Nursing - база тестів 2016 року

Категорія: **Бази тестів українською мовою 2016 року**

Кількість запитань: **629**

1. The client who has sickle cell trait has a sister with sickle cell disease and a husband with neither the disease nor the trait. She asks her nurse what her children’s chances are of having sickle cell disease. What is the nurse’s best response?

*** A) “Because you have the trait and your husband does not, none of your children will have the disease, but each child will have a 50\% risk for having the trait.”**

B) “Because your sister actually has sickle cell disease, the risk for your children having sickle cell disease is 50\% with each pregnancy.”

C) “Because you are a woman, your daughters will each have a 50\% risk for having the disease and all of your sons will be carriers of the trait.”

D) “Because you have the trait and your husband does not, only your daughters can have sickle cell disease.”

2. The client in sickle cell crisis has effective pain management. What is now the priority nursing diagnosis?

*** A) Risk for Injury related to decreased tissue oxygenation**

B) Deficient Knowledge related to contraception and pregnancy options

C) Deficient Knowledge related to prevention of crisis episodes

D) Risk for Infection related to decreased spleen function

3. The client has anemia and all the following clinical manifestations. Which manifestation indicates to the nurse that the anemia is a long-standing problem?

*** A) Clubbed fingers**

B) Headache

C) Circumoral pallor

D) Orthostatic hypotension

4. A nurse administered 8 mg of morphine intravenously 20 minutes ago to the client in sickle cell crisis. Which condition indicates that pain relief has been achieved?

*** A) The client tells the nurse the pain is better.**

B) The client is sleeping.

C) The client's skin is warm and dry.

D) The client's blood pressure is 120/80.

5. Which problem or condition is most likely to stimulate a crisis in a person who has sickle cell trait?

*** A) Having surgery under general anesthesia for colon cancer**

B) Becoming pregnant

C) Shoveling snow when the temperature is at 0 degrees

D) Having a cast placed on the wrist after sustaining a simple fracture

6. Which assessment finding alerts the home care nurse to the possibility of infection in the client with sickle cell disease who is recovering from a crisis episode?

*** A) Diminished breath sounds unilaterally**

B) Firm, nodular texture to the liver on palpation

C) Darkened areas of skin on the lower extremities

D) Oral temperature of 37.8o C (100o F)

7. Which intervention for the client with sickle cell disease prevents vascular occlusion?

*** A) Maintaining an oral fluid intake of at least 4500 mL/day**

B) Assessing pulse oximetry every 2 hours

C) Administering morphine sulfate every 6 hours

D) Keeping the room temperature at or below 68o F.

8. How does the drug hydroxyurea benefit the client with sickle cell disease?

*** A) Prevents crises by stimulating the RBCs to synthesize more hemoglobin F**

B) Prevents crises by decreasing blood viscosity and reducing vessel obstruction

C) Prevents anemia by stabilizing RBC plasma membranes

D) Prevents anemia by increasing cellular iron storage

9. Which person should the nurse be most alert for the development of glucose-6-phosphate dehydrogenase (G6PD) deficiency anemia?

*** A) 28-year-old man whose grandfather had the disorder**

B) 28-year-old woman whose grandfather had the disorder

C) 55-year-old man who had a myocardial infarction 5 years ago

D) 55-year-old woman who had a partial gastrectomy for stomach cancer last year

10. Which common agent(s) should the nurse teach the client with glucose-6-phosphate dehydrogenase deficiency anemia to avoid?

*** A) Aspirin**

B) Caffeine

C) Alcohol

D) Laxatives

11. Which menu selection made by the client with vitamin B12 deficiency anemia demonstrates adequate understanding of dietary management for this problem?

*** A) Fried liver and onions, orange juice, spinach salad**

B) Baked chicken breast, boiled carrots, glass of white wine

C) Eggplant Parmesan, cream-style cottage cheese, iced tea

D) Whole-grain pasta with cheese, apple sauce, glass of red wine

12. Which intervention should the nurse teach the client who has IgM-mediated immunohemolytic anemia?

*** A) Wear socks and gloves in cool weather.**

B) Use an electric shaver.

C) Avoid crowds and sick people.

D) Do not take aspirin or aspirin-containing products.

13. Which feature is characteristic of vitamin B12 deficiency anemia but not characteristic of folic acid deficiency anemia?

*** A) Paresthesias of the hands and feet**

B) Weight loss

C) Smooth, beefy-red tongue

D) Macrocytic red blood cells

14. The client is prescribed to receive iron dextran by the Z-track method of intramuscular injection. Which technique should the nurse use to adhere to the Z-track method?

*** A) Inject medication only into the dorsal gluteal site.**

B) Take care to ensure that no air is present in the syringe.

C) Select a 22-gauge, 1-inch needle to minimize tissue trauma.

D) Massage the site for a minimum of five minutes after the injection.

15. Which of the client's health problems alerts the nurse to the possibility of anemia related to dietary deficiency?

*** A) Ten years of chronic alcoholism**

B) Mild congestive heart failure

C) Poorly controlled diabetes mellitus

D) Ten years of antacid therapy for peptic ulcer disease

16. Which laboratory value indicates that the epoetin alfa (Procrit, Epogen) therapy is effective?

*** A) Red blood cell count has increased from 2.2 million to 3.0 million.**

B) Platelet count has decreased from 80,000 to 50,000.

C) Segmented neutrophils outnumber the band neutrophils.

D) Serum potassium level has increased from 3.5 to 4.5 mEq/L

17. What is the pathologic mechanism involved in aplastic anemia?

*** A) Decreased bone marrow production of red blood cells**

B) Decreased intake of iron

C) Increased rate of red blood cell lysis and destruction

D) Increased (excessive) cellular metabolic oxygen demand

18. What is the priority nursing diagnosis for the client with aplastic anemia who is being treated with a combination of prednisone and cyclophosphamide.

*** A) Risk for Infection**

B) Risk for Injury

C) Constipation

D) Risk for Activity Intolerance

19. Which teaching intervention should the nurse use for the client with polycythemia vera to prevent injury as a result of the increased bleeding tendency?

*** A) “Use a soft-bristled toothbrush.”**

B) “Drink at least 3 liters of liquids per day.”

C) “Wear gloves and socks outdoors in cool weather.”

D) “Exercise slowly and only on the advice of your physician.”

20. What is the priority nursing diagnosis for the client with polycythemia vera?

*** A) Risk for Injury related to thrombus formation**

B) Adult Failure to Thrive related to increased energy demands

C) Ineffective Thermoregulation related to excessive heat loss

D) Constipation related to dehydration

21. Which laboratory finding in a client with polycythemia vera indicates that phlebotomy alone is no longer effective in managing this problem?

*** A) Hematocrit has increased from 55\% to 75\%**

B) Hemoglobin A1c has decreased from 8.0\% to 7.0\%

C) Platelet count has increased from 120,000 to 150,000

D) Segmented neutrophils outnumber the band neutrophils.

22. Which serum electrolyte value in a client with polycythemia vera should the nurse report to the physician?

*** A) Potassium, 7.2 mEq/L**

B) Sodium, 132 mEq/L

C) Chloride, 98 mEq/L

D) Total calcium, 8.7 mg/dL

23. Which health problem is most likely to occur in people who have myelodysplastic syndrome?

*** A) Acute leukemia**

B) Polycythemia vera

C) Hodgkin’s lymphoma

D) Acute myocardial infarction

24. Which precaution has the highest priority for instruction of the client going home with thrombocytopenia?

A) “Drink at least 3 liters of fluid each day.”

B) “Avoid drinking alcoholic beverages until your CBC is normal.”

*** C) “Avoid flossing your teeth until platelets return to normal.”**

D) “Avoid the use of salt substitutes that contain potassium chloride.”

25. Why is the client with polycythemia vera at an increased risk for a myocardial infarction?

*** A) The increased number of erythrocytes increases blood viscosity and the workload of the heart.**

B) The rapid synthesis of cells greatly increases metabolism.

C) The abnormal hemoglobin in the erythrocytes inadequately oxygenates the myocardium.

D) The disease is most prevalent among men in their 60s and 70s who have other conditions that damage the heart.

26. Which clinical manifestation or assessment finding indicates effectiveness of the therapy for the client with polycythemia vera?

*** A) Blood pressure change from 180/150 to 160/90**

B) Hematocrit of 65\%

C) Bilateral darkening of the conjunctiva

D) Unplanned weight loss of 6 lb over a month’s time

27. Which precaution should the nurse teach the client who is prescribed to take thalidomide (Thalomid) as part of her treatment plan for multiple myeloma?

*** A) “Use multiple forms of birth control to prevent birth defects.”**

B) “Avoid high-fiber foods to prevent diarrhea.”

C) “Drink plenty of fluids to prevent the development of diabetes mellitus.”

D) “Avoid crowds and sick people to prevent contraction of contagious infections.”

28. Which question is appropriate when exploring the risk factors for the client newly diagnosed with acute leukemia?

*** A) “Have you ever worked around radioactive materials?”**

B) “How many packs of cigarettes do you smoke per day and for how many years have you smoked?”

C) “Have you ever been treated for a sexually transmitted disease?”

D) “How old was your mother when you were born?”

29. The client with leukemia asks his nurse why he is so susceptible to infection when his white blood cell count is so high. What is the nurse’s best response?

*** A) “Even though you have a lot of white blood cells, they are immature and not able to prevent or fight infection.”**

B) “The number of white blood cells is falsely high because of the severe dehydration that accompanies leukemia.”

C) “Your white blood cells have been poisoned by chemotherapy and are now nonfunctional.”

D) “It is the platelets, not the white blood cells, that protect you from infection.”

30. Which question or statement by the client about to undergo allogeneic bone marrow transplantation indicates a need for further discussion regarding the procedure?

*** A) “Which bone will the surgeon insert the marrow into?”**

B) “Until the marrow transplant takes, I should have few visitors.”

C) “How long will it be before we know if the transplant is successful?”

D) “After the bone marrow transplant grows in me, my blood type will be the same as the donor's.”

31. The client with lymphoma asks his nurse why his disease treatment regimen includes radiation and surgery as well as chemotherapy, when his 16-year-old female cousin only had chemotherapy for leukemia. What is the nurse's best response?

*** A) "Lymphomas can form discrete tumors that can be removed by surgery or treated locally with radiation, but leukemic cells are more widespread."**

B) "Radiation is not used as therapy in girls and women so as not to disrupt their childbearing ability."

C) "Your disease is probably more widespread and advanced than your cousin's was, requiring additional types of intensive therapy for cure."

D) "Lymphomas can be cured using multiple therapies and leukemia cannot be cured, only controlled with lifelong injections of chemotherapy."

32. Which client is at greatest risk for development of acute leukemia?

*** A) 50-year-old being treated with cyclophosphamide (Cytoxan) for a chronic autoimmune disease**

B) 55-year-old with diabetes mellitus type 1 who has received insulin injections for 43 years

C) 20-year-old with cystic fibrosis who has been on continuous enzyme replacement therapy since age 3 months

D) 38-year-old who has used combination oral contraceptives without a break for 15 years

33. For which client with leukemia should the nurse be prepared to teach about maintenance therapy?

*** A) The client with acute lymphocytic leukemia who is in remission**

B) The client with acute myelogenous leukemia who has relapsed

C) The client with acute myelogenous leukemia who is in remission

D) The client with acute lymphocytic leukemia who has relapsed

34. For which type of leukemia has imatinib mesylate (Gleevec) proven most effective?

*** A) Chronic myelogenous leukemia that is Philadelphia chromosome–positive**

B) Acute lymphocytic leukemia that has normal chromosomes

C) Acute myelogenous leukemia that has abnormal chromosomes

D) Chronic lymphocytic leukemia that is Philadelphia chromosome–negative

35. The client with lymphoma who is considering a stem cell transplant asks what is the difference between a stem cell transplant and a bone marrow transplant. What is the nurse's best response?

*** A) "A bone marrow transplant is one type of stem cell transplant. The only difference is the source of the stem cells."**

B) "Bone marrow transplantation requires more chemotherapy and radiation than does stem cell transplantation."

C) "A stem cell transplant is useful for solid tumor cancers, but a bone marrow transplant is needed for lymphoma."

D) "Cells for a stem cell transplant can come from a person other than a family member related by blood, but cells for a bone marrow transplant must come from a blood relative."

36. Which nursing diagnosis or collaborative problem has the highest priority for the bone marrow donor during the first 48 hours after the donation procedure?

*** A) Acute Pain**

B) Risk for Infection

C) Ineffective Coping

D) Potential for leukemia

37. What laboratory value indicates to the nurse that the conditioning regimen for bone marrow transplantation is successful?

*** A) Total white blood cell count of 0/mm3**

B) Hematocrit of 25\%

C) Hematocrit of 50\%

D) Total white blood cell count of 8000/mm3

38. Which clinical manifestation during the actual bone marrow transplantation alerts the nurse to the possibility of an adverse reaction?

*** A) Shortness of breath**

B) Fever

C) Red urine

D) Hypertension

39. At 6 weeks after bone marrow transplantation, a nurse observe that the client has rising white blood cell, erythrocyte, and platelet counts. What is the nurse’s interpretation of these findings?

*** A) The transplant has engrafted.**

B) The client has a systemic infection.

C) The leukemia is no longer in remission.

D) The client has graft-versus-host disease.

40. Approximately 6 weeks after the client has received an allogeneic bone marrow transplant, a nurse notes that the client has peeling skin on the hands, feet, and legs. What is the nurse’s best first action?

*** A) Notify the physician.**

B) Request a humidifier to increase the moisture of the room.

C) Apply lanolin-based creams to the client's skin.

D) Document the observation as the only action.

41. The client is being discharged after a percutaneous transluminal coronary angioplasty (PTCA) and is prescribed to take a calcium channel blocking agent. Which precaution should the nurse stress when teaching that is specific for this drug therapy?

*** A) “Change positions slowly.”**

B) “Avoid crossing your legs.”

C) “Weigh yourself daily.”

D) “Decrease salt intake.”

42. The post–percutaneous transluminal coronary angioplasty client complains of severe chest pain. What is the nurse’s best action?

*** A) Notify the physician.**

B) Administer IV morphine as ordered PRN.

C) Administer sublingual nitroglycerin.

D) Perform a standard 12-lead ECG.

43. Which of the following statements made by the client prescribed to take sublingual nitroglycerin for chest pain indicates a need for further discussion regarding this therapy?

*** A) “I keep my medicine in a clear plastic bag in my purse so that I can get to it easily if I have chest pain.”**

B) “Even if I have not used any of the nitroglycerin from one refill, I get another refill every 3 months.”

C) “If I still have chest pain after I have taken three nitroglycerin tablets, I will go to the hospital.”

D) “When my nitroglycerin tablet tingles under my tongue, I know that it is strong enough to work.”

44. A nurse is caring for a client who had PTCA 1 hour ago. Which complication of this procedure should the nurse remain alert for at this time?

*** A) Bleeding**

B) Hypertensive crisis

C) Hyperkalemia

D) Infection

45. The client who has just undergone a PTCA has been ordered to receive an IV infusion of abciximab (ReoPro). Which clinical manifestation should alert the nurse to the possibility of an adverse reaction to this medication?

*** A) Urticaria**

B) Joint pain

C) Pedal edema

D) Excessive thirst

46. The client who has undergone coronary artery bypass surgery graft (CABG) has a serum potassium level of 4.5 mEq/L. What would be the nurse’s best action?

*** A) Document the finding as the only action.**

B) Notify the physician.

C) Decrease the IV solution flow rate.

D) Administer potassium replacement as ordered.

47. A nurse notes the mediastinal tubes of a client who is 6 hours postoperative from CABG surgery have stopped draining. What action would be most appropriate for the nurse to take at this time?

*** A) Notify the physician.**

B) Replace the tubing.

C) Form a dependent loop in the tubing.

D) Document the finding as the only action.

48. Which specific assessment would be most important to include for a 78-year-old client who has had CABG surgery?

*** A) Mental status assessment**

B) Skin assessment

C) Otoscopic assessment

D) Gastrointestinal assessment

49. Which client would most likely benefit from a transmyocardial laser revascularization?

*** A) A client with unstable angina and inoperable CAD**

B) A client with a lesion of the left anterior descending artery

C) A client with a discrete, proximal, single-vessel, noncalcified lesion

D) A client who requires bypass with synthetic grafts

50. Which instruction should be included in the teaching plan for a client being discharged after coronary artery bypass graft surgery?

*** A) “Take your pulse before, midway through, and after exercising.”**

B) “Drink at least 3 L of fluid daily.”

C) “You should abstain from sexual activity for 6 months.”

D) “You should discontinue your antihyperlipidemic medication at this time.”

51. Which action can the nurse take to improve the quality of the electrocardiographic rhythm transmission to the monitoring system?

*** A) Remove the hair from the chest area before attaching the chest leads.**

B) Apply lotion to the client’s chest before attaching the chest leads.

C) Instruct the client not to wear any clothing made from synthetic fabrics during the test.

D) Place the first negative electrode in the left midclavicular position and place a second negative electrode in the V1 position.

52. Which property of cardiac cells is the ability to generate electrical impulses spontaneously?

*** A) Automaticity**

B) Excitability

C) Conductivity

D) Contractility

53. What should the nurse do to ensure the validity of comparison of electrocardiograms (ECGs) taken at different times?

*** A) Ensure that electrode placement is identical for each ECG.**

B) Remove electrodes after each ECG is completed.

C) Place new ECG chest leads on the client before each ECG is completed.

D) Position the client supine prior to each ECG.

54. What does the P wave on an ECG tracing represent?

*** A) Depolarization of the atria**

B) Contraction of the atria

C) Contraction of the ventricles

D) Depolarization of the ventricles

55. A nurse notes that the PR interval on a client’s ECG tracing is 0.14 seconds. What action should the nurse take?

*** A) Document the finding as the only action.**

B) Call the health care provider immediately.

C) Administer epinephrine immediately.

D) Apply oxygen via nasal cannula.

56. The client has exactly 8.0 R-R intervals in 150 small blocks on the ECG paper. Based on this information, the nurse calculates the client's ventricular heart rate to be which of the following?

*** A) 80 beats/min**

B) 160 beats/min

C) The heart rate cannot be calculated from the information provided.

D) 40 beats/min

57. In analyzing a client's ECG tracing, the nurse observes that not all QRS complexes are preceded by a P wave. What is the nurse's interpretation of this observation?

*** A) Ventricular depolarization is being initiated at a site different from atrial depolarization.**

B) The client has hyperkalemia.

C) The client is in ventricular tachycardia.

D) One of the chest leads is not making sufficient contact with the skin.

58. The nurse observes a prominent U wave present on a client's ECG tracing. What is the nurse's interpretation of this finding?

*** A) The client may have a potassium imbalance**

B) This is a normal finding.

C) The client is at risk for R-on-T phenomenon.

D) The client has an evolving myocardial infarction.

59. The client's heart rate increases slightly during inspiration and decreases slightly during expiration. What action should the nurse take?

*** A) Document the finding as the only action.**

B) Notify the physician

C) Assess the client for chest pain.

D) Prepare to administer antidysrhythmic drugs

60. The client with tachycardia is experiencing all of the following clinical manifestations. Which one alerts the nurse to the need for immediate intervention?

*** A) Chest pain**

B) Increased urine output

C) Mild orthostatic hypotension

D) ECG tracing with P wave touching the T wave

61. The client is experiencing sinus bradycardia with hypotension and dizziness. Which of the following drugs/agents should the nurse be prepared to administer?

*** A) Atropine**

B) Digoxin

C) Lidocaine

D) Metoprolol

62. The client with arthritis and all the following allergies is prescribed to take celecoxib (Celebrex) daily. Which allergy is most important for the nurse to report to the physician?

*** A) Sulfa drugs**

B) Shellfish

C) Peanut

D) Latex

63. During auscultation of the heart of a client with left ventricular failure, the nurse notes the presence of a third heart sound (S3) gallop. What can the nurse infer from this finding?

*** A) Left ventricular pressure is increased.**

B) There is a decrease in ventricular compliance.

C) The client has been noncompliant with the medication regimen.

D) The client should be prepared for transfer to the intensive care unit.

64. A nurse is performing auscultation of the posterior lungs of a client admitted with heart failure. There are increasing crackles from the bases to the lower third of both lungs. What would be the nurse's best action?

*** A) Notify the health care provider.**

B) Place the client in a semirecumbent position.

C) Increase the intravenous fluid rate.

D) Administer chest physiotherapy.

65. Which nursing diagnosis would be considered a priority for the client with heart failure?

*** A) Impaired Gas Exchange**

B) Altered Comfort

C) Anxiety related to hospitalization

D) Altered Health Maintenance

66. The client with heart failure is being treated with digoxin and has developed hypokalemia. What action should the nurse prepare to take?

*** A) Monitor the client for toxic effects that can occur at normal doses.**

B) Administer digoxin twice daily.

C) Reduce the digoxin dose to every other day.

D) Administer an intravenous bolus of potassium.

67. When completing the assessment for the client in the day surgery unit, the client states,"I am really afraid of having this surgery. I'm afraid of what they will find." Which statement would be the best therapeutic response by the nurse?

*** A) "Tell me about your fears of having this surgery."**

B) "Don't worry about your surgery. It is safe."

C) "Tell me why you're worried about your surgery."

D) "I understand how you feel. Surgery is frightening."

68. The client is scheduled for total hip replacement. Which behavior indicates to the nurse the need for further preoperative teaching?

*** A) The client gets out of bed by lifting straight upright from the waist and then swings both legs along the side of the bed.**

B) The client uses the diaphragm and abdominal muscles to inhale through the nose and exhale through the mouth.

C) The client takes three slow, deep, breaths and coughs forcefully after inhaling for the third time.

D) The client uses the incentive spirometer and inhales slowly and deeply so that the piston rises to the preset volume..

69. Which activities are the circulating nurse’s responsibilities in the operating room?

*** A) Monitor the position of the client, prepare the surgical site, and ensure the client’s safety.**

B) Give preoperative medication in the holding area and monitor the client’s response to anesthesia.

C) Prepare sutures; set up the sterile field; and count all needles, sponges, and instruments.

D) Prepare the medications to be administered by the anesthesiologist and change the tubing for the anesthesia machine.

70. While the circulating nurse compares the final sponge count with that of the scrub nurse, a discrepancy in the count is found. Which action should the circulating nurse take first?

*** A) Re-count all sponges.**

B) Notify the client’s surgeon.

C) Complete an Occurrence Report.

D) Contact the surgical manager..

71. Which violation of surgical asepsis would require immediate intervention by the circulating nurse?

*** A) The scrub nurse setting up the sterile field is wearing artificial nails.**

B) Surgical supplies were cleaned and sterilized prior to the case.

C) The circulating nurse is wearing a long-sleeved sterile gown.

D) Masks covering the mouth and nose are being worn by the surgical team.

72. The nurse identifies the nursing diagnosis “risk for injury related to positioning” for the client in the operating room. Which nursing action should the nurse implement?

*** A) Carefully pad the client’s elbows before covering the client with a blanket.**

B) Avoid using the cautery unit that does not have a biomedical tag on it.

C) Apply a warming pad on the OR table before placing the client on the table.

D) Check the chart for any prescription or over-the-counter medication use.

73. The unlicensed nursing assistant reports the vital signs for a first-day postoperative client of T 100.8_F, P 80, R 24, and B/P 148/80. Which intervention would be most appropriate for the nurse to implement?

*** A) Help the client turn, cough, and deep breathe every two (2) hours.**

B) Administer the antibiotic earlier than scheduled.

C) Change the dressing over the wound.

D) Encourage the client to ambulate in the hall.

74. The client is complaining of left shoulder pain. Which response would be best for the nurse to assess the pain?

*** A) Request that the client describe the pain.**

B) Inquire if the pain is intense, throbbing, or stabbing.

C) Ask if the client wants pain medication.

D) Instruct the client to complete the pain questionnaire.

75. When preparing the plan of care for the client in acute pain as a result of surgery, the nurse should include which intervention?

*** A) Administer pain medication as soon as the time frame allows.**

B) Use nonpharmacological methods to replace medications.

C) Use cryotherapy after heat therapy because it works faster.

D) Instruct family members to administer medication with the PCA.

76. Which situation is an example of the nurse fulfilling the role of client advocate?

*** A) The nurse contacts the health-care provider when pain relief is not obtained.**

B) The nurse brings the client pain medication when it is due.

C) The nurse collaborates with other disciplines during the care conference.

D) The nurse teaches the client to ask for medication before the pain gets to a “5.”

77. Which statement would be an expected outcome for a client experiencing acute pain?

*** A) The client will participate in self-care activities.**

B) The client will have decreased use of medication.

C) The client will use relaxation techniques.

D) The client will repeat instructions about medications.

78. Which intervention has the highest priority when administering pain medication to a client experiencing acute pain?

*** A) Discuss the pain with the client.**

B) Monitor the client’s vital signs.

C) Verify the time of the last dose.

D) Check for the client’s allergies.

79. Which intervention should the nurse delegate to the unlicensed nursing assistant when caring for the client experiencing acute pain?

*** A) Apply an ice pack to the site of pain.**

B) Take the pain medication to the room.

C) Check on the client 30 minutes after he or she takes the pain medication.

D) Observe the patient's ability to use the PCA.

80. Which intervention would be the best way for the nurse to assess a four (4)-year-old client for acute pain?

*** A) Have the child point to the face that describes the pain.**

B) Use words that a four (4)-year-old child can remember.

C) Explain the 0–10 pain scale to the child's parent.

D) Administer the medication every four (4) hours.

81. While conducting an interview with a 75-year-old client admitted with acute pain, which question would have priority when assisting with pain management?

*** A) "Have you ever had difficulty getting your pain controlled?"**

B) "What types of surgery have you had in the last 10 years?"

C) "Have you ever been addicted to narcotics?"

D) "Do you have a list of your prescription medications?"

82. At the end of the shift, the nurse clears the PCA and discovers that the client has used only a small amount of medication. Which intervention should the nurse implement?

*** A) Determine why the client is not using the PCA.**

B) Document the amount and take no action.

C) Chart that the client is not having pain.

D) Contact the HCP and request oral medication.

83. Which client problem would be most appropriate for the client experiencing acute physical pain?

*** A) Alteration in comfort.**

B) Ineffective coping.

C) Potential for injury.

D) Altered sensory input.

84. The staff on an oncology unit is interviewing applicants for a position as the unit manager. Which type of organizational structure does this represent?

*** A) Shared governance.**

B) Centralized decision-making.

C) Decentralized decision-making.

D) Pyramid with filtered-down decisions.

85. The nurse working in an outpatient clinic is interviewing clients. Which information provided by the client warrants further investigation?

*** A) The client has been coughing up blood in the mornings.**

B) The client uses Vicks VapoRub every night before bed.

C) The client has had an appendectomy.

D) The client takes a multiple vitamin pill every day.

86. Which assessment data support the client’s diagnosis of gastric ulcer?

*** A) Comparison of complaints of pain with ingestion of food and sleep.**

B) Presence of blood in the client’s stool for the past month.

C) Complaints of a burning sensation that moves like a wave.

D) Sharp pain in the upper abdomen after eating a heavy meal.

87. The client has been seen by the health-care provider and the suspected diagnosis is peptic ulcer disease. Which diagnostic test would confirm this diagnosis?

*** A) Esophagogastroduodenoscopy (EGD).**

B) Magnetic resonance imaging (MRI).

C) Occult blood test.

D) Gastric acid stimulation.

88. When the nurse is conducting the initial interview, which specific data should the nurse obtain from the client who is suspected of having peptic ulcer disease?

*** A) Use of nonsteroidal anti-inflammatory drugs (NSAIDs).**

B) History of side effects experienced from all medication.

C) Any known allergies to drugs and environmental factors.

D) Medical histories of at least three (3) generations.

89. When assessing the client with the diagnosis of peptic ulcer disease, which physical examination should the nurse implement first?

*** A) Auscultate the client’s bowel sounds in all four quadrants.**

B) Palpate the abdominal area for tenderness.

C) Percuss the abdominal borders to identify organs.

D) Assess the tender area progressing to nontender.

90. The client diagnosed with peptic ulcer disease is admitted into the hospital. Which nursing diagnosis should the nurse include in the plan of care to observe for physiological complications?

*** A) Potential for alteration in gastric emptying.**

B) Alteration in bowel elimination patterns.

C) Knowledge deficit in the causes of ulcers.

D) Inability to cope with changing family roles.

91. When planning the care for a client diagnosed with peptic ulcer disease, which expected outcome should the nurse include?

*** A) The client maintains lifestyle modifications.**

B) The client's pain is controlled with the use of NSAIDs.

C) The client has no signs and symptoms of hemoptysis.

D) The client takes antacids with each meal.

92. Which medication should the nurse question before administering to the client with peptic ulcer disease?

*** A) E-mycin, an antibiotic.**

B) Prilosec, a proton pump inhibitor.

C) Flagyl, an antimicrobial agent.

D) Tylenol, a nonnarcotic analgesic.

93. The nurse has administered an antibiotic, a proton pump inhibitor, and Pepto-Bismol for peptic ulcer disease secondary to H. pylori. Which data would indicate to the nurse that the medications are effective?

*** A) A decrease in gastric distress.**

B) A decrease in alcohol intake.

C) Maintaining a bland diet.

D) A return to previous activities.

94. The client is admitted to the medical department with a diagnosis of R/O acute pancreatitis. Which laboratory value should the nurse monitor to confirm this diagnosis?

*** A) Serum amylase and lipase.**

B) Creatinine and BUN.

C) Troponin and CPK-MB.

D) Serum bilirubin and calcium.

95. Which client problem has priority for the client diagnosed with acute pancreatitis?

*** A) Alteration in comfort.**

B) Risk for fluid volume deficit.

C) Imbalanced nutrition: less than body requirements.

D) Knowledge deficit.

96. The nurse is preparing to administer A.M. medications to the following clients. Which medication should the nurse question before administering?

*** A) Pancreatic enzymes to the client who has finished breakfast.**

B) The pain medication, morphine, to the client who has a respiratory rate of 20.

C) The loop diuretic to the client who has a serum potassium level of 3.9 mEq/L.

D) The beta blocker to the client who has an apical pulse of 68 bpm.

97. The client is diagnosed with acute pancreatitis. Which health-care provider's admitting order should the nurse question?

*** A) Low-fat, low-carbohydrate diet.**

B) Bed rest with bathroom privileges.

C) Initiate IV therapy at D5W 125 mL/hr.

D) Weigh client daily.

98. The nurse is completing discharge teaching to the client diagnosed with acute pancreatitis. Which instruction should the nurse discuss with the client?

*** A) Discuss the importance of stopping smoking.**

B) Instruct the client to decrease alcohol intake.

C) Explain the need to avoid all stress.

D) Teach the correct way to take pancreatic enzymes.

99. The male client diagnosed with chronic pancreatitis calls and reports to the clinic nurse that he has been having a lot of “gas,” along with frothy and very foul-smelling stools. Which action should the nurse take?

*** A) Arrange an appointment with the HCP for today.**

B) Explain that this is common for chronic pancreatitis.

C) Ask the client to bring in a stool specimen to the clinic.

D) Discuss the need to decrease fat in the diet so that this won’t happen.

100. The nurse is discussing complications of chronic pancreatitis with a client diagnosed with the disease. Which complication should the nurse discuss with the client?

*** A) Narcotic addiction.**

B) Diabetes insipidus.

C) Crohn’s disease.

D) Peritonitis.

101. The client has just had an endoscopic retrograde cholangiopancreatogram (ERCP). Which post-procedure intervention should the nurse implement?

*** A) Assess gag reflex.**

B) Assess for rectal bleeding.

C) Increase fluid intake.

D) Keep in supine position.

102. The client diagnosed with acute pancreatitis is in pain. Which position should the nurse assist the client to assume to help decrease the pain?

*** A) Place in side-lying position with knees flexed.**

B) Recommend lying in the prone position with legs extended.

C) Maintain a tripod position over the bedside table.

D) Encourage a supine position with a pillow under the knee

103. The nurse is administering a pancreatic enzyme to the client diagnosed with chronic pancreatitis. Which statement best explains the rationale for administering this medication?

*** A) It is an exogenous source of protease, amylase, and lipase.**

B) This enzyme increases the number of bowel movements.

C) This medication breaks down in the stomach to help with digestion.

D) Pancreatic enzymes help break down fat in the small intestine.

104. The client diagnosed with acute pancreatitis is being discharged home. Which statement by the client indicates the teaching has been effective?

*** A) “I will eat a low-fat diet and avoid spicy foods.”**

B) “I should decrease my intake of coffee, tea, and cola.”

C) “I will check my amylase and lipase levels daily.”

D) “I will return to work tomorrow but take it easy.”

105. The nurse and an unlicensed nursing assistant are caring for clients on an oncology floor. Which intervention should the nurse delegate to the assistant?

*** A) Assist the client with abdominal pain to turn to the side and flex the knees.**

B) Monitor the Jackson Pratt drainage tube to make sure it is draining properly.

C) Check to see if the client is sleeping after pain medication is given.

D) Empty the bedside commode of the client who has been having melena.

106. The client diagnosed with cancer of the pancreas is being discharged to start chemotherapy in the HCP’s office. Which statement made by the client indicates the client understands the discharge instructions?

*** A) “I should write down all my questions so I can ask them when I see the HCP.”**

B) “I will have to see the HCP every day for six (6) weeks for my treatments.”

C) “I am sure that this is not going to be a serious problem for me to deal with.”

D) “The nurse will give me an injection in my leg and I will get to go home.”

107. The client is being admitted to the outpatient department prior to an endoscopic retrograde cholangiopancreatogram (ERCP) to rule out cancer of the pancreas. Which pre-procedure instruction should the nurse teach?

*** A) Do not eat or drink anything after midnight the night before the test.**

B) Prepare to be admitted to the hospital after the procedure for observation.

C) If something happens during the procedure, then emergency surgery will be done.

D) If done correctly, this procedure will correct the blockage of the stomach.

108. The client is diagnosed with cancer of the head of the pancreas. When assessing the patient, which signs and symptoms would the nurse expect to find?

*** A) Clay-colored stools and dark urine.**

B) Night sweats and fever.

C) Left lower abdominal cramps and tenesmus.

D) Nausea and coffee-ground emesis.

109. The client diagnosed with cancer of the head of the pancreas is two (2) days postpancreatoduodenectomy (Whipple's procedure). Which nursing problem has the highest priority?

*** A) Fluid volume imbalance.**

B) Anticipatory grieving.

C) Acute incisional pain.

D) Altered nutrition.

110. The client admitted to rule out pancreatic islet tumors complains of feeling weak, shaky, and sweaty. Which should be the first intervention implemented by the nurse?

*** A) Perform a bedside glucose check.**

B) Start an IV with D5W.

C) Notify the health-care provider.

D) Give the client some orange juice.

111. The home health nurse is admitting a client diagnosed with cancer of the pancreas. Which information is the most important for the nurse to discuss with the client?

*** A) Ask the client if there is an advance directive.**

B) Determine the client's food preferences.

C) Find out about insurance/Medicare reimbursement.

D) Explain that the client should eat as much as possible.

112. The nurse caring for a client diagnosed with cancer of the pancreas writes the nursing diagnosis of "risk for altered skin integrity related to pruritus." Which interventions should the nurse implement?

*** A) Have the client keep the fingernails short.**

B) Assess tissue turgor.

C) Apply antifungal creams.

D) Monitor bony prominences for breakdown.

113. The nurse in a long-term care facility is teaching a group of new unlicensed assistive personnel. Which information regarding skin care should the nurse emphasize?

*** A) Turn clients who are immobile at least every two (2) hours.**

B) Keep the skin moist by leaving the skin damp after the bath.

C) Do not rub any lotion into the skin.

D) Only the licensed nursing staff may care for the client's skin.

114. The nurse is caring for clients in a long-term care facility. Which is a modifiable risk factor for the development of pressure ulcers?

*** A) Constant perineal moisture.**

B) Ability of the clients to reposition themselves.

C) Decreased elasticity of the skin.

D) Impaired cardiovascular perfusion of the periphery.

115. The nurse and unlicensed assistive personnel on a medical floor are caring for clients who are elderly and immobile. Which action by the assistant warrants immediate intervention by the nurse?

*** A) The assistant asks to take a meal break before turning the clients at the two (2)-hour time limit.**

B) The assistant elevates the head of the bed of a client that can feed himself with minimal assistance.

C) The assistant restocks the rooms that need unsterile gloves before clocking out for the shift.

D) The assistant mixes Thick-It® into the glass of water for a client who has difficulty swallowing.

116. The nurse is developing a plan of care for a client diagnosed with left-sided paralysis secondary to a right-sided cerebrovascular accident (stroke). Which should be included in the interventions?

*** A) Use a pillow to keep the heels off the bed when supine.**

B) Order a low air loss therapy bed immediately.

C) Prepare to insert a nasogastric feeding tube.

D) Order an occupational therapy consult for strength training.

117. The client who is debilitated and has developed multiple pressure ulcers complains to the nurse during a dressing change that he is “tired of it all.” Which is the nurse’s best therapeutic response?

*** A) “Are you tired of the treatments and needing to be cared for?”**

B) “These wound can heal if we get enough protein into you.”

C) “Why would you say that? We are doing our best.”

D) “Have you made out an advance directive to let the HCP know your wishes?”

118. The client diagnosed with stage IV infected pressure ulcers on the coccyx is scheduled for a fecal diversion operation. The nurse knows that client teaching has been effective when the client makes which statement?

*** A) “Stool will come out an opening in my abdomen so it won’t get in the sore.”**

B) “This surgery will create a skin flap to cover my wounds.”

C) “This surgery will get all the old black tissue out of the wound so it can heal.”

D) “The surgery is important to allow oxygen to get to the tissue for healing to occur.”

119. The school nurse is preparing to teach a health promotion class to high school seniors. Which information regarding self-care should be included in the teaching?

*** A) Perform a thorough skin check monthly.**

B) Wear a sunscreen with a protection factor of ten (10) or less when in the sun.

C) Try to stay out of the sun between 0300 and 0500 daily.

D) Remember that caps and long sleeves do not help prevent skin cancer.

120. Which client is at the greatest risk for the development of skin cancer?

*** A) The client with fair complexion who cannot get a tan.**

B) The African American male who lives in the northeast.

C) The elderly Hispanic female who moved from Mexico as a child.

D) The client who has a family history of basal cell carcinoma.

121. The client is prescribed phenytoin (Dilantin), an anticonvulsant, for a seizure disorder. Which statement indicates the client understands the discharge teaching concerning this medication?

*** A) “I will brush my teeth after every meal.”**

B) “I will check my Dilantin level daily.”

C) “My urine will turn orange while on Dilantin.”

D) “I won’t have any seizures while on this medication.”

122. Which statement by the female client indicates that the client understands factors that may precipitate seizure activity?

*** A) “I am going to take a class in stress management.”**

B) “It is all right for me to drink coffee for breakfast.”

C) “My menstrual cycle will not affect my seizure disorder.”

D) “I should wear dark glasses when I am out in the sun.”

123. The nurse asks the male client with epilepsy if he has auras with his seizures. The client says, “I don’t know what you mean. What are auras?” Which statement by the nurse would be the best response?

*** A) “Some people have a warning that the seizure is about to start.”**

B) “Auras occur when you are physically and psychologically exhausted.”

C) “You’re concerned that you do not have auras before your seizures?”

D) “Auras usually cause you to be sleepy after you have a seizure.”

124. The nurse educator is presenting an in-service on seizures. Which disease process is the leading cause of seizures in the elderly?

*** A) Cerebral vascular accident (stroke).**

B) Alzheimer’s disease.

C) Parkinson’s disease.

D) Brain atrophy due to aging.

125. The nurse instructs the client with a right BKA to lie on the stomach for at least 30 minutes a day. The client asks the nurse, “Why do I need to lie on my stomach?” Which statement would be the most appropriate statement by the nurse?

*** A) “Lying on your stomach will help prevent contractures.”**

B) “This position will help your lungs expand better.”

C) “Many times this will help decrease pain in the limb.”

D) “The position will take pressure off your backside.”

126. The recovery room nurse is caring for a client that has just had a left BKA. Which intervention should the nurse implement?

*** A) Keep a large tourniquet at the client's bedside**

B) Assess the client's surgical dressing every two (2) hours.

C) Do not allow the client to see the residual limb.

D) Perform passive range-of-motion exercises to the right leg.

127. The 62-year-old client diagnosed with Type 2 diabetes who has a gangrenous right toe is being admitted for a BKA amputation. Which nursing intervention should the nurse implement?

*** A) Assess the client's nutritional status.**

B) Refer the client to an occupational therapist.

C) Determine if the client is allergic to IVP dye.

D) Start a 22-gauge Angiocath in the right arm.

128. The Jewish client with peripheral vascular disease is scheduled for a left AKA. Which question would be most important for the operating room nurse to ask the client?

*** A) "Have you made any special arrangements for your amputated limb?"**

B) "What types of food would you like to eat while you're in the hospital?"

C) "Would like the rabbi to visit you while you are in the recovery room?"

D) "Will you start checking your other foot at least once a day for cuts?"

129. The client is three (3) hours postoperative left AKA. The client tells the nurse, "My left foot is killing me. Please do something." Which intervention should the nurse implement?

*** A) Medicate the client with a narcotic analgesic immediately.**

B) Explain to the client that his left leg has been amputated.

C) Instruct the client on how to perform biofeedback exercises.

D) Place the client's residual limb in the dependent position.

130. The nurse is caring for clients on a surgical unit. Which nursing task would be most appropriate for the nurse to delegate to an unlicensed nursing assistant?

*** A) Ask the assistant to take the client to the physical therapy department.**

B) Help the client with a 2-day postop amputation put on the prosthesis

C) Request the assistant double-check a unit of blood that is being hung.

D) Change the surgical dressing on the client with a Syme amputation.

131. The client with a right AKA is being taught how to toughen the residual limb. Which intervention should the nurse implement?

*** A) Instruct the client to push the residual limb against a pillow.**

B) Demonstrate how to apply an elastic bandage around the residual limb.

C) Encourage the client to apply vitamin B12 to the surgical incision.

D) Teach the client to elevate the residual limb at least three times a day.

132. The 27-year-old client has a right above-the-elbow amputation secondary to a boating accident. Which statement by the rehabilitation nurse indicates the client has accepted the amputation?

*** A) “The therapist is going to help me get retrained for another job.”**

B) “I am going to sue the guy that hit my boat.”

C) “I decided not to get a prosthesis. I don’t think I need it.”

D) “My wife is so worried about me and I wish she wouldn’t.”

133. The nurse is preparing the preoperative client for a total hip replacement (THR). Which information should the nurse include concerning postoperative care?

*** A) Sit in a high-seated chair for a flexion of less than 90 degrees.**

B) Keep abduction pillow in place between legs at all times.

C) Cough and deep breathe at least every four (4) to five (5) hours.

D) Turn to both sides every two (2) hours to prevent pressure ulcers.

134. The nurse is preparing the client who received a total hip replacement for discharge. Which statement would indicate that further teaching is needed?

*** A) “After three (3) weeks, I don’t have to worry about infection.”**

B) “I should not cross my legs because my hip may come out of the socket.”

C) “I will call my HCP if I have a sudden increase in pain.”

D) “I will sit on a chair with arms and a firm seat.”

135. When assessing the wound of a client who had a total hip replacement, the nurse finds small, fluid-filled lesions on the right side of the dressing. What explanation is the most probable rationale for this occurrence?

*** A) These are blisters from the tape used to anchor the dressing.**

B) These were caused by the cautery unit in the operating room.

C) These are papular wheals from herpes zoster.

D) These macular lesions are from a latex allergy.

136. The nurse is preparing a plan of care for the client who has had a total hip replacement. Which outcome would be most appropriate for this client?

*** A) The client will have adequate hip joint motion.**

B) The client has limited amount of pain relief.

C) The client will have limited ability to ambulate.

D) The client will have hip instability for several months.

137. The nurse is caring for the client who had a total knee replacement (TKR). Which data would the nurse observe to determine if the nursing interventions are effective?

*** A) The client participates in self-care activities.**

B) The client’s lungs have bilateral crackles.

C) The client’s knee has flexion of 45 degrees.

D) The client participates in self-care activities.

138. The nurse is working on an orthopedic floor. Which client should the nurse assess first after the change of shift report?

*** A) The 64-year-old female who had a left total knee replacement with confusion.**

B) The 84-year-old female with a fractured right femoral neck in Buck's traction.

C) The 88-year-old male who had a right total hip replacement with an abduction pillow.

D) The 50-year-old postoperative client who has a continuous passive motion (CPM) device.

139. Which client would the nurse identify as having the highest risk for developing postoperative complications?

*** A) The 67-year-old client who is obese, has diabetes, and takes insulin.**

B) The 50-year-old client with arthritis taking nonsteroidal anti-inflammatory drugs.

C) The 45-year-old client having abdominal surgery to remove the gallbladder.

D) The 60-year-old client with anemia who smokes one (1) pack of cigarettes per day.

140. The nurse is completing the preoperative checklist on a client going to surgery. Which information should the nurse report to the surgeon?

*** A) The client uses the oral supplements licorice and garlic.**

B) The client understands the purpose of the surgery.

C) The client stopped taking aspirin three (3) weeks ago.

D) The client has mild levels of preoperative anxiety.

141. Which statement explains the nurse's responsibility when obtaining a surgical permit for the client undergoing a surgical procedure?

*** A) The nurse should ensure that the client is voluntarily giving consent.**

B) The nurse should provide detailed information about the procedure.

C) The nurse should inform the client of any legal consultation needed.

D) The nurse should write a list of the risks for postoperative complications.

142. Which client outcome would the nurse identify for the preoperative client?

*** A) The client will demonstrate the use of a pillow to splint while deep breathing.**

B) The client's abnormal laboratory data will be reported to the anesthesiologist.

C) The nurse will develop a plan of care to prevent all postoperative complications.

D) The client will complete an advance directive before having the surgery.

143. Which client problem would be appropriate for the preoperative client preparing for an ankle repair?

*** A) Knowledge deficit of postoperative care.**

B) Alteration in skin integrity.

C) Alteration in gas exchange and pattern.

D) Alteration in urinary elimination.

144. The nurse and unlicensed nursing assistant (NA) are caring for clients in a surgery holding area. Which nursing task could be delegated to the NA?

*** A) Perform the skin preparation with povidone-iodine (Betadine).**

B) Explain to the client how to cough and deep breathe.

C) Discuss preoperative plans with the client and family.

D) Determine the ability of the caregivers to provide postoperative care.

145. Which action by the client would indicate that the preoperative teaching has been effective?

*** A) The client demonstrates how to use the incentive spirometer device.**

B) The client demonstrates the use of the patient-controlled analgesia pump.

C) The client names two (2) anesthesia agents that will be used.

D) The client ambulates down the hall to the nurse's station each hour.

146. The unlicensed nursing assistant (NA) can be overheard talking loudly to the scrub technologist discussing a problem that occurred during one (1) of the surgeries. Which intervention should the nurse implement?

*** A) Instruct the NA and scrub tech to stop the discussion.**

B) Close the curtains around the client's stretcher.

C) Tell the surgeon on the case what the nurse overheard.

D) Inform the client that the discussion was not about their surgeon.

147. The client has been placed in the lithotomy position during surgery. Which nursing intervention should be implemented to decrease the risk of developing hypotension?

*** A) Lower one leg at a time.**

B) Increase the intravenous fluids.

C) Raise the foot of the stretcher.

D) Administer epinephrine, a vasopressor.

148. The circulating nurse notices that a sponge is on the edge of the sterile field. Which action should the circulating nurse take?

*** A) Tell the surgical technologist about the sponge.**

B) Don't include the sponge in the sponge count.

C) Take the sponge off the field with forceps.

D) Throw the sponge in the sterile trashcan.

149. The nurse notes a discrepancy in the needle count. What action should the nurse implement first?

*** A) Inform the other members of the surgical team about the problem.**

B) Assume that the original count was wrong and change the record.

C) Call the radiology department to perform a portable x-ray.

D) Complete an occurrence report and notify the risk manager.

150. The client’s serum sodium level is 128 mEq/L and serum potassium level is 2.8 mEq/L. Which hormonal problem is most likely to have caused this clinical situation?

*** A) Increased ADH secretion**

B) Increased aldosterone secretion

C) Decreased aldosterone secretion

D) Decreased ADH secretion

151. Which condition would trigger the release of natriuretic peptide (NP)?

*** A) Hypervolemia with increased venous return**

B) Hypovolemia with interstitial edema formation

C) Hypernatremia secondary to dehydration

D) Hyperkalemia secondary to trauma

152. What problem is likely to occur when a client's fluid intake is so low that his or her urine output is less than 400 mL/day?

*** A) Reduced excretion of body wastes, especially nitrogen**

B) Cellular swelling and subsequent edema

C) Expansion of the interstitial volume, with reduced plasma volume

D) Dilution of serum sodium levels to the extent that excitable membranes can no longer depolarize

153. Why is it important to keep the sodium level of the plasma volume so much higher than the sodium level of the intracellular volume?

*** A) Excitable membranes are dependent on sodium concentration differences for depolarization.**

B) Intracellular sodium is toxic to living human cells.

C) Excess sodium displaces oxygen on the hemoglobin of red blood cells.

D) High plasma levels of sodium are needed to balance the high plasma levels of magnesium.

154. The client is taking a medication for an endocrine problem that inhibits aldosterone secretion and release. For what complications of this therapy should the nurse be alert?

*** A) Dehydration, hyperkalemia**

B) Dehydration, hypokalemia

C) Overhydration, hyponatremia

D) Overhydration, hypernatremia

155. Edema over the coccyx of a bedridden client is a result of what type of pressures, forces, or influences?

*** A) Filtration from the plasma volume to the interstitial space as a result of increased capillary hydrostatic pressure**

B) Filtration from the plasma volume to the interstitial space as a result of decreased capillary hydrostatic pressure

C) Osmosis from the interstitial space to the plasma volume as a result of increased cellular osmotic pressure

D) Osmosis from the interstitial space to the plasma volume as a result of decreased cellular osmotic pressure

156. The client who is being treated with radiation for cervical cancer asks if she should bother having a mammogram, especially because she is currently being exposed to radiation. What is the nurse's best response?

*** A) "Being treated for one kind of cancer does not prevent the development of another type of cancer. Have the mammogram."**

B) "Although you should delay the mammogram until your therapy is finished, perform a breast self-exam monthly."

C) "Absolutely do not have the mammogram this year, because you are already over the limit for safe exposure levels to radiation."

D) "The radiation therapy you are receiving will protect you against other cancer development, so it is okay to skip the mammogram this year."

157. Which surgery is considered a type of rehabilitative surgery for cancer?

*** A) Creation of a new vagina following radical therapy for pelvic cancer**

B) Creation of a colostomy during surgery for colorectal cancer

C) Removal of a mole that is present in area of constant irritation

D) Removing a wedge of tissue for cytologic examination from a lung lesion of uncertain origin

158. How does surgery for cure differ from surgery for palliation?

*** A) Palliative surgery may not extend the client's survival time.**

B) Palliative surgery is less painful than surgery for cure.

C) Curative surgery increases physical function.

D) Curative surgery prevents cancer.

159. The client receiving preoperative medication tells the nurse that all of the following medications (drugs or herbs) were ingested yesterday. Which one should the nurse report to the surgical team?

*** A) Motherwort**

B) Acetaminophen (Tylenol)

C) Vitamin C

D) Diphenhydramine (Benadryl)

160. What is the priority nursing diagnosis for an older adult client with sensory deficits who is scheduled for surgery?

*** A) Deficient Knowledge related to difficulty with sensory processing**

B) Risk for Impaired Skin Integrity related to incontinence and thin skin

C) Decreased Cardiac Output related to poor circulation and venous return

D) Risk for Activity Intolerance related to decreased respiratory reserve

161. When the nurse brings the preoperative medication to the client about to have abdominal surgery, she tells the nurse that she does not need the injection because she had a good night's sleep last night. What is the nurse’s best first action?

*** A) Tell the client that the preoperative medication is ordered to reduce the risk of some problems during surgery rather than to ensure adequate rest.**

B) Tell the client that her surgeon has ordered the medication; therefore, she should go ahead and take the medication because the surgeon knows what is best.

C) Appropriately discard the preoperative medication and notify the surgeon.

D) Document the client's statement and notify the charge nurse.

162. A 28-year-old woman has been diagnosed with endometriosis. She has been placed on a course of treatment with danazol (Danocrine). The woman exhibits understanding of this treatment when she says:

*** A) "I can experience a decrease in my breast size, oily skin, and hair growth on my face as a result of taking this medication."**

B) "Since this medication stops ovulation I do not need to use birth control."

C) "I will need to take this medication until 1 reach menopause."

D) "I will need to spray this medication into my nose twice a day."

163. A female client, age 26, describes scant bleeding between her menstrual periods. The nurse would record this finding as

*** A) Metrorrhagia**

164. Menorrhagia

A) Hypomenorrhea

165. Dysfunctional uterine bleeding (DUB) is most likely to occur when women:

*** A) Are experiencing signs of the onset of perimenopause**

B) Experience ovulatory cycles

C) Are less than their expected body weight

D) Secrete high levels of prostaglandin

166. A 55-year-old woman tells the nurse that she has started to experience pain when she and her husband have intercourse. The nurse would record that this woman is experiencing:

*** A) Dyspareunia**

B) Dysmenorrhea

C) Dysuria

D) Dyspnea

167. Infections of the female mid-reproductive tract such as chlamydia are dangerous primarily because these infections:

*** A) Are asymptomatic**

B) Cause infertility

C) Lead to pelvic inflammatory disease

D) Are difficult to treat effectively

168. A finding associated with human papillomavirus (HPV) infection would include which of the following?

*** A) Soft papillary swelling occurring singly or in clusters**

B) White, curd-like, adherent

C) Vesicles progressing to pustules and then to ulcers

D) Yellow to green frothy malodorous discharge

169. A recommended medication effective in the treatment of vulvovaginal candidiasis would be

*** A) Clotrimazole**

B) Metronidazole

C) Penicillin

D) Acyclovir

170. A woman is determined to be group B streptococcus (GBS) positive at the onset of her labor. The nurse should prepare this woman for

*** A) Intravenous administration of penicillin during labor**

B) Cesarean birth

C) Isolation of her newborn after birth

D) Application of acyclovir to her labial lesions

171. When providing a woman, recovering from primary herpes, with information regarding the recurrence of herpes infection of the genital tract, the nurse would tell her:

*** A) Itching and tingling often occur prior to the appearance of vesicles**

B) Fever and flu-like symptoms will precede a recurrent infection

C) Little can be done to control the recurrence of infection

D) Transmission of the virus is only possible when lesions are open and draining

172. A single, young adult woman received instructions from the nurse regarding the use of an oral contraceptive. The woman would demonstrate a need for further instruction if she:

*** A) Stops asking her sexual partners to use condoms with spermicide**

B) Enrolls in a smoking cessation program

C) Takes a pill every morning

D) Uses a barrier method of birth control if she misses two or more pills

173. The most common, and for some women the most distressing side effect of Norplant, is

*** A) Irregular menstrual bleeding**

B) Headache

C) Nervousness

D) Nausea

174. A woman with an IUD should confirm its placement by checking the IUD's string:

*** A) At the time of ovulation**

B) Before each menstrual period

C) After intercourse

D) During menstrual bleeding

175. When teaching women about the effective use of chemical barriers, the nurse should tell them to:

*** A) Reapply before each act of coitus**

B) Insert foams at least 1 hour prior to coitus

C) Insert suppositories just prior to penile contact with the vagina

D) Douche immediately after last intercourse

176. A woman must assess herself for signs that ovulation is occurring. Which of the following is a sign associated with ovulation?

*** A) Spinnbarkeit**

B) Drop in basal body temperature (BBT) following ovulation

C) Increase in amount and thickness of cervical mucus

D) Decrease in amount and thickness of cervical mucus

177. A couple is to undergo a postcoital test. The nurse should tell the couple that:

*** A) Intercourse should occur daily for 3 days prior to the test**

B) The test will be used to determine how sperm penetrate and survive in cervical mucus

C) The test will be scheduled for the day after menstruation ceases

D) The examination of cervical mucus must be performed within 30 minutes of intercourse

178. Lifestyle and sexual practices can affect fertility. Which of the following practices could enhance a couple's ability to conceive?

*** A) Couple only uses water-soluble lubricants if needed during intercourse**

B) Male wears boxer shorts instead of briefs

C) Female assumes a supine position with hips elevated for 1 hour after intercourse

D) Male relaxes in a hot tub every day after work

179. A woman taking human menopausal gonadotropin (Pergonal) for infertility should understand that:

*** A) She must report for ultrasound testing as scheduled to monitor follicular development**

B) She should take the medication orally, once a day after breakfast

C) The medication stimulates the pituitary gland to produce follicle stimulating (FSH) and luteinizing (LH) hormones

D) Clomiphene (Clomid) should be taken daily, along with the Pergonal, until ovulation occurs

180. An infertile woman may be given danazol (Danocrine) in order to:

*** A) Treat endometriosis**

B) Stimulate her pituitary gland

C) Induce ovulation

D) Help her to relax prior to intercourse

181. When teaching women about breast cancer the nurse should emphasize that:

*** A) Early menarche and late menopause may increase the risk for breast cancer**

B) The incidence of breast cancer is highest among African-American women

C) Breast cancer is most prevalent among women in their thirties and forties

D) Most women diagnosed with breast cancer exhibited clear and identifiable risk factors

182. The physician of a 46-year-old premenopausal woman with breast cancer has prescribed tamoxifen beginning in the postoperative period following lumpectomy. The nurse should understand that this medication:

*** A) Can cause hot flashes and menstrual irregularities**

B) Relieves postoperative discomfort

C) Is usually taken in an oral dose of 100 mg four times a day

D) Must be taken for a lifetime

183. When providing discharge instructions to a woman who had a modified right radical mastectomy, the nurse should emphasize the importance of:

*** A) Telling health care providers not to take a blood pressure or draw blood from her right arm**

B) Reporting any tingling or numbness in her incisional site or right arm immediately

C) Learning how to use her left arm to write and accomplish the activities of daily living such as combing her hair

D) Wearing clothing that snugly supports her right arm

184. A 26-year-old woman has just been diagnosed with fibrocystic change in her breasts. Nonproliferative lesions have been noted in both breasts. Which of the following nursing diagnoses would be a priority for this woman?

*** A) Acute pain related to cyclical enlargement of breast cysts or lumps**

B) Risk for infection related to altered integrity of the areola associated with leakage from the nipples

C) Anxiety related to anticipated surgery to remove the cysts in her breasts

D) Fear related to high risk for breast cancer

185. When assessing a woman with a diagnosis of fibroadenoma, a characteristic the nurse would expect to find would be:

*** A) Small, well-delineated lump in the upper outer quadrant of one breast**

B) Bilateral tender lumps behind the nipple

C) Milky discharge from one or both nipples

D) Soft and nonmovable lumps

186. When teaching a class of pregnant women about fetal development, the nurse would include:

*** A) You should be able to feel your baby move by week 16 to 20 of pregnancy.**

B) The sex of your baby is determined by the 9th week of pregnancy.

C) The baby's heart begins to pump blood during the 10th week of pregnancy.

D) The baby's heart beat will be audible using a special ultrasound stethoscope as early as the 18th week of pregnancy.

187. The results of an amniocentesis indicates that the pregnant woman's L/S ratio is 2:1. This result indicates that:

*** A) The newborn should be able to maintain effective respiration after birth.**

B) The woman is in her 2nd trimester of pregnancy.

C) The fetus has most likely developed a renal problem.

D) An open neural tube defect is present.

188. When caring for pregnant women, the nurse would recognize that a woman with which of the following disorders has the greatest risk for giving birth to a macrosomic newborn?

*** A) Diabetes**

B) Anemia

C) Hyperthyroidism

D) Hypertension

189. A pregnant woman at 10 weeks' gestation exhibits the following signs of pregnancy during a routine prenatal check-up. Which one would be categorized as a probable sign of pregnancy?

*** A) Human chorionic gonadotropin in the urine**

B) Breast tenderness

C) Morning sickness

D) Fetal heart sounds

190. A client asks the nurse what was meant when the physician told her she had a positive Chadwick's sign. Which of the following information about the finding would be appropriate for the nurse to convey at this time?

*** A) "It is a bluish coloration of your cervix and vagina."**

B) "It is a purplish stretch mark on your abdomen."

C) "It means that you are having heart palpitations."

D) "It means the doctor heard abnormal sounds when you breathed in."

191. A client enters the prenatal clinic. She states that she believes she is pregnant. Which of the following hormone elevations will indicate a high probability that the client is pregnant?

*** A) Chorionic gonadotropin.**

B) Oxytocin.

C) Prolactin.

D) Luteinizing hormone.

192. Immediately after a woman spontaneously ruptures her membranes, the nurse notes a loop of the umbilical cord protruding from the woman's vagina. Which of the following actions should the nurse perform first?

*** A) Put the client in the knee chest position**

B) Telephone the obstetrician with the findings

C) Administer oxygen by tight face mask

D) Assess the fetal heart rate

193. A 29-week-gravid client is admitted to the labor and delivery unit with vaginal bleeding. To differentiate between placenta previa and abruptio placentae, the nurse should assess which of the following?

*** A) Presence of abdominal pain**

B) Maternal blood pressure

C) Quantity of vaginal bleeding

D) Leopold’s maneuver results

194. Which of the following situations is considered a vaginal delivery emergency?

*** A) Shoulder dystocia**

B) Three-vessel cord

C) Fetal heart dropping during contractions

D) Third stage of labor lasting 20 minutes

195. A client who has been diagnosed with severe preeclampsia is being administered magnesium sulfate via IV pump. Which of the following medications must the nurse have immediately available in the client’s room?

*** A) Calcium gluconate**

B) Meperidine (Demerol)

C) Naloxone (Narcan)

D) Morphine sulfate

196. A client, 1 day postpartum (PP), is being monitored carefully after a significant postpartum hemorrhage. Which of the following should the nurse report to the obstetrician?

*** A) Urine output 200 mL for last 8 hours**

B) Pulse rate of 68 beats per minute

C) Drop in hematocrit of 2\% since admission

D) Weight decrease of 2 pounds since delivery

197. Which client is at greatest risk for the development of a pulmonary embolism?

*** A) 40-year-old woman who has used oral contraceptives for the past 15 years and who had abdominal surgery yesterday for cancer**

B) 30-year-old athlete who lifts weights and was diagnosed with a pneumothorax yesterday

C) 60-year-old man who caught his right hand in a piece of machinery and has five broken fingers, with extensive soft tissue damage

D) 50-year-old woman who has fragile capillaries and bruises very easily

198. Which diagnostic test most specifically confirms the presence of a pulmonary embolism?

*** A) Pulmonary angiography**

B) Ventilation-perfusion lung scan

C) Arterial blood gases

D) Chest x-ray

199. Which statement made by a client's spouse indicates the need for more teaching about prevention of a pulmonary embolism at home after major abdominal surgery?

*** A) "I will massage his feet and legs twice a day to help blood return."**

B) "I will check his breathing rate and level twice a day."

C) "He is prone to constipation, so I will increase the amount of fiber in his meals every day."

D) "While he is awake, I will make sure he gets up and walks for at least 5 minutes every 2 hours."

200. Which set of arterial blood gases would the nurse expect to find in a client who developed a pulmonary embolism 15 minutes ago?

*** A) pH 7.47, HCO_3^- 23 mEq/L, PCO_2 25 mm Hg, PO_2 82 mm Hg**

B) pH 7.30, HCO_3^- 28 mEq/L, PCO_2 65 mm Hg, PO_2 75 mm Hg

C) pH 7.38, HCO_3^- 22 mEq/L, PCO_2 45 mm Hg, PO_2 96 mm Hg

D) pH 7.30, HCO_3^- 22 mEq/L, PCO_2 60 mm Hg, PO_2 66 mm Hg

201. Which set of arterial blood gases would the nurse expect to find in a client who developed a pulmonary embolism 6 hours ago?

*** A) pH 7.30, HCO3– 22 mEq/L, PCO2 60 mm Hg, PO2 66 mm Hg**

B) pH 7.30, HCO3– 28 mEq/L, PCO2 65 mm Hg, PO2 75 mm Hg

C) pH 7.38, HCO3– 22 mEq/L, PCO2 45 mm Hg, PO2 96 mm Hg

D) pH 7.47, HCO3– 23 mEq/L, PCO2 25 mm Hg, PO2 82 mm Hg

202. A nurse discovers that a physician has prescribed that the client with a pulmonary embolism be started on oral warfarin while still receiving intravenous heparin. What is the nurse’s best action?

*** A) Administer the medications as prescribed**

B) Monitor the client for clinical manifestations of internal or external bleeding at least every 2 hours.

C) Remind the physician that two anticoagulants should not be administered concurrently.

D) Hold the dose of warfarin until the client's partial thromboplastin time is the same as the control value.

203. The client with ischemic heart disease has an ECG tracing that shows first-degree heart block. What is the nurse’s best first action?

*** A) Measure blood pressure**

B) Notify the physician.

C) Administer oxygen.

D) Document the finding as the only action.

204. Which statement, made by the client who is taking warfarin (Coumadin) daily to prevent blood clots from forming in deep veins, indicates a need for further discussion regarding this therapy?

*** A) "I have been eating more salads and other green, leafy vegetables to prevent constipation."**

B) "On hot days, I make sure I drink at least two quarts of water."

C) "I have two pairs of antiembolic stockings so that one pair can be washed each day."

D) "Instead of a safety razor, I have been using an electric shaver to shave."

205. Which client is at greatest risk for ARDS?

*** A) The 22-year-old who received 10 units of blood after a motor vehicle crash**

B) The 62-year-old with COPD who has pneumonia

C) The 78-year-old with chronic congestive heart failure and pulmonary edema

D) The 24-year-old with asthma who has not taken any of her asthma medications for 2 weeks

206. The client at risk for acute respiratory distress syndrome (ARDS) has become cyanotic and is diaphoretic. What assessment technique should the nurse perform next?

*** A) Measure pulse oximetry.**

B) Compare current ECG tracing with baseline measurement.

C) Auscultate breath sounds bilaterally.

D) Measure the blood pressure in both arms.

207. What is the most important intervention for the client with ARDS?

*** A) Oxygen therapy**

B) Diuretic therapy

C) Bronchodilators

D) Antibiotic therapy

208. The client with respiratory difficulty has a V/Q ratio of 0.5. What is the significance of this value?

*** A) The ratio is low; perfusion is exceeding ventilation.**

B) The ratio is low; ventilation is exceeding perfusion.

C) The ratio is high; ventilation is exceeding perfusion.

D) The ratio is high; perfusion is exceeding ventilation.

209. Which of the following clients could be expected to require mechanical ventilation longterm?

*** A) 24-year-old with muscular dystrophy**

B) 65-year-old with bilateral bacterial pneumonia

C) 45-year-old with morphine overdose

D) 27-year-old with status asthmaticus

210. What is the main purpose of a negative-pressure ventilator?

*** A) Assisting ventilation to healthy lungs by mimicking normal chest pressures**

B) Delivering an individualized preset tidal volume to the lower respiratory tract

C) Relieving hypoxemia by opening obstructed airways

D) Healing diseased lung tissue

211. A nurse is starting a new shift and assessing the client who has an oral endotracheal tube in place. Which finding requires immediate intervention?

*** A) The endotracheal tube is taped to the lower jaw.**

B) The client has hydrocolloid membrane on the skin of the cheeks

C) The endotracheal tube is midline in the mouth.

D) The client has been intubated for four days.

212. The pilot balloon on the endotracheal tube of a client being mechanically ventilated is completely deflated. What is the consequence of this situation?

*** A) The client's lungs may not be receiving the set tidal volume.**

B) The client's residual volume is too low.

C) The client has no airway and must be reintubated.

D) The endotracheal tube is too small for the client.

213. Which intervention promotes a more normal V/Q match for a client receiving mechanical ventilation?

*** A) Positioning the client so that the healthier lung is dependent to the more diseased lung**

B) Auscultating the lungs bilaterally every 4 hours for the presence of crackles, wheezes, and other abnormal breath sounds

C) Administering the prescribed muscle-paralyzing agents

D) Ensuring that the pilot balloon on the endotracheal tube cuff is inflated to its maximal pressure

214. Which assessment finding alerts the nurse to the possibility that the intrathoracic pressure in a mechanically ventilated client is too high?

*** A) Hypotension**

B) Increased diaphragmatic excursion

C) Low-pressure alarm sounds on the ventilator

D) Pulse oximetry value of 96\%

215. The client being mechanically ventilated has become more restless over the course of the shift. What is the nurse’s best action?

*** A) Check the client's oxygen saturation by pulse oximetry.**

B) Administer a dose of pain medication or sedative.

C) Document the observation as the only action.

D) Darken the room and ask visitors to leave.

216. The pressure reading on the ventilator of a client receiving mechanical ventilation is fluctuating widely. What is the correct action to take for this problem?

*** A) Assess the client's oxygen saturation to determine the adequacy of oxygenation.**

B) Disconnect the ventilator from the client and use a manual resuscitation bag until the machine has been checked.

C) Increase the tidal volume by at least 100 mL or by the client's weight in kg.

D) Determine whether there is an air leak in the client's endotracheal tube cuff.

217. Which nursing intervention has the highest priority when preparing the client for a surgical procedure?

*** A) Apply soft restraint straps to the extremities.**

B) Pad the client's elbows and knees.

C) Prepare the client's incision site.

D) Document the temperature of the room.

218. When receiving the client from the OR, which intervention should the PACU nurse implement first?

*** A) Assess the client's breath sounds.**

B) Apply oxygen via nasal cannula.

C) Take the client's blood pressure.

D) Monitor the pulse oximeter reading.

219. The nurse comes to the conclusion that a patient's elevated temperature, pulse, and respirations are significant. What step of the Nursing Process is being used when the nurse comes to this conclusion?

*** A) Diagnosis**

B) Evaluation

C) Assessment

D) Implementation

220. When the nurse considers the Nursing Process, the word “identify” is to “recognize” as the word “do” is to:

*** A) Implement**

B) Diagnose

C) Evaluate

D) Plan

221. The nurse is collecting subjective data associated with a patient’s anxiety. Which assessment method should be used to collect this information?

*** A) Interviewing**

B) Auscultation

C) Inspecting

D) Observing

222. Which nursing action reflects an activity associated with the diagnosis step of the Nursing Process?

*** A) Identifying the patient’s potential risks**

B) Making decisions about the effectiveness of patient care

C) Formulating a plan of care

D) Designing ways to minimize a patient’s stressors

223. The nurse collects objective data when a hospitalized patient states:

*** A) “I ate half my lunch.”**

B) “I am hungry.”

C) “I feel very warm.”

D) “I have the urge to urinate.”

224. The nurse understands that subjective data has been obtained when the patient states:

*** A) “My pain feels like a 5 on a scale of 1 to 5.”**

B) “The doctor said I can go home today.”

C) “I only ate half my breakfast.”

D) “I just went in the urinal and it needs to be emptied.”

225. During which of the five steps in the Nursing Process does the nurse determine whether outcomes of care are achieved?

*** A) Evaluation**

B) Implementation

C) Diagnosis

D) Planning

226. When considering the Nursing Process, the nurse understands that the word “observe” is to “assess” as the word “determine” is to:

*** A) Diagnose**

B) Plan

C) Analyze

D) Implement

227. An essential concept related to understanding the Nursing Process is that it:

*** A) Is dynamic rather than static**

B) Focuses on the role of the nurse

C) Moves from the simple to the complex

D) Is based on the patient’s medical problem

228. The nurse is caring for a male patient with a urinary elimination problem. Which is the most accurately stated goal? “The patient will:

*** A) Transfer independently and safely to a commode before discharge.”**

B) Be taught how to use a urinal when on bed rest.

C) Experience fewer incontinence episodes at night.

D) Be assisted to the toilet every two hours and whenever necessary.

229. The nurse understands that the word most closely associated with scientific principles is:

*** A) Rationale**

B) Data

C) Problem

D) Evaluation

230. The nurse teaches a patient to use visualization to cope with chronic pain. This action reflects which step of the Nursing Process?

*** A) Implementation**

B) Planning

C) Diagnosis

D) Evaluation

231. A patient has multiple diagnostic tests performed. Where in the patient’s chart can the nurse find documentation about the current medical diagnosis after the diagnostic tests results are reported?

*** A) Progress Notes**

B) Physician’s History and Physical

C) Social Service Record

D) Admission Sheet

232. During which of the five steps in the Nursing Process does the nurse analyze data critically?

*** A) Diagnosis**

B) Clustering

C) Collection

D) Assessment

233. The nurse is assessing a postoperative patient for signs of hemorrhage. Which adaptation is most indicative of shock?

*** A) Hypotension**

B) Hyperemia

C) Irregular pulse

D) Slow respirations

234. The nurse is monitoring the vital signs of a group of patients. When reviewing these results, the nurse must remember that body temperature usually is at its highest at:

*** A) 8 PM–10 PM**

B) 12 AM–2 AM

C) 6 AM–8 AM

D) 4 PM–6 PM

235. When assessing for borborygmi, which physical examination method should the nurse use?

*** A) Auscultation**

B) Percussion

C) Inspection

D) Palpation

236. The nurse plans to take a patient’s radial pulse. Which method of examination should be used by the nurse?

*** A) Palpation**

B) Inspection

C) Percussion

D) Auscultation

237. Which nursing action is common to all instruments when taking a temperature?

*** A) Ensure that the instrument is clean**

B) Place a disposable sheath over the probe

C) Wash with cool soap and water after use

D) Identify that the reading is below 96°F before insertion

238. The nurse concludes that a patient is experiencing hyperthermia. Which assessment precipitated this conclusion?

*** A) Rectal temperature of 101°F**

B) Decreased heart rate

C) Increased appetite

D) Mental confusion

239. The nurse in the Emergency Department is engaging in an initial assessment of a patient. Which assessment takes priority?

*** A) Airway clearance**

B) Blood pressure

C) Circulatory status

D) Breathing pattern

240. The nurse is obtaining a patient’s blood pressure. Which information is most important for the nurse to document?

*** A) Position of the patient if the patient is not in a sitting position**

B) Difference between the palpated and auscultated systolic readings

C) Patient’s tolerance to having the blood pressure taken

D) Staff member who took the blood pressure

241. The nurse is teaching a cancer prevention community health class. Which recommended cancer screening guideline for asymptomatic nonrisk people should the nurse include?

*** A) Sigmoidoscopies every 5 years for patients 50 years of age and older**

B) Prostate-specifi c antigens yearly for men 30 years of age and older

C) Pap smears annually for females 13 years of age and older

D) Mammograms annually for women 30 years of age and older

242. The nurse is planning to shave a male patient’s facial hair. The nurse should:

*** A) Shave in the direction of hair growth**

B) Use long, downward strokes with the razor

C) Hold the razor at a ninety-degree angle to the skin

D) Wrap the face with a hot, wet towel before shaving

243. The nurse is making an occupied bed. Which nursing action is most important?

*** A) Ensuring that the patient’s head is supported and is in functional alignment**

B) Securing top linens under the foot of the mattress and mitering the corners

C) Fan-folding soiled linens as close to the patient’s body as possible

D) Positioning the bed in the horizontal position

244. The nurse must bathe the feet of a patient with diabetes. What should the nurse do before bathing this patient's feet?

*** A) Assess for additional risk factors that may contribute to foot problems**

B) Teach the patient that daily foot care is essential to healthy feet

C) File the nails straight across with an emery board

D) Ensure a physician's order for hygienic foot care is obtained

245. The nurse is providing perineal care to a male patient. The nurse should wash the:

*** A) Penis with one hand while holding it firmly with the other hand**

B) Shaft of the penis while moving toward the urinary meatus

C) Genital area with hot, sudsy water

D) Scrotum before washing the glans penis

246. The nurse identifies that additional teaching about skin care is necessary when an older adult says, I should:

*** A) Use a bubble-bath preparation when I take a bath.**

B) Humidify my home in the winter.

C) Bathe twice a week.

D) Rinse well after using soap.

247. The school nurse identifies that teaching about skin care for acne has been effective when an adolescent states, I should:

*** A) Wash my face several times a day with soap and water.**

B) Squeeze the white heads gently and apply a topical antibiotic.

C) Wash with an alcohol-based facial cleanser every day.

D) Use an oil-based cream on my face after washing.

248. When providing fingernail care during a bath the nurse should:

*** A) Clean under the nails with an orange stick**

B) First soak the hands in hot water

C) Cut the nails in an oval shape

D) Push the cuticles back with the rounded end of a metal nail file

249. Which common problem with the hair should the nurse anticipate when patients are on complete bed rest?

*** A) Matted hair**

B) Split hair

C) Oily hair

D) Dry hair

250. The nurse covers the patient with a cotton blanket during a bath. This is done to prevent heat loss via:

*** A) Convection**

B) Diffusion

C) Conduction

D) Vasodilation

251. The nurse is caring for a patient who is experiencing an increase in symptoms associated with multiple sclerosis. Which term best describes a recurrence of symptoms associated with a chronic disease?

*** A) Exacerbation**

B) Adaptation

C) Variance

D) Remission

252. The nurse in the clinic must obtain the vital signs of each patient before each patient is assessed by the practitioner. The nurse should obtain a temperature via the rectal route for a patient:

*** A) Who is a mouth breather**

B) With a history of vomiting

C) Who cannot tolerate a semi-Fowler's position

D) With an intelligence of a seven-year-old child

253. When evaluating a patient's temperature, the nurse recalls that people usually have the lowest body temperature at:

*** A) 4 AM–6 AM**

B) 8 AM–10 AM

C) 4 PM–6 PM

D) 8 PM–10 PM

254. Which assessment requires the nurse to assess the patient further?

*** A) 65-year-old man with a respiratory rate of 10**

B) 50-year-old man with a BP of 112/60 upon awakening in the morning

C) 40-year-old woman with a pulse of 88

D) 18-year-old woman with a pulse rate of 140 after riding 2 miles on an exercise bike

255. The nurse is interviewing a newly admitted patient. Which patient statement indicates the onset of a fever? "I feel:

*** A) Cold."**

B) Warm."

C) Sweaty."

D) Thirsty."

256. The nurse is caring for a group of hospitalized patients. What should the nurse do first to prevent patient infections?

*** A) Identify patients at risk**

B) Provide small bedside bags to dispose of used tissues

C) Encourage staff to avoid coughing near patients

D) Administer antibiotics as ordered

257. The nurse identifies that a patient has an inflammatory response. Which local patient adaptation supports this conclusion?

*** A) Erythema**

B) Fever

C) Bradypnea

D) Tachycardia

258. A patient has a wound that is healing by secondary intention. To best support healing of the wound, the nurse should expect the practitioner's order to state, "Clean wound with:

*** A) Normal saline and apply a wet-to-damp dressing."**

B) Betadine and apply a dry sterile dressing."

C) Normal saline and cover with a gauze dressing."

D) Half peroxide and half normal saline and apply a wet to dry dressing."

259. The nurse identifies that the greatest risk for a wound infection exists for a patient with a:

*** A) Puncture of the foot by a nail**

B) Surgical creation of a colostomy

C) First-degree burn on the back

D) Paper cut on the finger

260. The nurse understands that the skin protects the body from infections because the:

*** A) Cells of the skin are constantly being replaced, thereby eliminating external pathogens**

B) Epithelial cells are loosely compacted on skin, providing a barrier against pathogens

C) Moisture on the skin surface prevents colonization of pathogens

D) Alkalinity of the skin limits the growth of pathogens

261. The nurse must collect the following specimens. Which specimen collection does not require the use of surgical aseptic technique?

*** A) Stool for ova and parasites**

B) Specimen for a throat culture

C) Exudate from a wound for culture and sensitivity

D) Urine from a retention catheter

262. A patient is positive for Clostridium difficile. The nurse should institute the isolation precaution known as:

*** A) Contact**

B) Droplet

C) Reverse

D) Airborne

263. Which patient information collected by the nurse reflects a systemic adaptation to a wound infection?

*** A) Hyperthermia**

B) Exudate

C) Edema

D) Pain

264. To interrupt the transmission link in the chain of infection, the nurse should:

*** A) Wash the hands before and after providing care to a patient**

B) Position a commode next to a patient’s bed

C) Provide education about a balanced diet

D) Change a dressing when it is soiled

265. The nurse is providing for the nutrition needs of several patients. The nurse identifies the need for an increase in caloric intake above average requirements for the patient who has:

*** A) Pneumonia**

B) Nausea

C) Dysphagia

D) Depression

266. The nurse is caring for patients with a variety of wounds. The nurse understands that healing by primary intention most likely occurs with:

*** A) Cuts in the skin from a kitchen knife**

B) Excoriated perianal areas

C) Abrasions of the skin

D) Pressure ulcers

267. The primary reason why the nurse should avoid glued-on artificial nails is because they:

*** A) Harbor microorganisms**

B) Interfere with dexterity of the fi ngers

C) Could fall off in a patient’s bed

D) Can scratch a patient

268. The nurse understands that subclinical infections most commonly occur in:

*** A) Older adults**

B) Children of school age

C) Adolescents

D) Infants

269. The nurse understands that the factor that places a patient at the greatest risk for developing an infection is:

*** A) Burns more than twenty percent of the body**

B) Multiple puncture sites from laparoscopic surgery

C) Presence of an indwelling urinary catheter

D) Implantation of a prosthetic device

270. The nurse understands that a secondary line of defense against infection is the:

*** A) Immune response**

B) Integumentary system

C) Urinary tract environment

D) Mucous membranes of the respiratory tract

271. Which nursing action protects the patient as a susceptible host in the chain of infection?

*** A) Administering childhood immunizations**

B) Wearing personal protective equipment

C) Recapping a used needle before discarding

D) Disposing of soiled gloves in a waste container

272. A patient tells the nurse, “I think I have an ear infection.” The nurse should assess this patient for which objective human response to an ear infection?

*** A) Purulent drainage**

B) Throbbing pain

C) Dizziness when moving

D) Hearing a buzzing sound

273. The nurse is concerned about a patient’s ability to withstand exposure to pathogens. What blood component should the nurse monitor?

*** A) Neutrophils**

B) Platelets

C) Hemoglobin

D) Erythrocytes

274. The nurse understands which primary (nonspecific) defense protects the body from infection?

*** A) Tears in the eyes**

B) Alkalinity of gastric secretions

C) Bile in the gastrointestinal system

D) Moist environment of the epidermis

275. When brushing a patient’s hair, the nurse notes white oval particles attached to the hair behind the ears. The nurse should assess the patient further for signs of:

*** A) Pediculosis**

B) Hirsutism

C) Dandruff

D) Scabies

276. Profuse smoke is coming out of the heating unit in a patient’s room. The nurse should

*** A) Move the patient out of the room**

B) Close the door to the patient’s room

C) Open the window

D) Activate the fire alarm

277. The nurse is planning care for a patient with a wrist restraint. The restraint should be removed, the area massaged, and the joints moved through their full range every:

*** A) Two hours**

B) Four hours

C) Hour

D) Shift

278. Which is the first action the home care nurse should employ to prevent falls by an older adult living at home?

*** A) Conduct a comprehensive risk assessment**

B) Encourage the patient to remove throw rugs in the home

C) Suggest installation of adequate lighting throughout the home

D) Discuss with the patient the expected changes of aging that place one at risk

279. The nurse is preparing a bed to receive a newly admitted patient. Which action is most important?

*** A) Ensure that the bed wheels are locked**

B) Place the patient’s name on the end of the bed

C) Position the call bell in reach

D) Make an open bed

280. An appropriately worded goal associated with the nursing diagnosis Risk for Injury is, “The patient will be:

*** A) Free from trauma.”**

B) Restrained when agitated.”

C) Kept on bed rest when dizzy.”

D) Taught how to call for help to ambulate.”

281. The nurse understands that in the hospital setting an electrical appliance should have a three-pronged plug because it:

*** A) Controls stray electrical currents**

B) Shuts off the appliance if there is an electrical surge

C) Promotes effi cient use of electricity

D) Divides the electricity among the appliances in the room

282. A patient with Parkinson’s disease is experiencing difficulty swallowing. The nurse understands that the most serious risk associated with dysphagia is:

*** A) Aspiration**

B) Anorexia

C) Self-care deficit

D) Inadequate intake

283. The nurse is caring for a confused patient. To prevent this patient from falling, the nurse should:

*** A) Maintain close supervision**

B) Reinforce how to use the call bell

C) Place the patient in a room near the nurses’ station

D) Encourage the patient to use the corridor handrails

284. When teaching children about fire safety procedures, the school nurse should teach them that if their clothes catch on fire they should:

*** A) Roll on the ground**

B) Yell for help

C) Take their clothes off

D) Pour water on their clothes

285. The physician orders a vest restraint for a patient. What should the nurse do first when applying this restraint?

*** A) Inspect the patient’s skin where the restraint is to be placed**

B) Secure the restraint to the bed frame using a slipknot

C) Permit four fingers to slide between the patient and the restraint

D) Ensure that the back of the vest is positioned on the patient’s back

286. An unconscious patient begins vomiting. In which position should the nurse place the patient?

*** A) Side-lying**

B) Supine

C) Orthopneic

D) Low-Fowler’s

287. The nurse is assisting a patient to use a bedpan. What is the most important nursing intervention?

*** A) Ensuring that the bedside rails are raised once the patient is on the bedpan**

B) Encouraging the patient to help as much as possible when using the bedpan

C) Positioning the rounded rim of the bedpan toward the front of the patient

D) Dusting powder on the rim before placing the bedpan under the patient

288. A toaster is on fire in the pantry of a hospital unit. The nurse should first:

*** A) Activate the fire alarm**

B) Unplug the toaster

C) Put out the fire with an extinguisher

D) Evacuate patients from the room next to the kitchen

289. The nurse understands that the most common factor that contributes to falls in the hospital setting is:

*** A) Advanced age of patients**

B) Wet fl oors

C) Frequent seizures

D) Misuse of equipment by nurses

290. The nurse is repositioning a patient on the left side. The nurse should place the patient’s:

*** A) Left shoulder protracted**

B) Right leg resting on top of the left leg

C) Ankles in plantar flexion

D) Knees in ninety degrees of flexion

291. The nurse turns a patient’s ankle so that the sole of the foot moves medially toward the midline. This motion is known as:

*** A) Inversion**

B) Adduction

C) Plantar flexion

D) Internal rotation

292. The nurse is transferring a patient from a bed to a wheelchair. To quickly assess this patient's tolerance to the change in position, the nurse should:

*** A) Determine if the patient feels dizzy**

B) Allow the patient time to adjust to the change in position

C) Monitor for bradycardia

D) Obtain a blood pressure

293. The nurse is transferring a patient from the bed to a wheelchair using a mechanical lift. Which is a basic nursing intervention associated with this procedure?

*** A) Ensure the patient's feet are protected when on the mechanical lift**

B) Keep the wheels of the mechanical lift locked throughout the procedure

C) Raise the mechanical lift so that the patient is six inches off the mattress

D) Lock the base lever in the open position when moving the mechanical lift

294. A patient has hemiplegia as a result of a brain attack. Which complication of immobility is of most concern to the nurse?

*** A) Contractures**

B) Hypertension

C) Incontinence

D) Dehydration

295. Which stage pressure ulcer requires the nurse to measure the extent of undermining?

*** A) Stage III**

B) Stage I

C) Stage II

D) Stage 0

296. Which of the following hematologic tests or assessment procedures should the nurse check to ensure that the client or the client's legal representative has signed an informed consent statement?

*** A) Bone marrow aspiration**

B) Reticulocyte count

C) Capillary fragility studies

D) Electrophoresis for hemoglobin type and quantity

297. Which tests indicates that the heparin therapy for the client at risk for thrombosis is adequate?

*** A) Partial thromboplastin time (PTT) twice the normal value**

B) Bleeding time of 4 minutes

C) Increased platelet aggregation

D) Decreased total iron-binding capacity (TIBC)

298. Which client should the nurse assess for hemolysis and jaundice?

*** A) 27-year-old with mitral valve prolapse taking penicillin daily**

B) 48-year-old taking one aspirin a day to prevent a second myocardial infarction

C) 42-year-old taking zidovudine and foscarnet (Foscavir) daily for HIV/AIDS

D) 78-year-old taking 40 mg of furosemide (Lasix) daily for mild CHF

299. Which assessment finding of the skin of an 82-year-old woman should be explored further?

*** A) Areas of petechiae on the trunk and arms**

B) Mottled pigmentation on the neck, cheeks, and forehead

C) Numerous cherry hemangiomas scattered across the anterior and posterior trunk

D) Discolored fingernails

300. Which client is most at risk for hematologic problems?

*** A) 55-year-old man with chronic alcoholism**

B) 48-year-old man who had a myocardial infarction 5 years ago

C) 62-year-old woman with diabetes mellitus on insulin therapy

D) 27-year-old woman taking oral contraceptives

301. A client’s warfarin (Coumadin) therapy was discontinued 3 weeks ago. Which laboratory test result indicates that all effects of the warfarin have been eliminated?

*** A) International normalized ratio (INR) of 0.9**

B) Total white blood count of 9000/mm3

C) Serum ferritin level of 350 ng/mL

D) Reticulocyte count of 1\%

302. When a person's hemoglobin is deficient in iron, which assessment finding is expected?

*** A) Increased respiratory rate**

B) Slow capillary refill

C) Bradycardia

D) Cherry red lips and mucous membranes

303. The client is concerned about pain during a bone marrow aspiration. What is the nurse’s best response?

*** A) “Most people have some pain during this short procedure. If you wish, you may have a tranquilizer or sedative before the procedure starts.”**

B) “There is no pain associated with this procedure.”

C) “The amount of discomfort is about the same as having your blood drawn.”

D) “You will be given a general anesthetic in the operating room and will be asleep during the procedure.”

304. After a bone marrow aspiration, the client has bruising at the site (left iliac crest). What is the nurse’s best action?

*** A) Apply an ice pack to the site.**

B) Document the finding as the only action.

C) Position the client on his/her right side.

D) Notify the physician.

305. What precaution should be given to a person who will be taking warfarin (Coumadin) for 6 months?

*** A) “Avoid aspirin and aspirin-containing drugs.”**

B) “Decrease your intake of sodium.”

C) “Sleep with the head of your bed elevated.”

D) “Avoid taking walks or performing any physical activity.”

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307. A client with a deep vein thrombosis is prescribed to be started on oral warfarin (Coumadin) while still receiving intravenous heparin. What is the nurse’s best action?

*** A) Administer the medications as prescribed.**

B) Remind the physician that two anticoagulants should not be administered concurrently.

C) Hold the dose of warfarin until the client's partial thromboplastin time is the same as the control value.

D) Monitor the client for clinical manifestations of internal or external bleeding at least every two hours.

308. The nurse should be sure to have which drug on the unit when the client is receiving intravenous heparin?

*** A) Protamine sulfate**

B) Aspirin

C) Vitamin K

D) Streptokinase

309. Which clinical manifestation is common to all types of anemia regardless of cause or pathologic mechanism?

*** A) Tachycardia at basal activity levels**

B) Jaundiced sclera and roof of the mouth

C) Hypertension and peripheral edema

D) Increased PaCO2

310. Which laboratory value in a client alerts the nurse to the probability of sickle cell disease?

*** A) Hgb S: 65\%**

B) Hgb A1: 97\%

C) Hgb F: 1.5\%

D) Hgb C: 0\%

311. When making assignments for nurses working in the OR, which case would the manager assign to the new nurse?

*** A) The client having a biopsy of the breast.**

B) The client having open-heart surgery.

C) The client having laser eye surgery.

D) The client having a laparoscopic knee repair.

312. When developing the plan of care for the surgical client having sedation, which intervention has highest priority for the nurse?

*** A) Assess the client’s respiratory status.**

B) Monitor the client’s urinary output.

C) Take a 12-lead ECG prior to injection.

D) Attempt to keep the client focused.

313. Which data indicate the nursing care has been effective for the client who is one (1)day postoperative surgery?

*** A) Lungs are clear bilaterally in all lobes.**

B) Urine output was 160 mL in the past eight (8) hours.

C) Bowel sounds occur four (4) times per minute.

D) T 99.0_F, P 98, R 20, and BP 100/60.

314. When working on the surgical floor, which task can the nurse delegate to the unlicensed nursing assistant (NA)?

*** A) Take vital signs every four (4) hours.**

B) Check the Jackson-Pratt insertion site.

C) Hang the client’s next IV bag.

D) Ensure that the client gets pain relief.

315. The charge nurse is making the shift assignments. Which postoperative client would be the most appropriate assignment to the graduate nurse?

*** A) A 24-year-old client who had an uncomplicated appendectomy the previous day.**

B) The four (4)-year-old client who had a tonsillectomy and is swallowing frequently.

C) The 74-year-old client with a repair of the left hip who is unable to ambulate.

D) An 80-year-old client with small bowel obstruction and congestive heart failure.

316. Which statement would be an expected outcome for the postoperative client who had general anesthesia?

*** A) The client will have a pulse oximetry reading of 97\% on room air.**

B) The client will be able to sit in the chair for 30 minutes.

C) The client will have a urine output of 30 mL per hour.

D) The client will be able to distinguish sharp from dull sensations.

317. Which client problem would be priority for client who is one (1) day postoperative?

*** A) Potential for hemorrhaging.**

B) Potential for injury.

C) Potential for fluid volume excess.

D) Potential for infection.

318. What is the scientific rationale for placing lift pads under an immobile client?

*** A) The pads will help prevent friction shearing when repositioning the client.**

B) The pads will absorb any urinary incontinence and contain stool.

C) The pads will prevent the client from being diaphoretic.

D) The pads will keep the staff from workplace injuries such as a pulled muscle.

319. What is the nurse’s best action for the client whose serum chloride level is 101 mEq/L?

*** A) Document the finding as the only action.**

B) Assess the client’s deep tendon reflexes.

C) Urge the client to drink more water.

D) Notify the physician.

320. Which statement made by the 74-year-old client should alert the nurse to the possibility of fluid and electrolyte imbalances?

*** A) “I don't drink liquids after 5 PM so I don't have to get up at night.”**

B) “My skin is always so dry, especially here in the Southwest.”

C) “I often use a glycerin suppository for constipation.”

D) “In addition to coffee, I drink at least one glass of water with each meal.”

321. Doulas are becoming important members of a laboring woman's health care team. Which of the following activities should be expected as part of the doula's role responsibilities?

*** A) Provide continuous support throughout labor and birth including explanations of labor progress**

B) Monitor hydration of laboring woman including adjusting IV flow rates

C) Interpret electronic fetal monitoring tracings to determine the well-being of the maternal-fetal unit

D) Eliminate the need for the husband/partner to be present during labor and birth

322. Changes occur as a woman progresses through labor. Which of the following maternal adaptations would be expected during labor?

*** A) Slight increase in temperature, pulse, and respiration findings**

B) Increase in both systolic and diastolic blood pressure during uterine contractions in the first stage of labor.

C) Decrease in white blood cell count

D) Increase in gastric motility leading to vomiting especially during the latent and active phases of the first stage of labor.

323. Which food item selections made by a client who needs to restrict sodium indicates correct understanding regarding the sodium content of food?

*** A) A chicken leg, one slice of whole wheat bread with butter, and ? cup of steamed carrots**

B) One cup of cottage cheese and a sliced chilled tomato

C) A grilled American cheese sandwich on two slices of white bread

D) A ham and cheddar cheese sandwich on two slices of whole wheat bread

324. In her birth plan, a woman requests that she be allowed to use the new whirlpool bath during labor. When implementing this woman's request the nurse would:

*** A) Cool the water or have the woman step out of the tub if the fetal heart rate or maternal temperature increases**

B) Assist the woman to maintain a reclining position when in the tub

C) Tell the woman she will need to leave the tub as soon as her membranes rupture

D) Limit her to no longer than 1 hour in the tub

325. The use of ataractics can potentiate the action of analgesics. An ataractic the nurse could expect to give to a laboring woman would be:

*** A) hydroxyzine (Vistaril)**

B) butorphanol tartrate (Stadol)

C) fentanyl (Sublimaze)

D) naloxone (Narcan)

326. The doctor has ordered meperidine (Demerol) 25 mg IV q 2-3 h prn for pain associated with. In fulfilling this order the nurse should know that:

*** A) The newborn should be observed for respiratory depression if birth occurs within 4 hours of the dose**

B) The onset of this analgesic's effect after IV administration would be approximately 10 minutes

C) The dosage of the analgesic is too high for IV administration, necessitating a new order

D) Respiratory depression of the woman or fetus is not a concern with this analgesic

327. On examining a woman who gave birth 5 hours ago, the nurse finds that the woman has completely saturated a perineal pad within 15 minutes. The nurse’s first action is to:

*** A) Massage the woman’s fundus**

B) Call the woman’s primary health care provider

C) Assess the woman’s vital signs

D) Begin an IV infusion of Ringer’s lactate solution -

328. The most prevalent clinical manifestation of abruptio placentae (as opposed to placenta previa) is:

*** A) Intense abdominal pain**

B) Bleeding

C) Cramping

D) Uterine activity

329. The client is admitted to the intensive care department (ICD) experiencing status epilepticus. Which collaborative intervention should the nurse anticipate?

*** A) Administer an anticonvulsant medication intravenous push.**

B) Assess the client’s neurological status every hour.

C) Monitor the client’s heart rhythm via telemetry.

D) Prepare to administer a glucocorticosteroid orally.

330. The male nurse is helping his friend cut wood with an electric saw. His friend cut two fingers of his left hand off with the saw. Which action should the nurse implement first?

*** A) Apply pressure to the radial artery of the left hand.**

B) Wrap the left hand with towels and apply pressure.

C) Instruct the neighbor to hold his hand above his head.

D) Go into the neighbor’s house and call 911.

331. The nurse is planning to meet the hygiene needs of a patient. Which is the fi rst assessment to be performed by the nurse?

*** A) Determine the patient’s preferences about hygiene practices**

B) Assess the patient’s ability to assist in hygiene activities

C) Collect the patient’s toiletries needed for the bath

D) Recognize the patient’s developmental stage

332. The nurse gives a bed-bound patient a bed bath. The primary reason the nurse provides hygiene to this patient is to:

*** A) Remove excess oil, perspiration, and bacteria by mechanical cleansing**

B) Support a sense of well-being by increasing self-esteem

C) Exercise muscles by contraction and relaxation of muscles when bathing

D) Promote circulation by stimulating the skin’s peripheral nerve endings

333. The nurse is bathing a febrile patient. The nurse should use tepid bath water to:

*** A) Increase heat loss**

B) Remove surface debris

C) Reduce surface tension of skin

D) Stimulate peripheral circulation

334. The nurse must make the decision to give a patient a full or partial bed bath. This decision depends on the:

*** A) Immediate needs of the patient**

B) Physician’s order for the patient’s activity

C) Time of the patient’s last bath

D) Wishes of the patient

335. The nurse is planning to shampoo the hair of a patient who has an order for bed rest. What should the nurse do first?

*** A) Brush the hair to remove tangles**

B) Tape eye shields over both eyes

C) Encourage the use of dry shampoo

D) Wet hair thoroughly before applying shampoo

336. A patient with impaired mobility is to be discharged within a week from the hospital. Which is the best example of a discharge goal for this patient? The patient will:

*** A) Transfer independently to a chair**

B) Be kept clean and dry

C) Be taught range-of-motion exercises

D) Understand range-of-motion exercises

337. The nurse concludes that a patient has the potential for impaired mobility. Which assessment refl ects a risk factor that precipitated this conclusion?

*** A) Limited range of motion**

B) Increased respiratory rate

C) Sedentary lifestyle

D) Exertional fatigue

338. The client’s platelet count is 30,000/mm3. What is the nurse’s first best action?

*** A) Institute bleeding precautions.**

B) Document the report as the only action.

C) Administer oxygen by nasal cannula.

D) Notify the physician.

339. During assessment of a client at risk for hematologic problems, the nurse palpates the client's spleen just below the ribs on the left side. What is the nurse’s best action?

*** A) Notify the physician.**

B) Document the finding as the only action.

C) Ask about a history of mononucleosis.

D) Apply an abdominal binder.

340. What is the most likely contributing factor for the laboratory result of the iron level being 42 mg/dL in a 45-year-old woman?

*** A) Heavy menses for the past 6 months**

B) 60 pack-year smoking history

C) Diet chronically low in vegetables and high in meats and fats

D) Presence of chronic allergies, for which she takes diphenhydramine (Benadryl) daily

341. Why is the transplantation of bone marrow cells separated from the preconditioning chemotherapy regimen by at least 2 days?

*** A) To ensure all chemotherapy is cleared and cannot exert killing effects on the transplanted cells**

B) To prevent a more profound neutropenic response

C) To give the client a rest period before the vigorous therapeutic regimen begins

D) To allow the client to recover from the severe nausea and vomiting caused by the conditioning chemotherapy

342. A client has received thrombolytic therapy after having a myocardial infarction. Which clinical manifestation would indicate to the nurse that reperfusion has been successful?

*** A) The onset of ventricular dysrhythmias**

B) ST-segment depression

C) Cessation of diaphoresis

D) Sudden onset of pleuritic chest pain

343. The client with acute MI had a stroke 1 month ago. Which of the following statements is correct regarding the administration of thrombolytic therapy?

*** A) The stroke is an absolute contraindication for administration of this therapy.**

B) The stroke should not affect administration of this therapy.

C) The stroke is a relative contraindication to administration of this therapy.

D) The stroke indicates increased risk for an extension of the current MI.

344. When two nursing diagnoses appear closely related, what should the nurse do first to determine which diagnosis most accurately reflects the needs of the patient?

*** A) Review the defining characteristics**

B) Analyze the secondary to factors

C) Reassess the patient

D) Examine the related to factors

345. The client with a myocardial infarction has been treated with thrombolytic therapy. Which intervention would reduce the risk of complications associated with this therapy?

*** A) Administration of heparin**

B) Application of ice to the injection site

C) Placing the client in Trendelenburg position

D) Instructing the client to take slow, deep breaths

346. The nurse performs an assessment of a newly admitted patient. The nurse understands that this admission assessment is conducted primarily to:

*** A) Identify important data**

B) Establish a therapeutic relationship

C) Ensure that the patient’s skin is intact

D) Diagnose if the patient is at risk for falls

347. The nurse identifies that the patient statement that provides subjective data is:

*** A) “I’m not sure that I am going to be able to manage at home by myself.”**

B) “I can call a home-care agency if I feel I need help at home.”

C) “What should I do if I have uncontrollable pain at home?”

D) “Will a home health aide help me with my care at home?”

348. The nurse understands that evaluation most directly relates to which aspect of the Nursing Process?

*** A) Goal**

B) Problem

C) Etiology

D) Implementation

349. A nurse observes yellow-tinged sclera on a client with dark skin. Based on this observation, what is the nurse’s best action?

*** A) Inspect the client’s oral mucosa and hard palate for other indications of jaundice.**

B) Examine the soles of the client's feet.

C) Nothing; this is a normal finding in all people with dark skin.

D) Notify the physician of the possibility that the client has a liver or hemolytic

350. Which of the following precautions taught to a client who is prescribed to take the platelet inhibitor abciximab (ReoPro) is specific to only this drug?

*** A) Observing for skin rashes or difficulty breathing**

B) Moving slowly when changing from a sitting position to a standing position

C) Stopping the drug at least 10 days before having planned surgery or dental work

D) Observing stools for color changes, such as bright red or tarry appearance, that may indicate GI bleeding

351. Which of the following clinical manifestations in a client taking a nonselective beta-blocking agent should the nurse explore as a complication of drug therapy?

*** A) Wheezing**

B) Headache

C) Postural hypotension

D) Nonproductive cough

352. How should the nurse assess for the presence of bruises in a client with dark skin who experienced blunt trauma to the right thigh?

*** A) Compare the contour and skin color of the injured area with the same area on the left thigh.**

B) Press a glass slide against the skin over the injured area and determine whether or not the skin blanches.

C) Use the back of the hand to compare the skin temperature on the area of trauma to the same area of the left thigh.

D) Palpate for and compare the popliteal and pedal pulses in both distal extremities.

353. Which nutritional group should the nurse teach the diabetic client with normal renal function to rigidly control to reduce the complications of diabetes?

*** A) Fats**

B) Carbohydrates

C) Fiber

D) Proteins

354. Which laboratory value indicates inadequate functioning of a transplanted pancreas?

*** A) 50\% decrease in urine amylase level**

B) Elevated bilirubin level

C) Blood urea nitrogen >30 mg/dL

D) Total white blood cell count <5000/mm3

355. A nurse is monitoring the labor of a client who is receiving IV oxytocin (Pitocin) at 6 mL per hour. Which of the following clinical signs would lead the nurse to stop the infusion?

*** A) Change in fetal heart rate from 128 to 102 bpm**

B) Change in maternal pulse rate from 76 to 98 bpm

C) Maternal blood pressure of 150/100

D) Maternal temperature of 102.4oF

356. There are four clients in active labor in the labor suite. Which of the women should the nurse monitor carefully for the potential of uterine rupture?

*** A) Age 25, G4P3003, last delivery by cesarean section**

B) Age 32, G2P0100, first baby died during labor

C) Age 22, G1P0000, eclampsia

D) Age 15, G3P0020, in active labor

357. A client is about to receive an intravenous dose of adenosine (Adenocard) for prolonged supraventricular tachycardia. What immediate response to this medication should the nurse expect

*** A) A short period of asystole**

B) Hypertensive crisis

C) Increased intraocular pressure

D) A brief tonic-clonic seizure

358. Based on genetic testing of a newborn, a diagnosis of dwarfism was made. The parents ask the nurse if this could happen to future children. Because this is an example of autosomal dominant inheritance, the nurse would tell the parents:

*** A) "For each pregnancy, there is a 50/50 chance the child will be affected by dwarfism."**

B) "This will not happen again because the dwarfism was caused by the harmful genetic effects of the infection you had during pregnancy."

C) "For each pregnancy there is a 25\% chance the child will be a carrier of the defective gene but unaffected by the disorder."

D) "Because you already have had an affected child there is a decreased chance for this to happen in future pregnancies."

359. A female carries the gene for hemophilia on one of her X chromosomes. Now that she is pregnant she asks the nurse how this might affect her baby. The nurse should tell her:

*** A) Hemophilia is always expressed if a male inherits the defective gene.**

B) A female baby has a 50\% chance of also being a carrier.

C) A male baby can be a carrier or have hemophilia.

D) Female babies are never affected by this disorder

360. When palpating the small breasts of a young slender woman, the nurse should:

*** A) Follow a systematic, overlapping pattern**

B) Wear sterile gloves

C) Lift hands when moving from one segment of the breast to another

D) Use both hands

361. A nurse instructed a female client regarding self-examination of the external genitalia. Which of the statements made by the client will require further instruction? I will:

*** A) Use the examination to determine when I should get medications at the pharmacy for yeast infections**

B) Perform this examination at least once a month especially if I change sexual partners or am sexually active

C) Become familiar with how my genitalia look and feel so that I will be able to detect changes

D) Wash my hands thoroughly before and after I examine myself

362. A women's health nurse practitioner is going to perform a pelvic examination on a female client. Which of the following nursing actions would be least effective in enhancing the client's comfort and relaxation during the examination?

*** A) Ask the client questions as the examination is performed**

B) Encourage the client to ask questions and express feelings and concerns before and after the examination

C) Allow the client to keep her shoes and socks on when placing her feet in the stirrups

D) Instruct the client to place her hands over her diaphragm and take deep, slow breaths

363. When assessing women, it is important for the nurse to keep in mind the possibility that they are victims of violence. The nurse should:

*** A) Use an abuse assessment screen during the assessment of every woman**

B) Recognize that abuse rarely occurs during pregnancy

C) Assess a woman's legs and back as the most commonly injured areas

D) Notify the police immediately if abuse is suspected

364. A 50-year-old woman asks the nurse practitioner about how often she should be assessed for the common health problems women of her age could experience. The nurse would recommend:

*** A) A fecal occult blood test annually**

B) An endometrial biopsy every 3 to 4 years

C) A mammogram every other year

D) Bone mineral density testing annually

365. Which of the following statements is most accurate regarding persons who should participate in preconception counseling?

*** A) All women and their partners as they make decisions about their reproductive future including becoming parents**

B) All women during their childbearing years

C) Sexually active women who do not use birth control

D) Women with chronic illnesses such as diabetes who are planning to get pregnant

366. Which of the following women is at greatest risk for developing hypogonadotropic amenorrhea?

*** A) 13-year-old figure skater**

B) 48-year-old woman experiencing perimenopausal changes

C) 18-year-old softball player

D) 30-year-old breastfeeding woman

367. Pharmacologic preparations can be used to treat primary dysmenorrhea. Choose the preparation that would be least effective in relieving the symptoms of primary dysmenorrhea.

*** A) Acetaminophen (Tylenol)**

B) Ibuprofen (Motrin)

C) Oral contraceptive pill (OCP)

D) Naproxen sodium (Anaprox)

368. Women experiencing primary dysmenorrhea should be advised to avoid what food?

*** A) Red meats**

B) Asparagus

C) Cranberry juice

D) Whole-grain cereals

369. The nurse counseling a 30-year-old woman regarding effective measures to use to relieve symptoms associated with premenstrual syndrome (PMS) could suggest:

*** A) Avoid tobacco, alcohol, and caffeine**

B) Decrease intake of fruits especially peaches and watermelon

C) Reduce exercise during the luteal phase of the menstrual cycle when symptoms are at their peak

D) Maintain a salt intake of 6 g/day or less

370. A pregnant woman with four children reports the following obstetric history: a stillbirth at 32 weeks' gestation, triplets (2 sons and a daughter) born via cesarean section at 30 weeks' gestation, a spontaneous abortion at 8 weeks' gestation, and daughter born vaginally at 39 weeks' gestation. Which of the following accurately expresses this woman's current obstetric history using the 5-digit system?

*** A) 5-1-2-1-4**

B) 5-1-4-1-4

C) 4-1-3-1-4

D) 5-2-2-0-3

371. An essential component of prenatal health assessment of pregnant women is the determination of vital signs. An expected change in vital signs findings as a result of pregnancy would be:

*** A) Increased awareness of the need to breathe as pregnancy progresses**

B) Increase in systolic blood pressure by 30 mm Hg or more after assuming a supine position

C) Increase in diastolic BP by 5-10 mm Hg beginning in the first trimester

D) Gradual decrease in baseline pulse rate of approximately 20 beats per minute

372. A woman exhibits understanding of instructions for performing a home pregnancy test to maximize accuracy if she:

*** A) Records the day of her last normal menstrual period and her usual cycle length**

B) Uses urine collected at the end of the day, just before going to bed

C) Avoids using Tylenol or aspirin for a headache for about 1 week prior to performing the test

D) Performs the test on the day after she misses her first menstrual period

373. During an examination of a pregnant woman the nurse notes that her cervix is soft on its tip. The nurse would document this finding as

*** A) Goodell sign**

B) Friability

C) Chadwick sign

D) Hegar sign

374. A nurse teaching a pregnant woman about the importance of iron in her diet would tell her to avoid consuming which of the following foods at the same time as her iron supplement because it will decrease iron absorption?

*** A) Eggs**

B) Tomatoes

C) Strawberries

D) Meat

375. A 25-year-old pregnant woman is at 10 weeks' gestation. Her BMI is calculated to be 24. Which one of the following is recommended in terms of weight gain during pregnancy?

*** A) First trimester weight gain of 1 to 2.5 kg**

B) Total weight gain of 18 kg

C) Weight gain of 0.4 kg each week for 40 weeks

D) Weight gain of 3.0 kg per month during the second and third trimester

376. A pregnant woman at 6 weeks' gestation tells her nurse-midwife that she has been experiencing nausea with occasional vomiting every day. The nurse could recommend which of the following as an effective relief measure?

*** A) Alter eating patterns to small meals every 2 to 3 hours**

B) Eat starchy foods such as buttered popcorn or peanut butter with crackers in the morning before getting out of bed

C) Avoid eating before going to bed at night

D) Skip a meal if nausea is experienced

377. A woman demonstrates an understanding of the importance of increasing her intake of foods high in folic acid when she includes which of the following foods in her diet?

*** A) Legumes**

B) Seafood

C) Corn

D) Cheese

378. A 30-year-old woman at 16 weeks' gestation comes for a routine prenatal visit. Her 24-hour dietary recall is evaluated by the nurse. Which of the following entries would indicate that this woman needs further instructions regarding nutrient needs during pregnancy?

*** A) Servings up to 10 ounces total from the meat, poultry, fish, dry beans, eggs, and nuts group**

B) Total kcal intake is 300 kcal above her calculated prepregnancy needs

C) Daily iron supplement taken at bedtime with a glass of orange juice

D) Four servings from the milk, yogurt, cheese group

379. A woman’s last menstrual period (LMP) began on November 9, 2003, and it ended on November 14, 2010. Using Nagele's rule, the estimated date of birth would be:

*** A) August 16, 2011**

B) February 2, 2011

C) July 6, 2011

D) August 21, 2011

380. A woman at 30 weeks' gestation assumes a supine position for a fundal measurement and Leopold maneuvers. She begins to complain about feeling dizzy and nauseous. Her skin feels damp and cool. The nurse's first action would be to:

*** A) Turn the woman on her side**

B) Assess the woman's respiratory rate and effort

C) Provide the woman with an emesis basin

D) Elevate the woman's legs 20 degrees from her hips

381. During an early bird prenatal class a nurse teaches a group of newly diagnosed pregnant women about their emotional reactions during pregnancy. Which of the following should the nurse discuss with the women?

*** A) A quiet period of introspection is often experienced around the time a woman feels her baby move for the first time**

B) Sexual desire (libido) is decreased throughout pregnancy

C) A referral for counseling should be sought if a woman experiences conflicting feelings about her pregnancy especially in the first trimester

D) The need to seek safe passage and prepare for birth begins early in the second trimester

382. The nurse evaluates a pregnant woman's knowledge about prevention of urinary tract infections at the visit following a class on infection prevention that the woman attended. The nurse would recognize that the woman needs further instruction when she tells the nurse about which one of the following measures that she now uses to prevent urinary tract infections:

*** A) "I drink about one quart of fluid a day."**

B) "I have stopped using bubble baths and bath oils."

C) "I have started wearing panty hose and underpants with a cotton crotch."

D) "I drink cranberry juice instead of orange juice and have yogurt for lunch."

383. Following administration of fentanyl (Sublimaze) IV for labor pain, a woman's labor progresses more rapidly than expected. The physician orders that a stat dose of naloxone (Narcan) 0.1 mg be administered intravenously to the woman to reverse respiratory depression in the newborn after its birth. In fulfilling this order the nurse would:

*** A) Assess the woman's level of pain since it will return abruptly**

B) Observe maternal pulse for bradycardia

C) Recognize that the dose is too low

D) Recognize that the dose is too high Observe maternal pulse for tachycardia

384. An anesthesiologist is preparing to begin a continuous epidural block using a combination local Anesthe tic and opioid agonist analgesic as a pain relief measure for a laboring woman. Nursing measures related to this type of nerve block would be:

*** A) Assist the woman into a modified Sims position or upright position with back curved**

B) Keep the woman in a semirecumbent position after administration to ensure equal distribution of the pharmacologic agents

C) Assess the woman for headaches especially after birth

D) Assist the woman to urinate every 4 hours to prevent bladder distention

385. A laboring woman's uterine contractions are being internally monitored. When evaluating the monitor tracing, which of the following findings would be a source of concern and require further assessment?

*** A) Average resting pressure of 20 to 25 mm Hg**

B) Frequency every V-h to 3 minutes

C) Duration of 80 to 85 seconds

D) Intensity during a uterine contraction of 85 to 90 mm Hg

386. External electronic fetal monitoring will be used for a woman just admitted to the labor unit in active labor. A guideline the nurse should follow when implementing this form of monitoring would be:

*** A) Apply contact gel to the ultrasound transducer prior to application over the point of maximum intensity**

B) Reposition the ultrasound transducer every hour and massage the site

C) Apply a spiral electrode if nonreassuring FHR signs are noted

D) Use Leopold maneuvers to determine correct placement of the tocotransducer

387. The nurse caring for women in labor should be aware of signs characterizing reassuring FHR patterns. A reassuring sign would be:

*** A) Moderate baseline variability**

B) Average baseline FHR of 90 to 110 BPM

C) Transient episodic deceleration with movement

D) Late deceleration patterns approximately every three or four contractions

388. A laboring woman's temperature is elevated as a result of an upper respiratory infection. The FHR pattern that reflects maternal fever would be:

*** A) Tachycardia**

B) Early decelerations

C) Diminished variability

D) Variable decelerations

389. A nulliparous woman is in the active phase of labor and her cervix has progressed to 6 cm dilatation. The nurse caring for this woman evaluates the external monitor tracing and notes the following: decrease in FHR shortly after onset of several uterine contractions returning to baseline rate by the end of the contraction; shape is uniform. Based on these findings the nurse should:

*** A) Document the finding on the woman's chart**

B) Notify the physician

C) Perform a vaginal examination to check for cord prolapse

D) Change the woman's position to her left side

390. A primigravida calls the hospital and tells a nurse on the labor unit that she knows that she is in labor. The nurse's initial response would be:

*** A) "Tell me why you know that you are in labor."**

B) "How far do you live from the hospital?"

C) "How far along are you in your pregnancy?"

D) "Have your membranes ruptured?"

391. A woman's amniotic membranes have apparently ruptured. The nurse assesses the fluid to determine its characteristics and confirm membrane rupture. An expected assessment finding would be:

*** A) Pale straw colored fluid with white flecks**

B) Strong odor

C) Absence of ferning

D) pH 5.5

392. A vaginal examination is performed on a multiparous woman who is in labor. The results of the examination were documented as: 4 cm, 75\%, +2, LOT. An accurate interpretation of this data would be:

*** A) Presentation is vertex**

B) Lie is transverse

C) Woman is in the latent phase of the first stage of labor

D) Station is 2 cm above the ischial spines

393. A nulliparous woman is in active labor. She is considered to be at low risk for complications. Which of the following is a standard recommendation for assessment during this phase of labor?

*** A) FHR—every 15 to 30 minutes**

B) Temperature—twice per shift once membranes rupture

C) Vaginal examination to determine progress of dilatation and effacement—every hour

D) Maternal blood pressure, pulse, respirations—every hour

394. A physical care measure for a laboring woman that has been identified as unlikely to be beneficial and may even be harmful would be:

*** A) Administering a Fleet enema at admission**

B) Ambulating periodically throughout labor as tolerated

C) Using a whirlpool bath once active labor is established

D) Allowing the laboring woman to drink fluids and eat light solids as tolerated

395. A nurse has assessed a woman who gave birth vaginally 12 hours ago. Which of the following findings would require further assessment?

*** A) Fundus firm at level of umbilicus and to the right of midline**

B) Bright to dark red uterine discharge—\% of pad saturated in 2 to 3 hours

C) Midline episiotomy—approximated, moderate edema, slight erythema, absence of ecchymosis

D) Protrusion of abdomen with sight separation of abdominal wall muscles

396. The nurse is assessing the laboratory report of a 40-week gestation client. Which of the following values would the nurse expect to find elevated above prepregnancy levels?

*** A) Fibrinogen.**

B) Glucose.

C) Hematocrit.

D) Bilirubin.

397. When analyzing the need for health teaching of a prenatal multigravida, the nurse should ask which of the following questions?

*** A) “Do you ever drink alcohol?”**

B) “What are the ages of your children?”

C) “What is your marital status?”

D) “Do you have any allergies?”

398. Because nausea and vomiting are such common complaints of pregnant women, the nurse provides anticipatory guidance to a 6-week gestation client by telling her to do which of the following?

*** A) Avoid eating greasy foods.**

B) Drink orange juice before rising.

C) Drink 2 glasses of water with each meal.

D) Eat 3 large meals plus a bedtime snack.

399. A client enters the prenatal clinic. She states that she missed her period yesterday and used a home pregnancy test this morning. She states that the results were negative, but “I still think I am pregnant.” Which of the following statements would be appropriate for the nurse to make at this time?

*** A) “We could do a blood test to check.”**

B) “Your period is probably just irregular.”

C) “Home pregnancy test results are very accurate.”

D) “My recommendation would be to repeat the test in one week.”

400. A gravida, G1 P0000, is having her first prenatal physical examination. Which of the following assessments should the nurse inform the client that she will have that day?

*** A) Pap smear.**

B) Mammogram.

C) Glucose challenge test.

D) Biophysical profile.

401. A 10-week gravid client is being seen in the prenatal clinic. For the nurse caring for this patient, providing anticipatory guidance for which of the following should be a priority?

*** A) Methods to relieve backaches.**

B) Pain management during labor.

C) Breastfeeding positions.

D) Characteristics of the newborn.

402. The nurse is circulating on a cesarean delivery of a G5P4004. All of the client's previous children were delivered via cesarean section. The physician declares after delivering the placenta that it appears that the client has a placenta accreta. Which of the following maternal complications would be consistent with this diagnosis?

*** A) Blood loss of 2000 mL**

B) Shortened prothrombin time

C) Jaundice skin color

D) Blood pressure of 160/110

403. A postpartum client has been diagnosed with deep vein thrombosis. For which of the following additional complications is this client high risk?

*** A) Stroke**

B) Hemorrhage

C) Endometritis

D) Hematoma

404. A mother, G4P4004, is 15 minutes postpartum. Her baby weighed 4595 grams at birth. For which of the following complications should the nurse monitor this client?

*** A) Hemorrhage**

B) Seizures

C) Infection

D) Thrombosis

405. A client is receiving IV heparin for deep vein thrombosis. Which of the following medications should the nurse obtain from the pharmacy to have on hand in case of heparin overdose?

*** A) Protamine**

B) Mannitol

C) Vitamin E

D) Vitamin K

406. A nurse massages the atonic uterus of a woman who delivered 1 hour earlier. The nurse identifies the nursing diagnosis: Risk for injury related to uterine atony. Which of the following outcomes indicates that the client's condition has improved?

*** A) Moderate lochia flow**

B) Fundus above the umbilicus

C) Stable blood pressure

D) Decreased pain level

407. A woman has just had a macrosomic baby after a 12-hour labor. For which of the following complications should the woman be carefully monitored?

*** A) Uterine atony**

B) Mastitis

C) Infection

D) Hypoprolactinemia

408. A nurse is assessing a 1 day-postpartum client who had a spontaneous vaginal delivery over an intact perineum. The fundus is firm at the umbilicus, lochia moderate, and perineum edematous. One hour after receiving ibuprofen 600 mg po, the client is complaining of perineal pain at level 9 on a 10 point scale. Based on this information, which of the following is an appropriate conclusion for the nurse to make about the client?

*** A) She should be assessed by her doctor**

B) She needs a narcotic analgesic

C) She may have a hidden laceration

D) She should have a sitz bath

409. A woman, contracting every 3 min _ 60 seconds, suddenly develops an amniotic fluid embolism. Which of the following signs/symptoms would the nurse observe?

*** A) Chest pain with dyspnea and cyanosis**

B) Precipitous dilation and expulsion of the fetus

C) Intense and unrelenting uterine pain

D) Sudden gush of fluid from the vagina

410. The nurse caring for a pregnant woman at 32 weeks' gestation with the diagnosis of severe preeclampsia with pulmonary edema is assisting with the insertion of a pulmonary artery catheter. As the catheter enters the right ventricle, the main priority of nursing assessments is to:

*** A) Monitor for premature ventricular contractions**

B) Observe for complaint of sudden chest pain

C) Assess fetal response to the procedure

D) Monitor maternal vital signs, especially blood pressure changes

411. A 25-year-old gravida 2, para 2-0-0-2 gave birth 4 hours ago to a 9-pound, 7-ounce boy after augmentation of labor with Pitocin. She puts on her call light and asks for her nurse right away, stating, “I’m bleeding a lot.” The most likely cause of postpartum hemorrhage in this woman would be:

*** A) Uterine atony**

B) Puerperal infection

C) Unrepaired vaginal lacerations

D) Retained placental fragments

412. A 26-year-old pregnant woman, gravida 2, para 1 0 0 1, is 28 weeks pregnant when she experiences bright red, painless vaginal bleeding. Upon her arrival at the hospital, what would be an expected diagnostic procedure?

*** A) Ultrasound for placental location**

B) Amniocentesis for fetal lung maturity

C) Internal fetal monitoring

D) Contraction stress test

413. A pregnant woman's amniotic membranes rupture. Prolapsed cord is suspected. Which of the following interventions would be the top priority?

*** A) Place the woman in the knee-chest position**

B) Cover the cord in sterile gauze soaked in saline

C) Prepare the woman for a cesarean birth

D) Start oxygen by face mask

414. The perinatal nurse is caring for a woman in the immediate postbirth period. Assessment reveals that the woman is experiencing profuse bleeding. The most likely etiology for the bleeding is:

*** A) Uterine atony**

B) Vaginal laceration

C) Vaginal hematoma

D) Uterine inversion

415. A primary nursing responsibility when caring for a woman experiencing an obstetric hemorrhage associated with uterine atony is to:

*** A) Fundal massage**

B) Establish venous access

C) Catheterize the bladder

D) Prepare the woman for surgical intervention

416. The nurse in the obstetric clinic received a telephone call from a bottlefeeding mother of a 3-day-old. The client states that her breasts are firm, red, and warm to the touch. Which of the following is the best action for the nurse to advise the client to perform?

*** A) Intermittently apply ice packs to her axillae and breasts.**

B) Apply lanolin to her breasts and nipples every 3 hours.

C) Express milk from the breasts every 3 hours.

D) Ask the primary health care provider to order a milk suppressant.

417. The nurse monitors his or her postpartum clients carefully because which of the following physiological changes occurs during the early postpartum period?

*** A) Decreased blood volume**

B) Decreased urinary output

C) Increased blood pressure

D) Increased estrogen level

418. A client is receiving an epidural infusion of a narcotic for pain relief after a cesarean section. The nurse would report to the anesthesiologist if which of the following were assessed?

*** A) Respiratory rate 8 rpm**

B) Complaint of thirst

C) Urinary output of 250 cc/hr

D) Numbness of feet and ankles

419. A nurse is assessing a 1-day postpartum woman who had her baby by cesarean section. Which of the following should the nurse report to the surgeon?

*** A) Pad saturation every 30 minutes**

B) Fundus at the umbilicus

C) Nodular breasts

D) Pulse rate 60 bpm

420. The nurse is assessing the laboratory report on a 2-day postpartum G1P1001. The woman had a normal postpartum assessment this morning. Which of the following results should the nurse report to the primary health care provider?

*** A) Hematocrit—26\%**

B) White blood cells—12,500 cells/mm3

C) Hemoglobin—11 g/dL

D) Red blood cells—4,500,000 cells/mm3

421. A client, G1P0101, postpartum 1 day, is assessed. The nurse notes that the client's lochia rubra is moderate and her fundus is boggy 2 cm above the umbilicus and deviated to the right. Which of the following actions should the nurse take first?

*** A) Massage the woman's fundus**

B) Notify the woman's primary health care provider

C) Escort the woman to the bathroom to urinate

D) Check the quantity of lochia on the peripad

422. Why are obstetric clients most at high risk for cardiovascular compromise during the one hour immediately following a delivery?

*** A) Because the excess blood volume from pregnancy is circulating in the woman's periphery**

B) Because the weight of the uterine body is significantly reduced

C) Because the cervix is fully dilated and the lochia flows freely

D) Because the maternal blood pressure drops precipitously once the baby's head emerges

423. A 24-week-gravid client is being seen in the prenatal clinic. She states, “I have had a terrible headache for the past 2 days.” Which of the following is the most appropriate action for the nurse to perform next?

*** A) Take the woman’s blood pressure**

B) Inquire whether or not the client has allergies

C) Ask the woman about stressors at work.

D) Assess the woman’s fundal height

424. A woman has just been admitted to the emergency department subsequent to a head-on automobile accident. Her body appears to be uninjured. The nurse carefully monitors the woman for which of the following complications of pregnancy?

*** A) Placental abruption**

B) Placenta previa

C) Severe preeclampsia

D) Transverse fetal lie

425. A 25-year-old client is admitted with the following history: 12 weeks pregnant, vaginal bleeding, no fetal heart beat seen on ultrasound. The nurse would expect the doctor to write an order to prepare the client for which of the following?

*** A) Dilation and curettage**

B) Amniocentesis

C) Nonstress testing

D) Cervical cerclage

426. Which finding should the nurse expect when assessing a client with placenta previa?

*** A) Painless vaginal bleeding**

B) History of renal disease

C) Previous premature delivery

D) Severe occipital headache

427. A woman has been diagnosed with a ruptured ectopic pregnancy. Which of the following signs/symptoms is characteristic of this diagnosis?

*** A) Sharp unilateral pain**

B) Severe nausea and vomiting

C) Dark brown rectal bleeding

D) Marked hyperthermia

428. A client, G2P1001, telephones the gynecology office complaining of left-sided pain. Which of the following questions by the triage nurse would help to determine whether the one-sided pain is due to an ectopic pregnancy?

*** A) “When was the first day of your last menstrual period?”**

B) “Did you have any complications with your first pregnancy?”

C) “How old were you when you first got your period?”

D) “When did you have your pregnancy test done?”

429. A woman with a diagnosis of ectopic pregnancy is to receive medical intervention rather than a surgical interruption. Which of the following intramuscular medications would the nurse expect to administer?

*** A) Amethopterin (methotrexate)**

B) Prometrium (progesterone)

C) Pergonal (menotropins)

D) Decadron (desamethasone)

430. The nurse is caring for a client who was just admitted to the hospital to rule out ectopic pregnancy. Which of the following orders is the most important for the nurse to perform?

*** A) Report complaints of dizziness or weakness**

B) Document the time of the client’s last meal

C) Obtain urine for urinalysis and culture

D) Assess the client’s temperature

431. A gravid client, G6P5005, 24 weeks' gestation, has been admitted to the hospital for placenta previa. Which of the following is an appropriate long-term goal for this client?

*** A) The client will be symptom-free until at least 37 weeks' gestation**

B) The client will state an understanding of need for complete bedrest

C) The client will call her children shortly after admission

D) The client will have a reactive nonstress test on day 2 of hospitalization

432. A 32-weeks' gestation client states that she "thinks" she is leaking amniotic fluid. Which of the following tests could be performed to determine whether the membranes had ruptured?

*** A) Fern test**

B) Biophysical profile

C) Amniocentesis

D) Kernig sign

433. A nurse works in a clinic with a high adolescent pregnancy population. The nurse provides teaching to the young women in order to prevent which of the following high risk complications of pregnancy?

*** A) Preterm birth**

B) Polycythemia

C) Macrosomic babies

D) Gestational diabetes

434. A woman with a history of congestive heart disease is 36 weeks pregnant. Which of the following findings should the nurse report to the primary health care practitioner?

*** A) Dyspnea on exertion**

B) 4-pound weight gain in a month

C) Presence of striae gravidarum

D) Patellar reflexes +2

435. After transferring the client from the PACU to the surgical unit, the client's vital signs are T 98_F, P 106, R 24, and BP 88/40. The client is awake and oriented times three (3). The client's skin is pale and damp. Which intervention should the nurse implement first?

*** A) Elevate the feet and lower the head.**

B) Call the surgeon and report the vital signs.

C) Start an IV of D5RL with 20 mEq KCl at 125 mL/hour.

D) Monitor the vital signs every 15 minutes.

436. The nurse receives a report that the postoperative client received Narcan, an opioid antagonist, in PACU. Which client problem should the nurse add to the plan of care?

*** A) Risk for depressed respiratory pattern.**

B) Alteration in comfort.

C) Potential for infection.

D) Fluid and electrolyte imbalance.

437. The nurse and an unlicensed nursing assistant are caring for a group of clients on a medical unit. Which information provided by the assistant warrants immediate intervention by the nurse?

*** A) The client receiving Procrit, a biologic response modifier, has a T 99.2°, P 68, R 24, and BP of 198/102.**

B) The client diagnosed with cancer of the lung has a small amount of blood in the sputum collection cup.

C) The client diagnosed with chronic emphysema is sitting on the side of the bed and leaning over the bedside table.

D) The client receiving prednisone, a steroid, is complaining of an upset stomach after eating breakfast.

438. The client is four (4) hours post-lobectomy for cancer of the lung. Which assessment data warrant immediate intervention by the nurse?

*** A) The client has 450 mL of bright-red drainage in the chest tube.**

B) The client has an intake of 1500 mL IV and an output of 1000 mL.

C) The client is complaining of pain at a “10” on a 1–10 scale.

D) The client has absent lung sound on the side of the surgery.

439. The nurse has been assigned to care for a client diagnosed with peptic ulcer disease. When the nurse is evaluating care, which assessment data require further intervention?

*** A) A decrease in systolic BP of 20 mm Hg from lying to sitting.**

B) Bowel sounds auscultated fifteen (15) times in one (1) minute.

C) Belching after eating a heavy and fatty meal late at night.

D) A decreased frequency of distress located in the epigastric region.

440. The nurse is caring for clients on a medical unit. After the shift report which client should the nurse assess first?

*** A) The 78-year-old client with pressure ulcers who has a temperature of 102.3_F.**

B) The 34-year-old client who is quadriplegic and cannot move his arms.

C) The elderly client diagnosed with a CVA who is weak on the right side.

D) The young adult who is unhappy with the care that was provided last shift.

441. A nurse is triaging clients in an emergency department. Which client should be assigned as the highest priority?

*** A) A 55-year-old client experiencing dyspnea, diaphoresis, and chest pain.**

B) A 16-year-old client with a severe sunburn injury that is blistering.

C) A 40-year-old client with a leg laceration that appears to need stitches.

D) A 19-year-old college student who has headaches, diplopia, and a temperature of 102.8°F (39.3°C).

442. An explosion occurred at a nearby factory at 1800 hours. An emergency department charge nurse receives a call from the emergency management systems (EMS) personnel that 35 clients will be transported to the hospital within 10 minutes by ambulance. These clients were triaged at the scene as red and yellow according to the NATO mass casualty categories; others will be coming, and the unit is already short-staffed. Which action should the nurse initiate first?

*** A) Activate the hospital's emergency response plan.**

B) Contact the emergency department nursing director.

C) Notify other emergency nurses of the need for extra help.

D) Call a nearby hospital to determine if 15 clients could be rerouted.

443. A nurse working in a military hospital's emergency department receives a call that an unknown number of clients have been exposed to a nerve agent during a terrorist attack on a government center. Which medication should the nurse prepare to have readily available in sufficient quantities to treat the clients?

*** A) Atropine sulfate**

B) Labetalol (Trandate®)

C) Dopamine (Intropin®)

D) Phentolamine (Regitine®)

444. Five families of clients injured in an apartment fire have arrived at an emergency department to inquire about the health status of their family members. Which is the nurse's best action?

*** A) Ensure that there is a designated area for family staffed by available social workers or clergy**

B) Take the families to the triage area so they can be with their loved ones

C) Ask the families to wait in the waiting area until information is available

D) Direct families to a lounge where a receptionist will be keeping families informed

445. During resuscitation efforts in an emergency department, the spouse of a trauma victim tells a nurse that her husband has terminal cancer, has completed an advance health care directive (HCD), and does not want cardiopulmonary resuscitation (CPR). What should be the nurse's next action?

*** A) Inform the health-care provider (HCP) in charge of the resuscitation team.**

B) Contact medical records to see if the client's HCD is on file.

C) In honor of the client's wishes, stop the actions of the resuscitation team.

D) Document the spouse's statement in the client's medical record.

446. A client's wife is allowed to be present during resuscitation efforts for a client in an intensive care unit. Which statement made by a nurse is most correct and appropriate?

*** A) "Another staff member will be with you; I will show you where you can stand near your husband."**

B) "You can hold your loved one's hand; sometimes a recovering person remembers that touch."

C) "Because the resuscitation team needs to work quickly, you need to stay out of their way and not interfere."

D) "If the resuscitation efforts fail, the health-care provider will ask you if you want to terminate resuscitation efforts."

447. Members of a resuscitation team have arrived at a client's bedside with a defibrillator. A nurse and a nursing assistant are performing cardiopulmonary resuscitation (CPR). What should be the nurse's next action?

*** A) Continue with rescue breathing while the resuscitation team is applying the conduction pads.**

B) Stop CPR to apply the conduction pads and analyze the rhythm.

C) Complete a full minute of CPR, then apply the conduction pads and analyze the rhythm.

D) Continue with CPR while the resuscitation team is applying the conduction pads and analyzing the rhythm.

448. Five hours after attending a family reunion picnic, three members of a family are admitted to an emergency department with nausea, vomiting, and abdominal cramping. A nurse asks a series of questions as part of the admission assessment. Which should be the nurse's priority question?

*** A) "What food was served at the reunion?"**

B) "How many people were at the reunion?"

C) "Was anyone sick when they came to the reunion?"

D) "What is the relationship of the family members who are sick?"

449. An nurse in an emergency department is admitting an agitated young adult who tried to jump from a bridge after taking a hallucinogenic drug at a party. What should be the nurse's initial action?

*** A) Stay with the client to protect the client from self-harm until relieved.**

B) Administer medications to reverse the effects of the hallucinogenic drug.

C) Call the mental health unit to arrange for inpatient treatment.

D) Call security to be present to protect the staff from injury.

450. A young woman presents to an emergency department with palpitations, tachycardia, diaphoresis, chest pain, a feeling of choking, and paresthesias. The woman acknowledges a fear of closed spaces where it is difficult to escape and feelings of "impending doom." Suspecting that the woman is experiencing a panic attack, a nurse should:

*** A) remain with the client and talk her through slow deep-breathing.**

B) notify a health-care provider (HCP) to obtain an order for an antianxiety medication.

C) place the client in a treatment room closest to the nurse's station where she can be observed.

D) involve the client in some physical activity to divert her attention from her anxiety.

451. Four clients present to an emergency department at the same time. Which client should a nurse assess first?

*** A) A distraught 45-year-old known cocaine abuser who states he plans to kill himself with the gun he is carrying**

B) An intoxicated 30-year-old who fell and needs stitches for an arm laceration

C) A 22-year-old who states she was raped but feels guilty because she “may have brought it on herself.”

D) An 18-year-old who sustained second-degree hand burns while trying to hide evidence of a methamphetamine lab

452. The occupational health nurse is concerned about preventing occupation-related acquired seizures. Which intervention should the nurse implement?

*** A) Ensure that helmets are worn in appropriate areas.**

B) Implement daily exercise programs for the staff.

C) Provide healthy foods in the cafeteria.

D) Encourage employees to wear safety glasses.

453. The client is scheduled for an electroencephalogram (EEG) to help diagnose a seizure disorder. Which preprocedure teaching should the nurse implement?

*** A) Instruct the client to stay awake 24 hours prior to the EEG.**

B) Tell the client to take any routine anti-seizure medication prior to the EEG.

C) Tell the client not to eat anything for eight (8) hours prior to the procedure.

D) Explain to the client that there will be some discomfort during the procedure.

454. The nurse enters the room as the client is beginning to have a tonic-clonic seizure. What action should the nurse implement first?

*** A) Note the first thing the client does in the seizure.**

B) Assess the size of the client’s pupils.

C) Determine if the client is incontinent of urine or stool.

D) Provide the client with privacy during the seizure.

455. The client that just had a three (3)-minute seizure has no apparent injuries and is oriented to name, place, and time but is very lethargic and just wants to sleep. Which intervention should the nurse implement?

*** A) Turn the client to the side and allow him to sleep.**

B) Perform a complete neurological assessment.

C) Awaken the client every 30 minutes.

D) Interview the client to find out what caused the seizure.

456. The unlicensed nursing assistant is attempting to put an oral airway in the mouth of a client having a tonic-clonic seizure. Which action should the primary nurse take?

*** A) Tell the assistant to stop trying to insert anything in the mouth.**

B) Help the assistant to insert the oral airway in the mouth.

C) Take no action because the assistant is handling the situation.

D) Notify the charge nurse of the situation immediately.

457. Which statement would be an expected outcome when the circulating nurse evaluates the goal of the intraoperative client?

*** A) The client has no injuries from the OR equipment.**

B) The client has no postoperative infection.

C) The client has stable vital signs during surgery.

D) The client recovers from anesthesia.

458. A person’s right thumb was accidentally severed with an axe. The amputated right thumb was recovered. Which action would preserve the thumb so that it could possibly be reattached in surgery?

*** A) Secure the thumb in a plastic bag and place on ice.**

B) Place the right thumb directly on some ice.

C) Put the right thumb in a glass of warm water.

D) Wrap the thumb in a clean piece of material.

459. The nurse is caring for a client with a right below the knee amputation. There is a large amount of bright red blood on the client's residual limb dressing. Which intervention should the nurse implement first?

*** A) Assess the client's blood pressure and pulse.**

B) Notify the client's surgeon immediately.

C) Reinforce the dressing with additional dressing.

D) Check the client's last hemoglobin and hematocrit level.

460. When assessing the client six (6) hours after having a right total knee replacement, which data should the nurse report to the surgeon?

*** A) Urinary output of 60 mL of clear yellow urine in three (3) hours.**

B) A total of 100 mL of red drainage in the autotransfusion drainage system.

C) Pain relief after using the patient-controlled analgesia (PCA) pump.

D) Cool toes, distal pulses palpable, and pale nail beds bilaterally.

461. The nurse is assessing the client who is immediately postoperative from a total knee replacement. Which assessment data would warrant immediate intervention?

*** A) Pain in the unaffected leg during dorsiflexion of the ankle.**

B) T 99_F, HR 80, RR 20, and BP 128/76.

C) Bowel sounds heard intermittently in four quadrants.

D) Diffuse, crampy abdominal pain.

462. The nurse is completing the preoperative checklist. Which laboratory value should be reported to the surgeon immediately?

*** A) Potassium 3.2 mEq/L.**

B) Hemoglobin 13.1 g/dL.

C) Glucose 90 mg/dL.

D) White blood cells 6.0 mm (103).

463. In reviewing the laboratory report of white blood cell count with differential for a client receiving chemotherapy for cancer, all of the following results are listed. Which laboratory finding should alert the nurse to the possibility of sepsis?

*** A) The “bands” outnumber the “segs.”**

B) The total white blood cell count is 9000/mm3.

C) The lymphocytes outnumber the basophils.

D) The monocyte count is 1800/mm3.

464. The client comes to the emergency room with a fever, diarrhea, and general malaise. Which information obtained during assessment provides clues to the nature of this illness?

*** A) The client just returned from a 14-day trip to Asia.**

B) The client is 52 years of age.

C) The client is allergic to aspirin.

D) The client received a blood transfusion 12 years ago.

465. The nurse requests a client to sign the surgical consent form for an emergency appendectomy. Which statement by the client indicates that further teaching is needed?

*** A) “I will be glad when this is over so that I can go home.”**

B) “I will not be able to eat or drink anything prior to my surgery.”

C) “I need to practice relaxing by listening to my favorite music.”

D) “I will need to get up and walk as soon as possible.”

466. When preparing a client for surgery, which intervention should the nurse implement first?

*** A) Complete the preoperative checklist.**

B) Check the permit for the spouse’s signature.

C) Take and document intake and output.

D) Administer the “on call” sedative.

467. The 68-year-old client scheduled for intestinal surgery does not have clear fecal contents after three tap water enemas. Which intervention should the nurse implement first?

*** A) Notify the surgeon of the client's status.**

B) Continue giving enemas until clear.

C) Increase the client's IV fluid rate.

D) Obtain stat serum electrolytes.

468. While completing the preoperative assessment, the male client tells the nurse that he is allergic to codeine. Which intervention should the nurse implement first?

*** A) Ask the client what happens when he takes the drug.**

B) Apply an allergy bracelet on the client's wrist.

C) Label the client's allergies on the front of the chart.

D) Document the allergy on the medication administration record.

469. A patient has a cast from the hand to above the elbow because of a fractured ulna and radius. After the cast is removed, the nurse teaches the patient active range-of-motion exercises. The nurse identifies that further teaching is necessary when the patient:

*** A) Keeps the elbow fl exed after the procedure**

B) Puts the elbow through its full range at least three times

C) Assesses the elbows response after the procedure

D) Moves the elbow to the point of resistance

470. Which word is most closely associated with nursing care strategies to maintain functional alignment when patients are bed bound?

*** A) Support**

B) Balance

C) Strength

D) Endurance

471. The nurse places a patient with a sacral pressure ulcer in the left Sims' position. The nurse should place the patient's right arm:

*** A) On a pillow**

B) Behind the back

C) With the palm up

D) In internal rotation

472. The nurse is performing passive range-of-motion exercises for a patient who is in the supine position. Which motion occurs when the nurse bends the patient's ankle so that the toes are pointed toward the ceiling?

*** A) Adduction**

B) Dorsal flexion

C) Plantar extension

D) Supination

473. The nurse is caring for a patient with impaired mobility. Which position contributes most to the formation of a hip flexion contracture?

*** A) Orthopneic**

B) Sims'

C) Supine

D) Low Fowler's

474. A patient is diagnosed with a stage IV pressure ulcer with eschar. Which medical treatment should the nurse anticipate the physician will order for this patient?

*** A) Debridement of the wound**

B) Cleansing irrigations twice daily

C) Application of a topical antibiotic

D) Heat lamp treatment three times a day

475. The nurse knows that raising a patient’s arm over the head during range-of-motion exercises is called:

*** A) Flexion**

B) Supination

C) Opposition

D) Hyperextension

476. A patient with a history of thrombophlebitis should not have pressure exerted on the popliteal space. The nurse should avoid placing this patient in which position?

*** A) Contour**

B) Supine

C) Trendelenburg

D) Prone

477. The nurse plans to teach a patient with hemiparesis to use a cane. The nurse should teach the patient to:

*** A) Hold the cane in the strong hand when walking**

B) Look at the feet when walking

C) Adjust the cane height twelve inches lower than the waist

D) Move up a step with the weak leg fi rst followed by the strong leg and cane

478. The nurse is caring for a variety of patients, each experiencing one of the following problems. Which health problem places a patient at the greatest risk for complications associated with immobility?

*** A) Quadriplegia**

B) Incontinence

C) Hemiparesis

D) Confusion

479. Older adults often are afraid of falling. The nurse understands that the most common consequence associated with this concern is:

*** A) Decreased physical conditioning**

B) Self-imposed social isolation

C) Occurrence of panic attacks

D) Impaired skin integrity

480. The nurse is evaluating an ambulating patient's balance. It is most important that the nurse assess the patient's:

*** A) Respiratory rate**

B) Energy level

C) Strength

D) Posture

481. The practitioner orders a clear liquid diet for a patient. Which food should the nurse teach the patient to avoid when following this diet?

*** A) Ice cream**

B) Strong coffee

C) Decaffeinated tea

D) Strawberry Jell-O

482. The nurse is caring for a patient who is expending energy that is greater than the caloric intake. Which human response most likely will occur?

*** A) Malnutrition**

B) Anorexia

C) Hypertension

D) Fever

483. The nurse teaches a postoperative patient about foods high in protein that will promote wound healing. The nurse identifies that the teaching is successful when from a list of foods the patient selects:

*** A) Meat**

B) Milk

C) Bread

D) Vegetables

484. Which nutrient should the nurse encourage a patient to include in the diet to provide vitamin D?

*** A) Fortified milk**

B) Green leafy vegetables

C) Vegetable oils

D) Organ meats

485. The nurse is reviewing the laboratory fi ndings of a patient to assess the patient’s nutritional status. The nurse understands that the laboratory fi nding that is the best indicator of inadequate protein intake is a:

*** A) Low serum albumin**

B) High blood urea nitrogen

C) Low specifi c gravity

D) High hemoglobin

486. A patient of Asian heritage is recommended to follow a low-fat diet to lose weight. The nurse understands that a food low in fat that generally is consumed by members of an Asian population is:

*** A) Hot and sour soup**

B) Crispy noodles

C) Spareribs

D) Egg rolls

487. A patient is scheduled for surgery and the nurse is teaching the patient about the importance of vitamin C in wound healing. Which source of vitamin C should the nurse include in the teaching plan?

*** A) Potatoes**

B) Yogurt

C) Beans

D) Milk

488. The nurse is teaching a patient about the importance of balancing protein, carbohydrates, and fats in the diet. The nurse identifies that the teaching about carbohydrates is understood when the patient states, “Carbohydrates are best known for providing:

*** A) Energy.”**

B) Vitamins.”

C) Minerals.”

D) Electrolytes.”

489. A patient has been blind in one eye for several years because of the complications associated with diabetes mellitus. The patient is admitted to the hospital with a detached retina and resulting loss of sight in the other eye. What should the nurse do to assist this patient with meals?

*** A) Explain to the patient where items are located on the plate according to the hours of a clock**

B) Encourage eating one food at a time according to the preference of the patient

C) Order fi nger foods that are permitted on the patient’s diet

D) Feed the patient

490. The nurse understands that the balance of calcium in the body is unrelated to:

*** A) Iron**

B) Tetany

C) Vitamin D

D) Osteoporosis

491. A patient is admitted to the hospital with a history of liver dysfunction associated with hepatitis. The nurse understands that this patient may have problems with:

*** A) Emulsifying fats**

B) Digesting carbohydrates

C) Manufacturing red blood cells

D) Reabsorbing water in the intestines

492. The nurse is assessing a patient who is admitted to the hospital with withdrawal from alcohol. The nurse knows that excessive alcohol intake directly contributes to health problems because it:

*** A) Decreases the absorption of many important nutrients**

B) Lengthens passage time of stool through the intestinal tract

C) Accelerates the absorption of medications

D) Interferes with the absorption of glucose

493. An obese resident of a nursing home who is receiving a 1500-calorie weight reduction diet has not lost weight in the past 2 weeks. The nurse should:

*** A) Keep a log of the oral intake for 3 days**

B) Schedule a multidisciplinary team conference

C) Instruct the patient to limit intake to 1000 calories per day

D) Inform the primary care physician of the patient’s lack of progress

494. A patient with a Latino heritage is to eat a low-fat diet. The patient tells the nurse, “I am going to have a hard time giving up my favorite family recipes.” Which food should the nurse recommend that is low in fat and generally is included in the Latino culture?

*** A) Salsa**

B) Pasta

C) Steamed fish

D) Refried beans

495. The nurse understands that the setting that is the organizational center of the United States health-care system is the:

*** A) Acute care setting**

B) Clinic setting

C) Community setting

D) Long-term care setting

496. The nurse is providing dietary teaching to a group of adolescents recently diagnosed with diabetes mellitus. The nurse understands that many foods are ingested by the adolescent because of:

*** A) Pressure**

B) Taste

C) Routine

D) Preference

497. When the nurse assesses patients in the following age groups, the nurse understands that the age group that has the greatest potential to demonstrate regression when ill is:

*** A) Toddlers**

B) Infants

C) Adolescents

D) Young adults

498. The nurse identifies which word as being unrelated to principles of growth and development?

*** A) Unpredictable**

B) Sequential

C) Integrated

D) Complex

499. The nurse working in a nursing home is providing care to a group of older adults. The decline in which system in the older adult most often in? uences the ability to maintain safety?

*** A) Sensory**

B) Respiratory

C) Integumentary

D) Cardiovascular

500. One of the participants attending a parenting class asks the teacher, “What is the leading cause of death during the ? rst year of life?” Besides exploring the person’s concerns, the nurse should respond:

*** A) Congenital anomalies**

B) Preterm birth

C) Sudden infant death syndrome

D) Unintentional injuries

501. Which intervention may decrease the rate at which erythrocytes are produced?

*** A) Continuous administration of oxygen by nasal cannula or mask**

B) Multiple platelet transfusions

C) Subcutaneous administration of epoetin (Epogen, Procrit)

D) Repeated (daily) venous blood sampling for laboratory testing

502. Which statement regarding platelet function in hemostasis is true?

*** A) Platelet aggregation helps maintain blood vessel integrity during tissue trauma.**

B) Platelets are required for erythrocyte aggregation.

C) Platelet aggregation is dependent on adequate amounts of all clotting factors.

D) Platelet aggregation prevents the extension of clot formation beyond the area of injury.

503. What is the priority nursing diagnosis for a client with inadequate production of platelets?

*** A) Risk for Injury related to increased bleeding tendency**

B) Decreased Cardiac Output related to hypovolemia

C) Risk for Infection related to decreased antibody production

D) Impaired Gas Exchange related to decreased oxygen-carrying capacity

504. Which precaution should the nurse teach a client regarding health care after he or she has undergone a splenectomy?

*** A) “You will need to avoid crowds and people with infections because it is harder now for you to develop antibodies.”**

B) “You will no longer develop a fever when you have an infection, so you must learn to identify other symptoms of infection.”

C) “You will be at an increased risk for developing allergies, so it will be important for you to avoid common allergens.”

D) “You will need to have yearly checkups because your risk for cancer development is greater now.”

505. Which hematologic problem would the nurse expect the client with liver failure to have?

*** A) Prolonged bleeding after IM injections**

B) Elevated blood pressure from hypercellularity

C) Increased formation of thromboses in deep veins

D) Spontaneous bleeding from the gums and mucous membranes

506. The client asks his nurse why he was told to avoid aspirin and other salicylates for 2 weeks before surgery. What is the nurse's best response?

*** A) "These drugs decrease platelet aggregation and increase your risk for excessive bleeding."**

B) "These drugs can counteract the effects of certain anesthetics."

C) "These drugs are toxic to white blood cells and increase your risk for developing an infection."

D) "These drugs inhibit the bone marrow from making new blood cells and increase your risk for anemia."

507. Where is the best site to assess capillary refill on an 88-year-old client?

*** A) Lips**

B) Fingernails

C) Forehead

D) Toenails

508. How are anticoagulants and fibrinolytic agents different?

*** A) Anticoagulants inhibit blood clot formation and fibrinolytics degrade existing clots.**

B) Fibrinolytics and anticoagulants both thin the blood to prevent clot formation.

C) Fibrinolytics are taken orally and anticoagulants can only be given parenterally.

D) Anticoagulants work by interfering with clotting factor synthesis and fibrinolytics work by disrupting platelet aggregation.

509. Which statement, made by the client who is taking warfarin (Coumadin) daily to prevent blood clots from forming in deep veins, indicates a need for further discussion regarding this therapy?

*** A) “I have been eating more salads and other green, leafy vegetables to prevent constipation.”**

B) “I have two pairs of antiembolic stockings so that one pair can be washed each day.”

C) “Instead of a safety razor, I have been using an electric shaver to shave.”

D) “On hot days, I make sure I drink at least two quarts of water.”

510. The client is 22 days post transplant from an allogeneic bone marrow transplantation. The nurse observes that the client's sclera and hard palate are yellow. Which additional clinical manifestation supports the possibility of veno-occlusive disease (VOD)?

*** A) Weight gain of 8 pounds in the last 3 days**

B) Total white blood cell count of 2000 per mm3

C) Six to 10 watery stools per day for the last 3 days

D) Hard, ropelike consistency of the peripheral vein proximal to the IV site

511. The home care nurse observes a break in the catheter lumen while changing the central venous catheter dressing of a client after bone marrow transplantation. What is the nurse’s best first action?

*** A) Remove the central venous catheter.**

B) Document the observation.

C) Cover the break with sterile tape.

D) Clamp the catheter proximal to the break.

512. The client being discharged home after a bone marrow transplantation for leukemia asks why protection from injury is so important. What is the nurse’s best response?

*** A) “Platelet recovery is slower than white blood cell recovery and you remain at risk longer for bleeding than you do for infection.”**

B) “The transplanted bone marrow cells are very fragile and trauma could result in rejection of the transplant.”

C) “Trauma is likely to result in loss of skin integrity, increasing the risk for infection when you are already immunosuppressed.”

D) “The medication regimen after transplantation includes drugs that slow down cell division, making healing after any injury more difficult.”

513. The client who has been diagnosed with Hodgkin's lymphoma is scheduled for numerous tests. The client asks if these tests are really necessary, because the exact type of cancer has already been established. What is the nurse’s best response?

*** A) “Different treatments are used depending on where the cancer is, so it is first necessary to determine the exact sites.”**

B) “You may be eligible for new and experimental therapy. These tests will determine whether or not you would qualify for such treatment.”

C) “It is best to determine how healthy your major organs are before undergoing the strenuous and uncomfortable therapies for cancer.”

D) “The doctors want to be very sure, because it is possible to have two different kinds of cancer at the same time.”

514. The 27-year-old male client with Hodgkin's lymphoma in the abdominal and pelvic regions is about to start radiation therapy. What long-term side effect of this therapy should the nurse be sure that he understands?

*** A) Sperm production will be permanently disrupted.**

B) Constipation will be continuous throughout therapy.

C) Baldness from radiation therapy is likely to be permanent.

D) This treatment increases the risk for prostate cancer later in life.

515. What is the priority nursing diagnosis for a client newly diagnosed with autoimmune thrombocytopenic purpura?

*** A) Risk for Injury**

B) Impaired Gas Exchange

C) Impaired Skin Integrity

D) Acute Pain

516. Which laboratory test result indicates to the nurse that the factor VIII cryoprecipitate therapy for the client with hemophilia is effective?

*** A) Activated partial thromboplastin time of less than 30 seconds**

B) Hematocrit of 43\%

C) Platelet count of 200,000/mm3

D) Prothrombin time of 15 seconds (INR of 1.3)

517. How should the nurse modify the standard transfusion therapy procedure when administering a platelet transfusion?

*** A) Use a transfusion set that has short tubing and no filter.**

B) Warm the platelets to body temperature before initiating the transfusion.

C) Administer the platelet solution by rapid IV push instead of as an infusion.

D) Co-administer amphotericin B as prophylaxis against fungal contamination.

518. A nurse observes that the client, whose blood type is AB negative, is receiving a transfusion with type O negative packed red blood cells. What is the nurse’s best first action?

*** A) Take and record the client's vital signs.**

B) Call the blood bank.

C) Stop the transfusion and keep the IV open.

D) Document the observation as the only action.

519. What identification means should the nurse use to ensure that a blood transfusion is administered to the correct client?

*** A) Compare the name and ID number on the blood product tag with the name and ID number on the client’s ID band.**

B) Ask the client if his name is the one on the blood product tag.

C) Ask the client’s spouse if the client is the correct person who is to have the transfusion.

D) Compare the bed and room number of the client with the bed and room number listed on the blood product tag.

520. The client is prescribed to receive two units of packed red blood cells. When the blood products arrive, a nurse notes that the client's current IV is infusing Ringer's lactate solution. What should the nurse do in this situation?

*** A) Change the intravenous solution to normal saline.**

B) Change the intravenous solution to dextrose 5\% in water.

C) Hang the blood with the currently infusing solution.

D) Start an additional intravenous infusion site.

521. For which of the following blood products is ABO compatibility a requirement for administration?

*** A) Fresh frozen plasma**

B) Single-donor platelets

C) Pooled donor platelets

D) Granulocytes

522. The client, a Jehovah's Witness scheduled for surgery, has expressed concern that she might receive blood products, an act condemned by her religion. What is the nurse’s best response?

*** A) “Transfusions are not routine and there are now good alternatives to transfusions if you should lose an excessive amount of blood.”**

B) “You should allow the health care professionals to do whatever is needed to save your life.”

C) “Your chances of needing a transfusion during or after surgery are so small that this is not really a problem.”

D) “If you are worried about contamination, you could have members of your family make blood donations ahead of time specifically for you.”

523. Which type of transfusion reaction should the nurse assess for in the client who is receiving an autologous blood transfusion?

*** A) Bacterial**

B) Allergic

C) Febrile

D) Hemolytic

524. For which client receiving a blood transfusion should the nurse remain especially alert for the possible development of transfusion-associated graft-versus-host disease (TA-GVHD)?

*** A) 45-year-old man on immunosuppressant therapy after a kidney transplant**

B) 68-year-old man receiving an autologous transfusion after hip replacement surgery

C) 56-year-old woman who is AB-positive receiving a transfusion with O-negative blood products

D) 27-year-old pregnant woman with sickle cell anemia

525. By what pathophysiologic processes does atherosclerosis contribute to the development of coronary artery disease (CAD)?

*** A) Macrophages and T cells form a connective tissue matrix in the vessel intima where lipids accumulate.**

B) Atherosclerotic plaques cause spasm and subsequent narrowing of the coronary vessels.

C) Coronary vessels become inflamed and injured as a result of excess cholesterol and triglycerides.

D) Atherosclerosis causes coronary vessels to become stiff, limiting their ability to respond to increases in blood flow.

526. A nurse is taking the history of a client with suspected coronary artery disease. Recently, the client has had episodes of chest discomfort while mowing the lawn with a push mower. The chest discomfort subsides when the client rests. What conclusion can the nurse draw from this information?

*** A) The client may have stable angina**

B) The client may have variant angina.

C) The client may have had a myocardial infarction.

D) The client need not be concerned about this pain, because it is relieved with rest.

527. A client presents with a history of variant (Prinzmetal's) angina. What symptoms would the nurse expect to be manifested in this client?

*** A) Chest pain occurring with minimal exertion that limits the client's activity**

B) Chest discomfort that appears with exertion and is relieved with nitroglycerin

C) A burning sensation in the chest wall that is relieved with rest

D) Chest pressure or tightness that radiates to the arm and jaw

528. Which of the following would be considered a modifiable risk factor for coronary artery disease?

*** A) Smoking**

B) Age

C) Gender

D) Family history

529. An 82-year-old client is admitted with a suspected myocardial infarction. What specific clinical manifestation of myocardial infarction would the nurse expect to see in an older adult?

*** A) Disorientation or confusion**

B) Exophthalmos

C) Posterior wall chest pain

D) Numbness and tingling of the arm

530. Which of the following statements made by the client with CAD serves to alert the nurse that the client may be experiencing difficulty in adapting to the illness?

*** A) “I usually wait about 2 hours after I feel chest discomfort before calling my doctor to be sure it is really angina.”**

B) “I know I will have some chest discomfort with some activities, so I carry my nitroglycerin with me at all times.”

C) “When I was in the hospital last time for my heart attack, I felt afraid.”

D) “I feel a little anxious whenever I get chest discomfort.”

531. A client presents to the emergency department with complaints of substernal chest pain. Eight hours later, it is noted on laboratory assessment that myoglobin levels have not risen. What conclusion can be drawn from this information?

*** A) The client has not experienced a myocardial infarction.**

B) The client is experiencing an evolving myocardial infarction.

C) The client most likely had a myocardial infarction several days ago.

D) The client has experienced a myocardial infarction within the last 24 hours.

532. A client hospitalized for unstable angina has undergone laboratory assessment. Which laboratory test is most specific in diagnosing acute coronary syndrome?

*** A) Troponin T**

B) Serum LDH

C) Serum myoglobin

D) CK-MB isoenzyme

533. The client is diagnosed with acute myocardial infarction. Which laboratory test is most specific in diagnosing acute MI?

*** A) CK-MB isoenzyme**

B) Myoglobin

C) Serum LDH

D) Troponin T

534. The client with a myocardial infarction has undergone electrocardiography (ECG). What changes in the ECG tracing would the nurse expect to see in this client?

*** A) ST-segment elevation, T-wave inversion, abnormal Q wave**

B) ST-segment depression, flattened T wave, normal Q wave

C) ST-segment depression, T-wave inversion, normal Q wave

D) ST-segment inversion, T-wave elevation, abnormal Q wave

535. The client’s ECG reveals ST-segment depression and T-wave inversion in leads II, III, and aVF. What is the nurse’s interpretation of these findings?

*** A) The client is experiencing an anginal episode.**

B) The client is experiencing variant angina.

C) The client is experiencing acute MI.

D) The client is experiencing cardiac arrest.

536. A nurse is caring for a client admitted to the hospital with a complaint of chest pain. After receiving a total of three nitroglycerin sublingual tablets, the client states that there is no change in the level of discomfort experienced. What would be the nurse's best action?

*** A) Notify the health care provider.**

B) Place the client in a semi-Fowler's position.

C) Administer oxygen via a nasal cannula.

D) Administer morphine sulfate IV.

537. What is the priority nursing diagnosis for a client admitted with a medical diagnosis of acute myocardial infarction?

*** A) Acute Pain**

B) Potential for Heart Failure

C) Potential for Dysrhythmia

D) Altered Tissue Perfusion

538. Why is the administration of aspirin recommended along with nitroglycerin when a client is experiencing angina-like chest pain?

*** A) Aspirin inhibits platelet aggregation and clot formation.**

B) Aspirin has analgesic properties without sedation.

C) Aspirin can trigger vasodilation and improve blood flow.

D) Aspirin has cardiotonic properties and improves contraction.

539. A client brought to the emergency room has been diagnosed with an acute myocardial infarction. The physician has ordered thrombolytic therapy with reteplase (Retavase). What is the indication for this therapy?

*** A) This therapy restores perfusion to the injured area, reducing the size of the infarct.**

B) This therapy will reverse any myocardial damage if given within 2 hours of the event.

C) This therapy restores coronary reperfusion without risk of internal bleeding.

D) This therapy makes percutaneous transluminal coronary angioplasty (PTCA) unnecessary.

540. The client diagnosed with acute MI is to receive tenecteplase (TNKase). What is an advantage of this therapy over other fibrinolytic drugs?

*** A) TNKase is administered in a single bolus over 5 seconds.**

B) TNKase restores perfusion to coronary arteries.

C) TNKase limits damage to the myocardium.

D) TNKase decreases mortality in clients with MI.

541. What specific actions or precautions should the nurse use when providing care to a client receiving thrombolytic therapy with streptokinase instead of t-PA?

*** A) Observe the client for the presence of hives or shivering.**

B) Assess neurologic status every hour.

C) Observe all IV sites and wounds for bleeding.

D) Monitor the client for evidence of chest pain.

542. The client is undergoing progressive ambulation on the third day after a myocardial infarction. Which clinical manifestation would indicate to the nurse that the client should not yet be advanced to the next level?

*** A) Onset of chest pain**

B) Facial flushing

C) Heart rate increase of 10 beats/min at completion of ambulation

D) Systolic blood pressure increase of 10 mm Hg at completion of ambulation

543. A 44-year-old client who has had a myocardial infarction complies with the treatment regimen but avoids discussing the illness with health care providers and family members. What is the nurse’s interpretation of this client’s behavior?

*** A) The client is using denial.**

B) The client is clinically depressed.

C) The client is expressing underlying anger.

D) The client is demonstrating grief and loss.

544. A client who has experienced a myocardial infarction develops left ventricular heart failure. Which sign of poor organ perfusion should the nurse remain alert for?

*** A) Urine output of less than 30 mL/hr**

B) Headache

C) Hypertension

D) Heart rate of 55 to 60 beats/min

545. A client admitted to the coronary care unit with a myocardial infarction begins to develop increased pulmonary congestion, an increase in heart rate from 80 to 102 beats/min, and cold, clammy skin. What is the nurse's best first action?

*** A) Notify the physician.**

B) Increase the IV flow rate.

C) Place the client in supine position.

D) Prepare the client for emergency echocardiography.

546. The client with Class II heart failure as a result of an acute myocardial infarction is prescribed to receive dobutamine. What specific response(s) should the nurse expect to see if this therapy is successful?

*** A) Increased heart rate, increased pulse quality**

B) Decreased heart rate, increased pulse quality

C) Decreased heart rate, decreased pulse quality

D) Increased heart rate, decreased pulse quality

547. The client is experiencing infrequent bouts of premature atrial contractions (PACs) that are accompanied by heart palpitations. These episodes resolve spontaneously without treatment. What instructions should be included in a teaching plan for this client?

*** A) Limit or abstain from caffeine.**

B) Lie on your left side until the attack subsides.

C) Use your oxygen anytime you experience PACs.

D) Take your quinidine twice daily on the days you experience palpitations.

548. The client’s ECG reveals tachycardia with a heart rate of 170 beats/min that was initiated after a premature atrial contraction. This rhythm resolved spontaneously without treatment. What is the nurse’s interpretation of this finding?

*** A) The client may have a potassium imbalance**

B) Paroxysmal supraventricular tachycardia (PSVT)

C) Ventricular tachycardia

D) Ventricular fibrillation

549. The client is experiencing a heart rate of 200 beats/min. The ECG pattern demonstrates absent P waves and normal and consistent QRS complexes and duration. What is the nurse’s interpretation of these findings?

*** A) Supraventricular tachycardia**

B) Ventricular tachycardia

C) Second-degree heart block

D) Premature ventricular contraction.

550. The client has supraventricular tachycardia lasting several hours. The nurse is prepared to administer which of the following drugs/agents as an intervention for this dysrhythmia?

*** A) Diltiazem**

B) Atropine

C) Epinephrine

D) Lidocaine

551. The client has a consistent and regular slow heart rate, averaging 56 beats/min. The client has no adverse symptoms associated with this bradycardia and is not being treated for it. Which of the following activity modifications should the nurse suggest to avoid further slowing of the heart rate?

*** A) Avoid bearing down or straining while having a bowel movement**

B) Make certain that your bath water is warm (100° F).

C) “Avoid strenuous exercise, such as running, during the late afternoon.”

D) “Limit your intake of caffeinated drinks to no more than two cups per day.”

552. Which of the following clients is most at risk for atrial fibrillation?

*** A) 42-year-old woman 3 days postoperative from coronary artery bypass surgery**

B) 48-year-old man taking an aspirin daily for prevention of coronary thrombosis.

C) 70-year-old woman 1 day postoperative from a carotid endarterectomy

D) 64-year-old man with diabetes mellitus and chronic hypertension

553. What physical assessment findings would be expected in a client with atrial flutter with a rapid ventricular response?

*** A) Palpitations, shortness of breath, and anxiety**

B) The presence of a split S1 and rhonchi

C) Halo vision, anorexia, and nausea and vomiting

D) Diaphoresis, hypertension, and mental status changes.

554. Which alteration when manifested in a client with atrial fibrillation should alert the nurse to the possibility of an embolic stroke?

*** A) Speech alterations**

B) Distended neck veins

C) Hyperresponsive deep tendon reflexes

D) A pulse deficit

555. A nurse is caring for a client who had a myocardial infarction (MI) 4 days ago. The monitor displays premature ventricular contractions (PVCs) at the rate of 5 per minute. What other dysrhythmia may develop as a result of this?

*** A) Ventricular tachycardia**

B) Sinus tachycardia

C) Rapid atrial flutter

D) Atrioventricular junctional rhythm

556. A client's ECG shows slow, irregular QRS complexes that are wide and regular atrial rhythm. What is the nurse's interpretation of this observation?

*** A) AV conduction block**

B) Atrial flutter

C) Ventricular flutter

D) Junctional dysrhythmia

557. What A client's ECG tracing shows normal sinus rhythm followed by a complex of three PVCs, with a return to normal sinus rhythm. What is the nurse's interpretation of this finding?

*** A) Nonsustained ventricular tachycardia**

B) Ventricular escape rhythm

C) Atrial flutter

D) Trigeminy

558. A client with myocardial ischemia is having frequent PVCs. What medications should the nurse be prepared to administer?

*** A) Lidocaine**

B) Dobutamine

C) Atropine sulfate

D) Lanoxin

559. A client undergoing a colonoscopy experiences a decrease in pulse rate from 76 beats/min to 50 beats/min. What medication should the nurse be prepared to administer?

*** A) Atropine**

B) Lidocaine

C) Epinephrine

D) Procainamide

560. The nurse is preparing a client for an ultrasound of the abdomen. What statement by the client indicates a need for further teaching?

*** A) “I will empty my bladder completely before the test.”**

B) “I will lie on my back during the test.”

C) “I will lie still during the test.”

D) “I will need to consume extra liquids.”

561. Which of the following complications would the nurse expect to observe in the client with progressive dysphagia and a history of achalasia?

*** A) Weight loss**

B) Pneumothorax

C) Esophageal varices

D) Aneurysm

562. The nurse is caring for a client who has undergone esophageal dilation for achalasia. Two hours later, the client develops chest and shoulder pain. What would be the nurse’s best action?

*** A) Notify the physician.**

B) Administer an analgesic.

C) Document the finding as the only action.

D) Reposition the client.

563. The nurse is performing an assessment of a client with suspected esophageal cancer. Which statement made by the client is indicative of a more advanced disease?

*** A) “I have difficulty with swallowing liquids.”**

B) “I have difficulty swallowing solids, particularly meat.”

C) “I usually have a sticking feeling in my throat.”

D) “I have difficulty swallowing soft foods.”

564. A client with esophageal cancer and dysphagia states it has become more difficult to swallow, and the client has experienced several choking episodes during meals. What strategy would the nurse recommend to assist this client in obtaining adequate nutrition?

*** A) Encourage the client to eat semisoft foods and thickened liquids.**

B) Tell the client that artificial feeding will now be required.

C) Instruct the client to drink only clear liquids.

D) Monitor caloric intake.

565. In assessing a client with esophageal cancer being treated with radiation therapy, what finding would alert the nurse to a possible complication of this treatment?

*** A) Worsening of dysphagia or odynophagia**

B) Development of nausea or vomiting

C) A profound feeling of tiredness

D) Redness of the skin at the site of radiation

566. On assessment, the nurse notes the presence of bloody nasogastric tube drainage from a client who underwent an esophagogastrostomy 2 days ago. What conclusion should the nurse draw from this assessment?

*** A) The client has developed bleeding at the suture line.**

B) The client's nasogastric tube requires irrigation.

C) The drainage is as expected for this time period.

D) The client's nasogastric tube requires repositioning.

567. Which dietary instructions should be included in a teaching plan for the client newly diagnosed with diverticula?

*** A) "You should eat soft foods and smaller meals because they are better tolerated."**

B) "You have no dietary restrictions; you may eat anything you wish."

C) "You should avoid drinking liquids with your meals."

D) "You should avoid dairy products."

568. A client with a gastric ulcer develops a sudden, sharp pain in the mid-epigastric region. On assessment, the nurse notes that the abdomen is tender and rigid. What is the nurse's priority action?

*** A) Notify the health care provider.**

B) Place the client in a knee-chest position.

C) Prepare to administer an H2 antagonist.

D) Increase the IV fluid rate.

569. A nurse is collecting initial data from a 75-year-old client with a duodenal ulcer. What would be the first symptom or clinical manifestation the nurse would expect to see in this client?

*** A) Melena**

B) Syncope

C) Hematemesis

D) Pain

570. What instructions should be given to a client preparing to undergo urea breath testing?

*** A) “You may not eat or drink after midnight on the night before the test.”**

B) “You should drink eight glasses of water 3 hours before the test.”

C) “You will need to have an IV started just before the test.”

D) “You will be given a sedative, so you will need someone to drive you home.”

571. Which statement made by the client indicates an understanding of dietary management for dumping syndrome?

*** A) “I will eat a high-fat, low-carbohydrate, high-protein diet.”**

B) “I will eat a low-fat, low-carbohydrate, high-protein diet.”

C) “I will eat a high-fat, high-carbohydrate, low-protein diet.”

D) “I will eat a high-fat, high-carbohydrate, high-protein diet.”

572. Which statement concerning the etiology of irritable bowel syndrome is true?

*** A) The exact cause is unknown.**

B) It is a hereditary disorder.

C) It results from chronic inflammation confined to the colon and rectum.

D) It is the result of an inflammatory process resulting in crater-like scarring throughout the intestinal tract.

573. A client with a mechanical bowel obstruction reports that the abdominal pain that was previously intermittent and colicky is now more constant. What would be the nurse’s priority action?

*** A) Notify the health care provider.**

B) Place the client in a knee-chest position.

C) Medicate the client with an opioid analgesic.

D) Measure the abdominal girth.

574. Which instructions should be included in the teaching plan for a client being discharged after the resolution of a mechanical obstruction resulting from fecal impaction?

*** A) “Eat a high-fiber diet and drink plenty of fluids.”**

B) “Make a weekly appointment for disimpaction.”

C) “Take any over-the-counter laxative to prevent constipation.”

D) “Give yourself a Fleet enema if you are unable to have a bowel movement.”

575. While assessing the abdomen of a client admitted for blunt abdominal trauma, the nurse notes the presence of ecchymosis present in the area protected by the seat’s lap belt. What should be the nurse’s next action?

*** A) Notify the health care provider.**

B) Percuss the abdomen.

C) Measure the abdominal girth.

D) Document the finding as the only action.

576. On percussion of the client with abdominal trauma, the nurse identifies resonance over the right flank while the client is in a left side-lying position. What does this finding indicate?

*** A) The client has a ruptured spleen.**

B) The client has an injury to the liver.

C) The client has retroperitoneal bleeding.

D) The client has a fractured rib.

577. What instructions should be provided to the client diagnosed with hemorrhoids?

*** A) “Increase your fluid intake and eat a diet high in fiber.”**

B) “Avoid sitz baths that can contaminate the lesions.”

C) “Use a stimulant laxative as needed.”

D) “Lie on your side at night to sleep.”

578. Which nursing intervention would be appropriate for a client posthemorrhoidectomy taking a sitz bath?

*** A) Place an ice bag on the client’s head during the sitz bath.**

B) Use a cool water temperature to reduce swelling.

C) Administer a stimulant laxative.

D) Administer the initial sitz bath within the first 6 hours postoperatively.

579. The client has undergone surgical placement of a pancreatic drainage tube to facilitate drainage of a pancreatic abscess. Which nursing intervention would prevent a complication resulting from this procedure?

*** A) Application of a skin barrier around the drainage tube**

B) Administration of pancreatic enzymes through the tube

C) Clamping the drainage tube every 2 hours

D) Placing the client in a right side-lying position

580. Which observation indicates to you that your client with COPD is effectively using interventions for airway clearance

*** A) The oxygen saturation is consistently above 88\%.**

B) The client consistently uses “pursed-lip” breathing.

C) The serum albumin level is within the normal range.

D) The client’s cough is nonproductive.

581. Which clinical manifestation in a client with a urinary tract infection alerts the nurse to the possibility of acute pyelonephritis?

*** A) Fever and chills**

B) Hematuria

C) Cloudy, dark urine

D) Burning on urination

582. The client with acute glomerular nephritis has periorbital edema. What additional assessment should the nurse obtain or perform with this client?

*** A) Auscultate breath sounds.**

B) Check blood glucose levels.

C) Measure deep tendon reflexes.

D) Test urine for the presence of protein.

583. The client with glomerular nephritis has a glomerular filtration rate (GFR) of 40 mL/min, as measured by a 24-hour creatinine clearance. What is the nurse's interpretation of this finding?

*** A) Reduced glomerular filtration rate, client at risk for fluid overload**

B) Reduced glomerular filtration rate, client at risk for dehydration

C) Excessive glomerular filtration rate, client at risk for fluid overload

D) Excessive glomerular filtration rate, client at risk for dehydration

584. The client with diabetes is visually impaired and wants to know if syringes can be prefilled and stored for use later. What is the nurse's best response?

*** A) "Yes, prefilled syringes can be stored for up to 3 weeks in the refrigerator in a vertical position with the needle pointing up."**

B) "Insulin reacts with plastic, so prefilled syringes must be made of glass."

C) "No, insulin cannot be stored for any length of time outside of the container."

D) "Yes, prefilled syringes can be stored for up to 3 weeks in the refrigerator, placed in a horizontal position."

585. What intervention should the nurse suggest to the diabetic client who self-injects insulin to prevent or limit local irritation at the injection site?

*** A) "Allow the insulin to warm to room temperature before injection."**

B) "Try to make the injection deep enough to enter muscle."

C) "Massage the site for 1 full minute after injection."

D) "Do not reuse needles."

586. The client who has just had a mastectomy for breast cancer is crying as the nurse enters the room. When asked why she is crying, the client responds “I know I shouldn't cry because this surgery may well save my life, but I was so pleased with my figure before and I know that things will not be the same.” What is the nurse’s best response?

*** A) “It is all right to cry. Mourning this loss is important in getting past this point.”**

B) “You're right. It is silly to carry on like this when a prosthesis is available.”

C) “Would you like to talk to someone who also has had a mastectomy?”

D) “How have you coped with difficult situations in the past?”

587. For which types of cancer is radiation therapy most effective?

*** A) Cancers that are localized to one tissue or body area**

B) Cancers of the blood, such as leukemia

C) Superficial cancers on the outside of the body

D) Cancers that are large, with evidence of distant metastasis

588. What is the most important precaution or advice the nurse should teach the client receiving radiation therapy for thyroid cancer with an injection of iodine-131 as an unsealed source?

*** A) “Do not share a toilet with other people for about three days.”**

B) “You are only radioactive when the radiation machine is turned on.”

C) “No special precautions are needed because this type of radiation is weak.”

D) “Avoid all contact with other people until the radiation device is removed.”

589. Which health problem in a woman who had radiation therapy 10 years ago for cancer in the right breast is most likely to be a consequence of the therapy?

*** A) Pathologic fracture of two ribs on the right chest**

B) Asthma

C) Myocardial infarction

D) Chronic esophagitis with gastroesophageal reflux

590. The bedridden client has cancer metastasis to the bone. Which intervention is most important for the nurse to implement to prevent injury for this client?

*** A) Using a lift sheet when repositioning the client**

B) Ensuring that the client's heels are not touching the mattress

C) Providing small, frequent meals that are rich in calcium and phosphorus

D) Applying pressure for a full 5 minutes after any intramuscular injections

591. The client with a diagnosis of lung cancer is scheduled to have a liver scan and asks why this procedure is being done. What is the nurse’s best response?

*** A) “The treatment for lung cancer is different if it has spread to the liver than if it is confined to only the lungs.”**

B) “Cigarette smoking can also cause liver cancer.”

C) “Some treatments are toxic to the liver and it is best to test liver function before these treatments are started.”

D) “An enlarged liver can interfere with cancer therapy, so the doctor wants to make certain of the liver's size and position before therapy is started.”

592. Whic Which pre-existing client problem or characteristic would preclude the use of radiation therapy for breast cancer treatment?

*** A) The client has severe arthritis and cannot assume the position needed for radiation therapy.**

B) The client is a Jehovah's Witness.

C) The client is over 75 years of age.

D) The client underwent a lumpectomy for the breast cancer one month ago.

593. The client scheduled to undergo radiation therapy for breast cancer asks why 6 weeks of daily treatment are necessary. What is the nurse's best response?

*** A) "Research has shown that more cancer cells are killed if the radiation is given in smaller doses over a longer time period."**

B) "Your cancer is widespread and requires more than the usual amount of radiation treatment."

C) "The cost of giving larger doses of radiation for a shorter period of time is unjustified by the results."

D) "It is less likely that your hair will fall out or that you will become anemic if the radiation is given in small doses over a longer time period."

594. The client is a 56-year-old woman receiving brachytherapy with a sealed radiation source for cervical cancer. Which nurse should be assigned to provide personal care to this client while the radiation source is within the client?

*** A) The 30-year-old nurse, who is experienced with brachytherapy and efficient in her work**

B) The 35-year-old male nurse, who has never worked with a client receiving brachytherapy

C) The 28-year-old pregnant nurse, who has special expertise in oncology

D) The 60-year-old nurse, who is also assigned to provide care to 2 other clients receiving brachytherapy

595. Upon entering the room of a 74-year-old client receiving brachytherapy for cervical cancer, the nurse finds that the radiation implant and the position-holding devices are in the client's bed. What is the nurse's first best action?

*** A) Use tongs to place the implant into the radiation container.**

B) Assess the client's mental status.

C) Notify the physician and move the client to a different room.

D) Don gloves and attempt to reposition the implant and position-holding device.

596. For which type of cancer is chemotherapy most beneficial?

*** A) Cancers that are large, with evidence of distant metastasis**

B) Brain tumors

C) Superficial cancers on the outside of the body

D) Cancers that are localized to one tissue or body area

597. The client who is receiving intravenous chemotherapy (into a peripheral line) with an agent that is an irritant says that her arm burns terribly at and around the IV site. What is the nurse's best first action?

*** A) Discontinue the infusion.**

B) Check for a blood return.

C) Slow the rate of infusion.

D) Apply a cold compress to the site.

598. The client receiving intravenous chemotherapy asks the nurse why the nurse is wearing a mask, gloves, and gown when giving the drugs to the client. What is the nurse's best response?

*** A) The drugs are powerful and I handle them every day. The clothing protects me from accidentally absorbing these strong, cancer-killing drugs."**

B) "These drugs will reduce your immune response and, with these coverings, I am protecting you from getting an infection from me."

C) "Because your immunity is reduced by this therapy, I am preventing the spread of infection from you to me or any other client here."

D) "The hospital policy is for any nurse giving these drugs to wear a gown, glove, and mask to prevent other people from getting cancer."

599. The client’s spouse reports that the last time the client received lorazepam (Ativan) before receiving chemotherapy, the client didn’t remember the drive home. What is the nurse’s best action?

*** A) Explain to the client and spouse that this is a normal response to the drug and that the client shouldn’t drive home.**

B) Hold the dose of lorazepam for this round of chemotherapy until the client is seen by the physician.

C) Perform a Mini-Mental Status Examination and assess the client’s pupillary reflexes before administering the lorazepam.

D) Document the response as the only action.

600. The client is receiving chemotherapy with an agent that causes thrombocytopenia. Which intervention is most important to teach the client for this problem?

*** A) “Use a soft-bristled toothbrush and do not floss.”**

B) “Eat a low-bacteria diet.”

C) “Take your temperature daily.”

D) “Avoid using mouthwashes that contain alcohol.”

601. The client has chemotherapy-induced thrombocytopenia. Which agent should the nurse be prepared to administer?

*** A) Oprelvekin (Neumega)**

B) Filgrastim (Neupogen)

C) Epoetin alfa (Procrit)

D) Sargramostim (Prokine)

602. The client with chemotherapy-induced bone marrow suppression has received filgrastim (Neupogen). Which laboratory finding or clinical manifestation indicates that this therapy is effective?

*** A) The client's segmented neutrophil count is 3500/mm3.**

B) The client's hematocrit is 28\%.

C) The client's hematocrit is 38\%.

D) The client's segmented neutrophil count is 2500/mm3.

603. What is the priority nursing diagnosis for the client experiencing chemotherapy-induced anemia?

*** A) Fatigue related to decreased cellular oxygenation**

B) Risk for Injury related to poor blood clotting

C) Disturbed Body Image related to skin color changes

D) Imbalanced Nutrition, Less than Body Requirements related to anorexia

604. It is time for the client's third round of chemotherapy for colon cancer. After checking the client's white blood cell count, the decision is made to delay the treatment for an additional week because of the low white blood cell count and the increased risk for infection. The client is upset at the delay. What is the nurse’s best response?

*** A) “Try not to worry. Your counts will probably be high enough next week and the chemotherapy will work just as well then.”**

B) “This extra time will give your hair a chance to grow back in.”

C) “This is for the best. It is too dangerous to give you the chemotherapy now.”

D) “I will call the physician and request a prescription for something to calm your nerves.”

605. The client who has just been diagnosed with breast cancer asks why her treatment plan does not include the new drug, Herceptin, that she has read about. What is the nurse's best response?

*** A) "Your breast cancer does not have the protein that this drug works on, so you would not benefit from this therapy."**

B) "Your immune system is too weak to tolerate Herceptin."

C) "This drug is experimental and too dangerous for you to take before trying other therapies."

D) "Your breast cancer does not have the protein that this drug works on, so you would not benefit from this therapy."

606. For what type of cancer should the nurse be prepared to administer chemotherapy by the intrathecal route?

*** A) Brain tumor**

B) Lung tumor

C) Ovarian tumor

D) Prostate tumor

607. The client with prostate cancer is taking estrogen daily to control tumor growth. He reports that his left calf is swollen and painful. What is the nurse's best first action?

*** A) Measure the calf circumference and assess for Homan's sign.**

B) Instruct the client to keep the leg elevated for two days.

C) Apply ice to the calf after massaging it for at least 5 minutes.

D) Document this expected response to hormonal manipulation.

608. What is the priority nursing diagnosis for the client receiving interleukin-2 (IL-2) therapy for cancer?

*** A) Impaired Comfort related to drug side effect.**

B) Risk for Injury related to excessive bleeding

C) Deficient Fluid Volume related to persistent diarrhea

D) Risk for Infection related to drug-induced neutropenia

609. The client receiving tamoxifen asks how this therapy helps fight breast cancer. What is the nurse’s best response?

*** A) “The breast cancer cells need estrogen to continue growing. This agent blocks the receptors for estrogen, reducing its availability to the cancer cells.”**

B) “The breast cancer cells need estrogen to continue growing. This agent decreases your circulating levels of estrogen.”

C) “The breast cancer cells need estrogen to continue growing. This agent causes you to secrete testosterone instead of estrogen.”

D) “The breast cancer cells need estrogen to continue growing. This agent kills off both the normal estrogen-secreting cells and the cancer cells.”

610. Which laboratory result in a client with cancer who has gained 2 pounds in 1 day suggests the possibility of SIADH?

*** A) Serum sodium of 120 mmol/L**

B) Serum potassium of 5.2 mmol/L

C) Hematocrit of 40\%

D) BUN of 10 mg/dL

611. The client with hypercalcemia from advanced cancer is being treated with intravenous mithramycin. Which clinical manifestation indicates to the nurse that the treatment is effective?

*** A) Bowel sounds are present and active in all four quadrants.**

B) The client's serum sodium level is 138 mmol/L.

C) The pulse rate is 68 and bounding.

D) Urine output has increased.

612. Which intervention is most important for the nurse to implement to prevent complications from tumor lysis syndrome during chemotherapy?

*** A) Ensure that the client has a fluid intake of 3000 to 5000 mL per day.**

B) Monitor electrocardiograph rhythms every hour during therapy.

C) Apply pressure to all injection sites for 5 minutes.

D) Assist the client in all ambulatory activities.

613. Which clinical manifestation indicates that the client's superior vena cava syndrome is resolving?

*** A) The client's hands are less swollen.**

B) Breath sounds are clear bilaterally.

C) The client's back pain is relieved.

D) Pedal edema is present.

614. The client is a 64-year-old man with late-stage colon cancer being cared for at home by his 63-year-old wife. Which nursing diagnosis has the highest priority for teaching the wife how to manage symptoms?

*** A) Acute Pain related to metastasis**

B) Imbalanced Nutrition, Less than Body Requirements related to fatigue and increased metabolism

C) Constipation related to decreased activity and medication regimen

D) Activity Intolerance related to dyspnea and fatigue

615. Which client should the nurse consider at an increased risk for infection as a result of a chronic health problem?

*** A) 28-year-old client with type 1 diabetes mellitus**

B) 28-year-old client who wears contact lenses

C) 48-year-old client with a known hypersensitivity to latex

D) 48-year-old client taking analgesics for migraine headaches

616. Which client is at greatest risk for development of a bacterial cystitis?

*** A) Older female client not taking estrogen replacement**

B) Older male client with mild congestive heart failure

C) Middle-aged female client who has never been pregnant

D) Middle-aged male client who takes an aspirin every day

617. Which disorder is caused by a microorganism that uses the bloodstream as its main portal of entry?

*** A) Lyme disease**

B) Syphilis

C) Hepatitis A

D) Genital herpes

618. What type of protection should the nurse use in addition to standard precautions when caring for a client who has meningococcal meningitis?

*** A) Airborne precautions**

B) Contact precautions

C) Droplet precautions

D) Sharps precautions

619. Under which circumstance is washing hands with soap and water more necessary than just using an alcohol-based hand rub for decontaminating the hands?

*** A) After providing direct care to an older client who is taking antibiotics**

B) After removing the gloves after starting an IV on an adult client

C) Before donning sterile gloves when preparing to insert a urinary catheter

D) Before carrying a dinner tray to a client who is infected with methicillin-resistant S. aureus

620. How does palliative surgery differ from any other type of surgery?

*** A) Palliative surgery is performed to provide temporary relief of distressing symptoms rather than to cure a problem or condition.**

B) The main purpose is cosmetic in nature rather than functional repair or comfort.

C) There are fewer risks associated with palliative surgery than with any other type of surgery.

D) The outcomes of palliative surgery cannot be ensured to produce the desired effect or restoration of functional ability.

621. In which situation is the nurse performing the role of client advocate during the preoperative period?

*** A) Assuring the client whose religion does not permit blood transfusions that his or her wishes will be followed**

B) Serving as a witness to the informed consent procedure

C) Teaching the client how to perform coughing and deep breathing exercises

D) Ensuring that the client's impaired hearing problem is clearly communicated to the entire surgical team

622. The client undergoing preoperative assessment before an elective procedure tells the nurse that she has been taking 10 mg of prednisone daily for rheumatoid arthritis. What is the nurse’s best action?

*** A) Notify the surgeon and anesthesiologist.**

B) Document the information as the only action.

C) Reschedule the surgery in 2 weeks when the client has cleared the drug from her system.

D) Suggest that the client switch to a nonsteroidal anti-inflammatory agent for pain relief.

623. The client tells the nurse during the preoperative history that he is a three-pack a day cigarette smoker. This information alerts the nurse to which potential complication during the intraoperative and postoperative periods?

*** A) An increased risk for atelectasis and hypoxia**

B) A decreased tolerance to pain

C) A decreased clotting ability

D) An increased risk for excessive scar tissue formation

624. On admission to the preoperative area, the client who is scheduled for a hip replacement tells the nurse that she has made three autologous blood donations for this surgery in the past 5 weeks. What is the nurse's best action?

*** A) Call the laboratory to ensure that the blood is physically available at the operating facility.**

B) Check the client's international normalized ratio (INR).

C) Ensure that the client has given consent to receive blood if a transfusion is necessary.

D) Inform the client that an autologous transfusion does not eliminate her risk for the development of bloodborne diseases.

625. On discharge, the nurse teaches the patient to observe for signs of surgically induced hypothyroidism. The nurse would know that the patient understands the teaching when she states she should notify the MD if she develops:

*** A) Progressive weight gain**

B) Insomnia and excitability

C) Dry skin and fatigue

D) Intolerance to heat

626. If a client has severe bums on the upper torso, which item would be a primary concern?

*** A) Frequently observing for hoarseness, stridor, and dyspnea**

B) Establishing a patent IV line for fluid replacement

C) Administering antibiotics

D) Debriding and covering the wounds

627. Contractures are among the most serious long-term complications of severe burns. If a burn is located on the upper torso, which nursing measure would be least effective to help prevent contractures?

*** A) Helping the client to rest in the position of maximal comfort**

B) Avoiding the use of a pillow for sleep, or placing the head in a position of hyperextension

C) Encouraging the client to chew gum and blow up balloons

D) Changing the location of the bed or the TV set, or both, daily

628. Ms. Sy undergoes surgery and the abdominal aortic aneurysm is resected and replaced with a graft. When she arrives in the RR she is still in shock. The nurse's priority should be

*** A) Assessing her VS especially her RR**

B) Monitoring her hourly urine output

C) Putting several warm blankets on her

D) Placing her in a trendeleburg position

629. Forty-eight hours after a burn injury, the physician orders for the client 2 liters of IV fluid to be administered q12 h. The drop factor of the tubing is 10 gtt/ml. The nurse should set the flow to provide:

*** A) 28 gtt/min**

B) 18 gtt/min

C) 32 gtt/min

D) 36 gtt/min