first instinct is usually correct.

7. **Breathe. If** you start feeling overwhelmed or panicky, take several deep breaths and let them out slowly. Slow down your thinking and refocus in order to stay calm and on track.

8. **Read carefully.** Read through each question carefully. If the question seems confusing, trying to re-word the question in a different manner may bring clarity.

9. **Answer before looking at options.** See if you know the answer to the question before you look at the options given. You may find your answer more easily this way.

10. **Take your breaks.** 10 minute breaks are offered but not all are mandatory. Take full advantage of these breaks to stretch your legs and clear your mind so you can come back to the test with a better focus.

11. **Celebrate.** After the test is finished, do something special for yourself. Indulge in a professional massage, go to dinner at your favorite restaurant, or just kick back with a night full of movies knowing you don't have to worry about studying.

## Guidelines to follow during the exam:

1. **Budget your time** – Although you may not know exactly how many questions you'll be asked to answer, you can estimate a little over 1 minute per question. Keep moving at a steady pace.
2. **Read each question thoroughly but quickly** – In general, your first reaction to a question is the correct one. Remember that the examination is designed to determine if you're minimally competent and safe.
3. **Concentrate on one item at a time**. Don't worry about how many questions you'll have to answer.
4. **Answer questions as if the situation were ideal**. Assume the nurse had all the time and resources needed. You're only concerned about one patient, the one in the question.
5. **Focus on the key words in the stem**.
6. **Identify whether the stem is seeking a true response or a false response**. Those stems asking for false responses are easily misread.
7. **Reword a difficult stem**.
8. Try answering the question before you've read the options provided.
9. **Always read all options before selecting the best one**.
10. **Relate each option to the stem**.
11. **Use logic and common sense** to figure out the correct response.
12. **Remember that the correct option** will tend to have greater applicability and flexibility.
13. **Clueless?** Look for clues in answer choices instead of in the stem of the question.

## Strategy No. 1

Sometimes pure hard work and mental preparedness is not enough. The ability to answers exams or any test faster is a must especially if it is bounded by time. Usually the pressure sets in if the time is working against you and even if you've prepared 100%, it can ruin entirely what you have poured in. We have outlined test taking tips and strategies applicable not only in the **November 2009 Nursing Board Exam** but also in any type of multiple choice exams including **NCLEX.**

**The Parts of a Question**
The question contains several parts:
the case (sometimes called scenario) – the description of the client and what is happening to him/ her

the stem – the part of the question that asks the question
the correct response
distracters – incorrect but feasible choices

**Key Words**
The most important skill for the test taker is the ability to read the question carefully and determine the key elements in each question. Each question has key words. Key words relate to the client; to the problem; and to specific aspects of the problem.

**Client**
Factors such as age, sex, and marital status may be relevant. When a child's age is given it often is very relevant to the answer. Vital signs vary with age. Preoperative teaching methods vary with age. Appropriate toys and diversional activities vary with age. Always pay special attention to the age of a client when it is given. Also consider who is the client for this question. That is, who is the focus of the question. The client may be the identified sick person, or it might be a relative of the identified sick person, or even a staff member.

**Problem/Behavior**
The problem may be a disease, a symptom or a behavior.

**Details of the Problem**
- Is the question asking for nursing actions or client symptoms or family responses?
- Does the question ask about a specific aspect of nursing care assessment, planning, implementation, evaluation?
- Does the question ask details relevant to a specific symptom or behavior the client exhibits?
- Is there additional information about the client or the problem that is important?

**Priority Setting**
- "What action takes priority?"
- "What should the nurse do first?"
- "What should the nurse do initially?"
- "What is essential for the nurse to do?"

Physiologic needs are first, followed by safety needs, then love and belonging, self-esteem and self-actualization.

The first step of the nursing process is assessment! When the stem of a question asks for the initial nursing action always look to see if there is a relevant assessment answer. The nurse will take an action only when there is enough data to act. Call the physician only when there is not a nursing action that should be taken first. The stem of the question may ask for a nursing action and the correct answer may be to assess.
When the stem of the question asks what is essential for the nurse to do, think safety. Remember many of the test questions are safety questions.

***What is the Time Frame?***
Whenever a specific time frame is indicated in a question it is very important. Pay attention to it. Time related words may be like early or late in relation in symptoms, pre operative or post operative, care on the day of surgery or later postoperative care.

***Repeated Words***
Words from the question are repeated in the answer. Frequently the same word or a synonym will be in both the question and the answer.

***Opposites***
When two answers are opposite such as high blood pressure and low blood pressure or increase the drip rate and stop the IV, or turn on the right side and turn on the left side, the answer is usually one of the two.

***Same Answer***
If two or three answers say the same thing in different words none can be correct. If the answers are too alike, then neither one is correct.

***Odd Answer Wins***
The answer that is different from the others is apt to be the correct answer. It may be the longest or the shortest or simply very different in content or style.

***Umbrella Answer***
One answer includes the others. There may be more than one correct answer. One answer is better than all the others because it includes them.

***Test Item Check List***
Use this handy list to check yourself every time you answer a test question.
Say to yourself, **DID I CAREFULLY…**

- Read the stem?
- Read all of the options?
- Read the stem again?
- Look for key words?

Eliminate obviously incorrect options?

Deadly
- ☐ all
- ☐ every
- ☐ total
- ☐ nothing
- ☐ always
- ☐ each
- ☐ only
- ☐ any
- ☐ nobody
- ☐ never
- ☐ none

Dangerous
- ☐ main
- ☐ chief
- ☐ avoid
- ☐ primarily
- ☐ major
- ☐ shall
- ☑ inevitable
- ☐ eliminate
- ☐ rarely
- ☐ impossible
- ☐ too

Safe
- ☐ usually
- ☐ almost
- ☐ frequently
- ☐ probably
- ☐ potentially
- ☐ may
- ☐ sometimes
- ☐ partial
- ☐ some
- ☐ might
- ☐ should
- ☐ few
- ☐ essentially
- ☐ generally
- ☐ occasionally
- ☐ nearly
- ☐ maybe
- ☐ could
- ☐ commonly
- ☐ average
- ☐ seldom
- ☐ often
- ☐ normally

**Choosing between the two best options**

After eliminating the incorrect options and you are having difficulty choosing between two seemingly correct responses, use the following strategies:

**Eliminate Similar Distracters** - If two options are essentially saying the same thing or include the same idea, then neither of them can be the answer. The answer has to be the option that is different.

**Reread two seemingly correct options** – If two options seem equally correct, reread them carefully; there must be some difference between them. Reread the stem; you may notice something you missed before.

**Look for a global response** – A more general statement may also include correct ideas from other options.

# Strategy No. 2

## Ways to Improve your Test Score

**1. Read Questions Carefully**

Scores on tests are greatly affected by reading ability. In answering a test item, you should begin by carefully reading the stem and then asking yourself the following questions:

- What is the question really asking?
- Are there any key words?
- What information relevant to answering this question is included in the stem?
- How would I ask this question in my own words?
- How would I answer this question in my own words?

After you have answered these questions, carefully read the options and then ask yourself the following questions:

- Is there an option that is similar to my answer?
- Is this option the best, most complete answer to the question?

Deal with the question as it is stated, without reading anything into it, or making assumptions about it. Answer the question asked, not the one you would like to answer. For simple recall items the self-questioning process usually will be completed quickly. For more complex items the self-questioning process may take longer, but it should assist you in clarifying the item and selecting the best response.

2. **Identify Key Words**

Certain key words in the stem, the options, or both should alert you to the need for caution in choosing your answer. Because few things are absolute without exception, avoid selecting answers that include words such as *always, never, all, every, only, must,* no*, except,* and *none.* Answers containing these key word are rarely correct because they place special limitations and qualifications on potentially correct answers.

*For example:*
All of the following are services of the National Kidney Foundation except:

- Public education programs
- Research about kidney disease
- Fund-raising affairs for research activities
- Identification of potential transplant recipients

This stem contains two key words: *all* and *except.* They limit the correct answer choice to the one option that does not represent a service of the National Kidney Foundation. When *except,* not, or a phrase such as *all* but one of the following appears in the stem, the inappropriate option is the correct answer—in this instance, option 4. If the options in an item do not seem to make sense because more than one option is correct, reread the question; you may have missed one of the key words in the stem. Also be on guard when you see one of the key words in an option; it may limit the context in which such an option would be correct.

3. **Pay Attention to Specific Details**

The well-written multiple-choice question is precisely stated, providing you with only the information needed to make the question or problem clear and specific. Careful reading of details in the stem can provide important clues to the correct option.

*For example:*
A male client is told that he will no longer be able to ingest alcohol if he wants to live. To effect a change in his behavior while he is in the hospital, the nurse should attempt to:

- Help the client set short-term dietary goals
- Discuss his hopes and dreams for the future
- Discuss the pathophysiology of the liver with him
- Withhold approval until he agrees to stop drinking

The specific clause *to effect a change in his behavior while he is in the hospital* is critical. Option 2 is not really related to his alcoholism. Option 3 may be part of educating the alcoholic, but you would not expect a behavioral change observable in the hospital to emerge from this discussion. Option 4 rejects the client as well as his behavior instead of only his behavior. Option 1, the correct answer, could result in an observable behavioral change while the client is hospitalized; for example, he could define ways to achieve short-term goals relating to diet and alcohol while in the hospital.

4. **Eliminate Clearly Wrong or Incorrect Answers**

Eliminate clearly incorrect, inappropriate, and unlikely answers to the question asked in the stem. By systematically eliminating distractors that are unlikely in the context of a given question, you increase the probability of selecting the correct answer. Eliminating obvious distractors also allows you more time to focus on the options that appear to be potentially sound answers to the question.

*For example:*
The four levels of cognitive ability are:

- Assessing, analyzing, applying, evaluating
- Knowledge, analysis, assessing, comprehension
- Knowledge, comprehension, application, analysis
- Medical-surgical nursing, obstetric nursing, psychiatric nursing

Option 1 contains both cognitive levels and nursing behaviors, thus eliminating it from consideration. Option 4 is clearly inappropriate since the choices are all clinical areas. Both options 2 and 3 contain levels of cognitive ability; however, option 2 includes assessing, which is a nursing behavior. Therefore option 3 is correct. By reducing the plausible options, you reduce the material to consider and increase the probability of selecting the correct option.

**5. Identify Similar Options**

When an item contains two or more options that are similar in meaning, the successful test taker knows that all are correct, in which case it is a poor question, or that none is correct, which is more likely to be the case. The correct option usually will either include all the similar options or exclude them entirely.

*For example:*
When teaching newly diagnosed diabetic clients about their condition, it is important for the nurse to focus on:

- Dietary modifications
- Use of sugar substitutes
- Their present understanding of diabetes
- Use of diabetic nutritional exchange lists

Options 1, 2, and 4 deal only with the diabetic diet, involving no other aspect of diabetic teaching; it is impossible to select the most correct option because each represents equally plausible, though limited, answers to the question. Option 3 is the best choice because it is most complete and allows the other three options to be excluded.

*As another example:*
A child's intelligence is influenced by:

- A variety of factors
- Socioeconomic factors
- Heredity and environment
- Environment and experience

The most correct answer is option 1. It includes the material covered by the other options, eliminating the need for an impossible choice, since each of the other options is only partially correct.

6. **Identify Answer (Option) Components**
When an answer contains two or more parts, you can reduce the number of potentially correct answers by identifying one part as incorrect.

*For example:*
After a cholecystectomy the postoperative diet is usually:

- High fat, low calorie
- High fat, low protein
- Low fat, high calorie
- Low fat, high protein

If you know, for instance, that the diet after a cholecystectomy is usually low or moderate in fat, you can eliminate options 1 and 2 from consideration. If you know that the cholecystectomy client usually is overweight, you can eliminate option 3 from consideration. Therefore option 4 is correct.

**7. Identify Specific Determiners**

When the options of a test item contain words that are identical or similar to words in the stem, the alert test taker recognizes the similarities as clues about the likely answer to the question. The stem word that clues you to a similar word in the option or that limits potential options is known as a specific determiner.

*For example:*
The government agency responsible for administering the nursing practice act in each state is the:

- Board of regents
- Board of nursing
- State nurses' association
- State hospital association

Options 2 and 3 contain the closely related words nurse and nursing. The word *nursing,* used both in the stem and in option 2, is a clue to the correct answer.

8. **Identify Words in the Options** *That Are Closely Associated With Words in the Stem*

Be alert to words in the options that may be closely associated with but not identical to a word or words in the stem.

*For example:*
When a person develops symptoms of physical illness for which psychogenic factors act as causative agents, the resulting illness is classified as:

- Dissociative
- Compensatory
- Psychophysiologic
- Reaction formation

Option 3 should strike you as a likely answer since it combines physical and psychologic factors, like those referred to in the stem.

9. **Watch for Grammatical Inconsistencies**

If one or more of the options are not grammatically consistent with the stem, the alert test taker usually can eliminate these distractors. The correct option must be consistent with the form of the question. If the question demands a response in the singular, plural options usually can be safely eliminated. When the stem is in the form of an incomplete sentence, each option should complete the sentence in a grammatically correct way.

*For example:*
Communicating with a male client who is deaf will be facilitated by:

- Use gestures
- Speaking loudly
- Find out if he has a hearing aid
- Facing the client while speaking

Options 1 and 3 do not complete the sentence in a grammatically correct way and can therefore be eliminated. Option 2 would be of no assistance with a deaf client, so option 4 is the correct answer.

10. **Be Alert to Relevant Information *From Earlier Questions***

Occasionally, remembering information from one question may provide you with a clue for answering a later question.

*For example:*
A client has an intestinal tube inserted for treatment of intestinal obstruction. Intestinal suction can result in excessive loss of:

- Protein enzymes
- Energy carbohydrates
- Water and electrolytes
- Vitamins and minerals

If you determined that the correct answer to this question was option 3, it may help you to answer a later question.

*For example:*
Critical assessment of a client with intestinal suction should include observation for:

- Edema
- Nausea
- Belching
- Dehydration

The correct answer is option 4. If you knew that excessive loss of water and electrolytes may lead to dehydration, you could have used the clue provided in the earlier question to assist you in answering the later question.

11. **Make Educated Guesses**

When you are unsure about the correct answer to a question, it is better to make an educated guess than not to answer the question. You generally can eliminate one or more of the distractors by using partial knowledge and the methods just listed. The elimination process increases your chances of selecting the correct option from those remaining. Elimination of two distractors on a four-option multiple-choice item increases your probability of selecting the correct answer from 25% to 50%.

# Strategy No. 3

**Multiple Choice Test Taking Tips**

1. Read the question before you look at the answer.
2. Come up with the answer in your head before looking at the possible answers, this way the choices given on the test won't throw you off or trick you.
3. Eliminate answers you know aren't right.
4. Read all the choices before choosing your answer.
5. If there is no guessing penalty, always take an educated guess and select an answer.
6. Don't keep on changing your answer, usually your first choice is the right one, unless you miss-read the question.
7. In "ALL OF THE ABOVE" and "NONE OF THE ABOVE" choice, if you see that at least two correct statements are false don't choose "ALL OF THE ABOVE".
8. In a question with an "ALL OF THE ABOVE" choice, if you see that at least two correct statements, then "ALL OF THE ABOVE" is probably the correct answer.
9. A positive choice is more likely true than a negative one.
10. Usually the correct answer is the choice with the most information.

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